csurma · aorma
California State University Risk Management Authority
Auxiliary Organizations Risk Management Alliance

2026 BENEFITS

Your Benefits, your way!

Who is Eligible?

Employees

You are eligible if you are a full time regular (FTR) or part time regular (PTR) employee working 30 or more hours per week.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).
- For additional information, please refer to the benefit booklets for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to): Parents, grandparents, and siblings.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire. You must enroll within 31 days of becoming eligible. If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

When you can enroll

New Hire Enrollment	New hire coverage begins on the **1st day of the month after** your hire date.You must enroll before the last day of the month after your hire date.
Open Enrollment	The one time each year that you can make changes to your benefits for any reason. Open enrollment is generally held in October every year for a January 1st effective date.
Qualifying Life Event	A qualifying life event is a significant change in your life that allows you to make changes to your benefits outside of open enrollment. See the next page for more information.

OPEN ENROLLMENT

Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents, and enroll or re-enroll in Flexible Spending Accounts. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2026, unless you experience an eligible life event.

Open Enrollment begins October 6, 2025, through October 24, 2025

Any changes made during OE will be effective on January 1, 2026.

Do I need to enroll?

If you do not have any changes to make to your 2026 benefits and you do not want to enroll in a 2026 Flexible Spending Account, **no action is required.**

What's new or changing

At University Corporation we are committed to continuously reevaluating our benefits program to offer you and your family comprehensive and affordable option. This year we would like you to be aware of changes in costs for your benefits and new benefit offerings:

- Navitus-Replaces ESI for all Anthem members pharmacy benefit
- Digbi Replaces Livongo for all Anthem members.
- Premium Changes

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 31 days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 31-day period, you will not be able to add the dependent(s) until the next open enrollment period.

MEDICAL

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video

- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **OUT-OF-POCKET MAXIMUM:** Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

UNDERSTANDING PLAN TYPES

University Corporation offers 2 medical plan types so that you can pick the plan that best fits your budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HMO Health Maintenance Organization	**PPO** Preferred Provider Organization
Deductible		✔
Out-of-Network Care Covered		✔
Referral Needed to see Specialist	✔	
Must select Primary Care Physician	Kaiser: ✔ Anthem: ✔	
Pros	• More predictable costs	• You can go anywhere, whether in-network or out-of-network
Cons	• Less flexibility • No out-of-network coverage • May have to select Primary Care Physician	• You pay more for out-of-network providers

Click to play video

All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

Kaiser HMO vs Anthem HMO

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Kaiser HMO $20
	In-Network
Plan Year Deductible[1]	
Individual	None
Family	None
Embedded/Aggregate[2]	Embedded
Plan Year Out-of-Pocket Maximum[1]	
Individual	$1,500
Family	$3,000
Embedded/Aggregate[3]	Embedded
Office Visit	
Primary Care	$20
Specialist	$20
Online Visit	No Charge
Preventive Services	No Charge
Chiropractic (up to 30 visits/year)	$10
Lab and X-ray	No Charge
Urgent Care	$20
Emergency Room	$100 (waived if admitted)
Inpatient Hospitalization	No Charge
Outpatient Surgery	$20 / procedure
PRESCRIPTION DRUGS (Navitus)	
Plan Year Deductible	None
Out-of-Pocket Maximum	Combined with Medical
Retail- 30 Day Supply	
Generic	$10
Brand	$30
Specialty	20% up to $150
Mail Order- 100 Day Supply	
Generic	$20
Brand	$60
Specialty	N/A

	Anthem HMO Full $20
	In-Network
Plan Year Deductible[1]	
Individual	None
Family	None
Embedded/Aggregate[2]	Embedded
Plan Year Out-of-Pocket Maximum[1]	
Individual	$1,500
Family	$3,000
Embedded/Aggregate[3]	Embedded
Office Visit	
Primary Care	$20
Specialist	$20
Online Visit	$20
Preventive Services	No Charge
Chiropractic (up to 60 visits/year)[4]	$20
Lab and X-ray	No Charge
Urgent Care	$20 (waived if admitted)
Emergency Room	$100 (waived if admitted)
Inpatient Hospitalization	$200 / Admit
Outpatient Surgery	$100 / Surgery
PRESCRIPTION DRUGS (Navitus)	
Plan Year Deductible	None
Out-of-Pocket Maximum	Combined with Medical
Retail- 30 Day Supply	
Tier 1	$5
Tier 2	$20
Tier 3	$60
Specialty	20% up to $150
Mail Order- 90 Day Supply	
Tier 1	$5
Tier 2	$40
Tier 3	$120
Specialty	20% up to $300

[1]Deductibles and out-of-pocket maximums accumulate on a plan year January 1st through December 31st.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[4] 30 day supply only

Kaiser Resources

One Pass Select Affinity by Optum

Through One Pass Select Affinity from Optum members can choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources. Members can choose the plan that fits their needs, with competitive plans starting at $10 per month. Members that sign up can also access the Optum Additional service include healthy meal delivery and 20% discounts on chiropractors, acupuncturists and massage therapists. Learn more at healthy.kaiserpermanente.org/health-wellness/fitness-offerings.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (866) 454-8855.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Visit healthy.kaiserpermanente.org/get-care/traveling to learn about what to do if you need emergency or urgent care during your trip.

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care's highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Get started today at kp.org/selfcareapps.

Finding a Kaiser Provider

To find a Kaiser Permanente provider near you, please visit kp.org or call (800) 464-4000.

My Health Manager

Stay engaged with your health and simplify your busy life by using the Kaiser Website or download the Kaiser Permanente app from the App Store℠ or Google Play®.

Kaiser Resources, Cont.

Online wellness tools

Visit healthy.kaiserpermanente.org/health-wellness for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more – all at no cost.

Health classes

Sign up for health classes and support groups at many of our facilities. See what's available near you at healthy.kaiserpermanente.org/health-wellness/classes-programs– some may require a fee.

Personal wellness coaching

Get help reaching your health goals. Work one on one with a wellness coach by phone at no cost. Find out more at healthy.kaiserpermanente.org/health-wellness/wellness-coaching or call (866) 862-4295.

Anthem Premier PPO 80

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Anthem Premier PPO 80	
	In-Network	**Out-of-Network**
Plan Year Deductible[1] Individual Family Embedded/Aggregate[2]	 $500 $1,000 Embedded	 $500 $1,000 Embedded
Plan Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[3]	 $3,500 $7,000 Embedded	 $3,500 $7,000 Embedded
Office Visit Primary Care Specialist	 $20 $20	 40%[4] 40%[4]
Online Visit	$10 (primary care) $20 (specialist care)	40%[4]
Preventive Services	No Charge	40%[4]
Chiropractic (up to 30 visits/year)	$20	40%[4]
Lab and X-ray	20%[4]	40%[4] ($350 max / day)
Urgent Care	$20	40%[4]
Emergency Room	$50 copay then 20% (waived if admitted) [4]	$50 copay then 20% (waived if admitted) [4]
Inpatient Hospitalization	20%[4]	40%[456]
Outpatient Surgery	20%[4]	40%[4] ($350 max / day)
PRESCRIPTION DRUGS (Navitus)		
Plan Year Deductible	Combined with Medical	Combined with Medical
Out-of-Pocket Maximum	$2,350 / $4,700	Unlimited
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Specialty	 $5 $20 $60 20% up to $150	 $5 $20 $60 20% up to $150
Mail Order- 90 Day Supply Tier 1 Tier 2 Tier 3 Specialty	 $5 $40 $120 20% up to $300	 Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a plan year from January 1st through December 31st.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[4]After deductible.
[5]Member is responsible for an additional $500 copay if prior authorization is not obtained from Anthem
[6]Coverage for Out-of-Network Provider is limited to $600 maximum per day for non-emergency admission

Anthem Premier PPO 90

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	Anthem Premier PPO 90	
	In-Network	**Out-of-Network**
Plan Year Deductible[1] Individual Family Embedded/Aggregate[2]	 $500 $1,000 Embedded	 $500 $1,000 Embedded
Plan Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[3]	 $2,500 $5,000 Embedded	 $2,500 $5,000 Embedded
Office Visit Primary Care Specialist	 $20 $20	 40%[4] 40%[4]
Online Visit	$10 (primary care) $20 (specialist care)	40%[4]
Preventive Services	No Charge	40%[4]
Chiropractic (up to 30 visits/year)	$20	40%[4]
Lab and X-ray	10%[4]	40%[4] ($350 max / day)
Urgent Care	$20	40%[4]
Emergency Room	$50 copay then 10% (waived if admitted) [4]	$50 copay then 10% (waived if admitted) [4]
Inpatient Hospitalization	10%[4]	40%[456]
Outpatient Surgery	10%[4]	40%[4] ($350 max / day)
PRESCRIPTION DRUGS (Navitus)		
Plan Year Deductible	Combined with Medical	Combined with Medical
Out-of-Pocket Maximum	$1,500 / $3,000	Unlimited
Retail- 30 Day Supply Tier 1 Tier 2 Tier 3 Specialty	 $5 $20 $60 20% up to $150	 $5 $20 $60 20% up to $150
Mail Order- 90 Day Supply Tier 1 Tier 2 Tier 3 Specialty	 $5 $40 $120 20% up to $300	 Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a plan year from January 1st through December 31st.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[4]After deductible.
[5]Member is responsible for an additional $500 copay if prior authorization is not obtained from Anthem
[6]Coverage for Out-of-Network Provider is limited to $600 maximum per day for non-emergency admission

Anthem Value Added Services

Take advantage of these value added services available to Anthem plan members to help you get and stay healthy.

Benefit Highlights	Availability & How To Get Started
Physical Therapy for Back or Joint Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. Available for preventative, acute, and chronic needs at no cost.	*PPO* **Call:** (855) 902-2777 **Visit** hingehealth.com/prism/
Hip, Knee & Spine Surgical Benefit & Breast Cancer Treatment Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel for patient and companion, and medical bills. Oncology benefit also available; guidance for all cancers; treatment for Breast Cancers.	*PPO* **Visit** carrumhealth.com
Medicine to treat Diabetes, Obesity & GI **Digbi Health** Access personalized digital care programs that utilize genetic and gut microbiome analysis to address obesity, diabetes, digestive disorders, and related conditions. Services include at-home DNA and gut biome testing, continuous glucose monitoring, personalized nutrition and lifestyle recommendations, access to health coaches, plus medically managed weight loss programs.	*PPO* **Call:** (866) 344-2189 **Visit** digbihealth.com/prism
Free Generic Maintenance Medications **Rx 'N Go** As part of your benefits, you have the option to receive up to a 90-day supply of generic maintenance medication by mail at no cost to you ($0 copay, $0 shipping) through a convenient program called, Rx 'n Go.	*PPO* **Call:** (888) 697-9646 **Visit** rxngo.com
Discount Medications **GoodRx** Discounts on medications for non-benefit eligible employees. GoodRx allows you to simply and easily search for retail pharmacies that offer the lowest price for specific medications.	*All non-benefit eligible employees* **Members Call:** (888) 799-2553 **Pharmacies Call:** (844) 857-4351 **Visit** gold.goodrx.com

Anthem Resources

Sydney Mobile App

Use Sydney™ Health to keep track of your health and benefits- all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

Building Healthy Families

Building Healthy Families offers personalized, digital support through the Sydney℠ Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

Virtual Primary Care

Through Anthem's LiveHealth Online Virtual Primary Care (LHO VPC), members can choose from board-certified, in-network PCPs, and have that same doctor take care of them overtime for treatments including chronic conditions, preventative care, and acute care, at no extra cost to the member. Copay will still apply.

24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call the number on the back of your ID card.

Anthem ID Cards

For PPO plans, one ID card will be issued to subscriber and one to spouse/domestic partner. Two cards will be issued in the subscriber's name for subscriber plus child(ren) contracts. ID cards with child dependent names can be requested by calling the member service number on the ID card. For HMO plans all members will receive an ID card. All Anthem Members will also be issued a Navitus ID card to access pharmacy benefits.

Provider Finder

To find a provider in your plan network, please visit anthem.com/ca/prism/home.

NEW! Anthem Total Health Connections

Helping you and your family feel confident and protected

Employees enrolled in an Anthem medical plan have access to Total Health Connections which provides you and your family with a dedicated Family Advocate — a personal health champion who offers proactive, compassionate, and no-cost support for everyday and emergency health needs. They can help you:

- Find and schedule care with top doctors and facilities in your plan
- Manage preventive care and chronic conditions
- Understand and use your health plan benefits
- Get quick pre approvals for urgent treatments
- Access in-house clinical experts who collaborate with your doctor to create a personal care plan

Focus on your whole health

Whole health also includes your mental health, along with social and community needs. Your dedicated Family Advocate can also connect you with community resources to help with food, childcare, transportation, and other social, financial, or mental health concerns.

A connected health record

You and your Family Advocate, doctors, and pharmacist all have access to the most up-to-date information on your health in a single record. These real-time insights can help improve your care and may lower your healthcare costs over time.

Sydney℠ Health App

Chat with your Family Advocate on our Sydney℠ Health mobile app. The Sydney℠ Health app also gives you a quick way to:

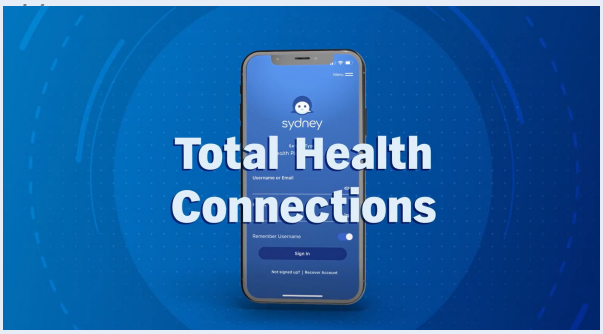
- Use your digital ID card
- Track your health goals and activities
- Check costs and view health plan details
- Access virtual care through video visits or chat

Get Started Today

Download or log in to the Sydney℠ Health mobile app or visit sydneyhealth.com to get started.

Watch the video to learn more about how to get connected with your Family Advocate and access the resources available via the Sydney℠ Health app.

Click to play



NEW! Digbi Health - Diabetes, Obesity & GI Care for Anthem Members

Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you're managing your weight, Type 2 Diabetes, digestive health, or taking GLP-1s for weight management, Digbi is here to support you with care tailored to your biology. Digbi Health is available at no cost for eligible members covered by Anthem through your employer.

This program includes:

- Gut & Gene Testing Kits
- Glucose Monitoring Device
- Tailored Meals
- Health Coach
- GLP-1s for weight management

Contact Digbi at prism@digbihealth.com or at (866) 344-2189 if you have any questions.

GLP-1 Eligibility

Eligibility requirements for accessing GLP-1s for weight management:

- 18 years or older and enrolled in Anthem (Mandatory).
- BMI 40 or higher without any comorbidity (OR)
- BMI 35 - 39 with at least one related comorbidity (OR)
- Mandatory: If you're on a GLP-1 for weight management, you should have lost 5% weight within 90 days of starting them.
- Digbi to be the sole prescriber for all weight loss medications.

Get Started

1. Check your eligibility and sign up for the program at digbihealth.com/prism.
2. If you are eligible, download mobile app -onelink.to/digbi.
3. On the app, please confirm shipping address and answer onboarding questions - your kits will be ordered to your address, automatically.
4. Starting January 1, 2026, you will have 90 days to go through Digbi Health's Reauthorization for weight management GLP-1 medication based on the new eligibility criteria.

Digbi Health App

- **Get at-home Test Kits -** Within a week, you'll receive a comprehensive testing kit including a Genetic Test, a Gut Microbiome Test, and an Abbott Libre Continuous Glucose Monitor. Please follow instructions to collect samples and return kits using pre-labeled shipping.
- **Sync your Health Apps -** Connect Apple or Google Health Apps with the Digbi App. Navigate to settings, choose "Health", then connect by tapping "Refresh" under "Apple Health".
- **Say hi to your Coach! -** Tap the 'Coach' button at the bottom to start engaging with your health coach on the app and upload meal pictures for scoring while you await test results.

Prescription Drugs – Navitus – Anthem Members

Filling Your Prescriptions

Anthem members have access to prescription drug coverage through Navitus.

- **Network Pharmacy –** Most independent and all major chain pharmacies, are part of your benefit network.
- **Costco Mail Order –** A 90-day supply of maintenance medications can be mailed right to your door. You don't need to be a Costco member to use their pharmacies. Just register online at pharmacy.costco.com or call (800) 607-6861 to get started.
- **Specialty Pharmacy -** Lumicera Health Services, our specialty pharmacy partner, provides a high level of personalized care for members with complex conditions. Their clinical team will help you manage side effects and reduce complications, so you can focus on the things that matter most. Visit lumicera.com/patients/ or call (855) 847-3553 for more information.

Member Portal & App

Go to navitus.com/members to access the member portal or download the Navitus mobile app. Register for your account, if you haven't already done so. Log into the Navitus member portal and app with the same username and password. Once registered, click Sign In, then enter your login details and password. From here you can:

- View or print your member ID card
- Perform a Drug Search for coverage details
- Find drug prices and pharmacy locations
- Easily track your medication history

Simplifying Prior Authorization, Step Therapy & Exception to Coverage

There are certain conditions and medications which require extra steps to gain approval to fill the prescription, but Navitus tries to make it as easy as possible.

Simplifying Prior Authorization, Step Therapy & Exception to Coverage

There are certain conditions and medications which require extra steps to gain approval to fill the prescription, but Navitus tries to make it as easy as possible.

- **Prior Authorization (PA) –** Some prescriptions require prior authorization to be filled, which your health care provider will need to help facilitate. Drugs that need prior authorization are listed on your formulary with a PA. Most prior authorization requests are reviewed within two business days and urgent requests within one business day.
- **Step Therapy –** When there's an effective alternative available that's less expensive for you, you may be asked to try that before a more expensive prescription is authorized.
- **Exception to Coverage (ETC) –** If a drug isn't approved, you and your doctor can submit an ETC request showing alternative medications aren't effective or suitable for your personal situation.
- **Coverage Details -** If there are any limits or requirements on your medications like the ones listed above, a Coverage Details button will appear on the medicine's description page in the portal. Clicking on that button will outline what's needed to get the prescription filled.

Navitus Customer Care

Carrier ID: NVPSM

Phone: 855-847-1035

Website: https://benefitplans.Navitus.com/NVPSM

Available 24 hours a day, 7 days a week; Closed Thanksgiving & Christmas

FIND A PROVIDER MEDICAL

Medical - Anthem

1. Log in or register at anthem.com/ca
2. Navigate to and select “Find Care”
3. Click on Basic Search as a guest
4. Under Select the type of plan or network – Medical Plan or Network
5. Under Select State, Enter California (HMO and Prudent Buyer Only) or the state where you reside (National PPO Only)
6. Enter what type of plan you want to search with (Medical - Employer-Sponsored)
7. Select your plan
    A. California Members
        1) Full HMO $20 – Blue Cross HMO (CACare) Large Group Network
        2) Premier PPO 80 – Prudent Buyer PPO/EPO
        3) Premier PPO 90 – Prudent Buyer PPO/EPO
8. Click Continue
9. Next, Enter the City, County, or Zip
10. Next, choose who you like to see. You can search for a doctor by specialty or by name
11. Next, select a provider for more details

Medical - Kaiser

1. Go to https://healthy.kaiserpermanente.org/doctors-locations
2. Select your state
3. Select Search for and choose either doctors or locations
4. Type in ZIP code
5. Click on Search

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

DO YOU PAY FOR DEPENDENT CARE?

Look in the Financial Wellness section for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through benxcel.

How the FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,200, the 2026 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/2026 and 12/31/2026 and claims must be submitted for reimbursement no later than 03/31/2027. If you don't spend all the money in your account, you can rollover up to $640 to use the following year. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- **You must re-enroll in this program each year.**
-

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution		
$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings
$120,000 Annual Pay, with $2,750 FSA Contribution		
$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings
Your tax savings may vary depending on tax filing status and other variables		

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by benxcel.

Here's how the DCFSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Turning 65? Understand Your Medicare Options

Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65.

Alliant MEDICARE SOLUTIONS
A Non-Government Entity

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

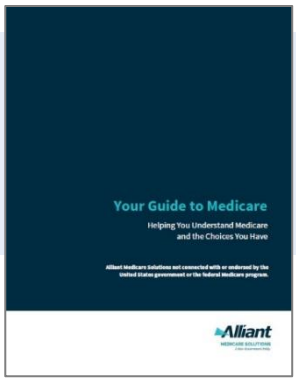
Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More



Your Guide to Medicare

Medicare 101 Video

Social Security Planning Video

alliantmedicaresolutions.com

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Potential Insurance Cost Savings

With Alliant Individual Health Solutions (AIHS), affordable health insurance is within reach.

Alliant
INDIVIDUAL HEALTH SOLUTIONS

Could your family get health insurance subsidies?

As part of our commitment to providing benefit options that meet your specific needs, we have partnered with Alliant Individual Health Solutions (AIHS). AIHS does not replace the company-sponsored group health insurance plans—rather, it expands options available to you and your dependents, with the opportunity for significant savings.

New rules make insurance more affordable for many

Changes in recent legislation could mean your dependents may now qualify for subsidies in the Affordable Care Act Marketplace (also called the Exchange), possibly lowering your family's healthcare premiums. The federal government has changed who may be eligible for Marketplace subsidies. If your family members previously were ineligible for Marketplace subsidies, they may now qualify.

How does it work?

The AIHS team can help you:

- Explore whether your dependents are eligible for subsidies.
- Learn whether an individual health plan could be a more affordable option than the company-sponsored group plans.
- Secure health coverage if you or your dependents are leaving a company plan.

AIHS may be able to help you find affordable coverage if:

- Your dependent child is turning 26 (making them no longer eligible for coverage under a company plan).
- You are retiring early (before Medicare benefits start at 65).
- Your spouse is younger than 65 (and not eligible for Medicare yet).
- You're leaving the company and want to explore options that may be more affordable than COBRA.

Contact AIHS

Schedule an appointment at alliantindividualhealthsolutions.com or call (877) 328-1195 to speak with a licensed insurance agent.

Did you know?

Your extended family and friends can also use Alliant Individual Health Solutions (AIHS) at no charge!

DENTAL

OUR PLANS

Delta Dental DPPO C

We offer dental plan through Delta Dental.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontic** treatment to properly align teeth within the mouth.

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

Delta Dental DPPO C

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	DPPO C	
	In-Network	**Out-of-Network**
Annual Deductible Individual / Family	$50 / $150	$50 / $150
Annual Plan Maximum	$2,000 per person	$1,500 per person
Waiting Period	None	None
Diagnostic & Preventive	100% (deductible waived)	100% (deductible waived)
Basic Services Fillings Root Canals Periodontics	90%	80%
Major Services	60%	50%
Orthodontia Adults & Children	50%	50%
Ortho Lifetime Max	$1,000	$1,000

What you need to know about this plan

Features:	ALT DPPO: See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my FSA?	If you participate in a healthcare FSA, you can use your account to pay for dental expenses.
Where can I get more details?	Use the Delta Dental website (deltadentalins.com) or app.

DELTA DENTAL RESOURCES

FINDING A DELTA PROVIDER

To find a Delta Dental provider near you, please visit deltadentalins.com and click "Find a Dentist". For PPO plans choose "Delta Dental PPO".

SmileWay® Wellness Benefits

If you or a covered family member has been diagnosed with a chronic medical condition like diabetes, cancer or rheumatoid arthritis, you may benefit from additional teeth and gum cleanings. your membership card. Opt in by visiting www.deltadentalins.com/smileway or by calling Customer Service Monday through Friday.

Delta Dental Mobile App

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

Toothpic

Toothpic is a photo-based tele-dentistry app for PPO & premier plan members. Although Toothpic is not available for dental emergencies, members can set up a virtual dental screening or even send in photos for dental issues. A Delta Dental dentist that is part of the PPO Network, can highlight issues from the photos, such as cavities, gum disease, oral hygiene, or other dental concerns. The dentist can then assist with next steps or possible treatments or a home care regimen.

Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized based on benefits. Members can compare procedure costs at nearby dentists should members need to plan in terms of costs. Members can also receive a detailed explanation of their costs based on upcoming treatment.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get savings on the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive a discount off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

LifePerks

Wellness is more than just oral health, that's why Delta Dental members have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life.

VISION

OUR PLANS

VSP Vision Plan C

100% employer paid

Click to play video

We offer vision plan through VSP.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like laser vision correction, additional glasses and sunglasses, and other related services. Visit the plan's website to check out these extra savings.

VSP Vision Signature Plan C

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision Signature Plan C	
	In-Network	**Out-of-Network**
Exams Benefit Materials Frequency	 $20 copay N/A Once every 12 months	 Plan Pays up to $50 N/A Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 Covered in full Covered in full Covered in full Once every 12 months	 Plan Pays up to $50 Plan Pays up to $75 Plan Pays up to $100 Once every 12 months
Frames Benefit Frequency	 $140 Allowance Once every 12 months	 Plan Pays up to $70 Once every 12 months
Contacts (Elective) Conventional Medically Necessary Frequency	$130 Allowance (up to $60 copayment for fitting and evaluation) Covered in full Once every 12 months	 Plan Pays up to $105 Plan Pays up to $210 Once every 12 months

What you need to know about this plan

Features:
See any provider, but you'll pay more out of network

What other services are covered?
The plan can also help you save money on laser vision correction, additional glasses and sunglasses, and lens enhancements

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?
Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Where can I get more details?
Contact 800-877-7195 or use the VSP website (VSP.com) or app.

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

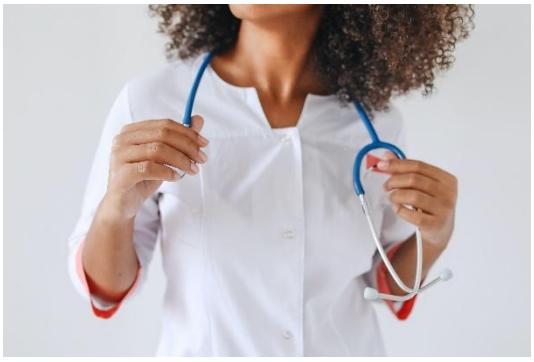
Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

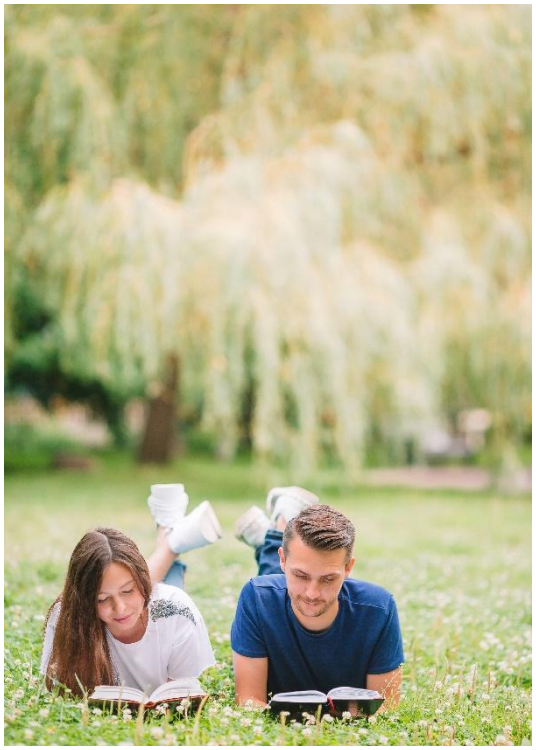
Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by The Hartford and premiums are paid in full by University Corporation.

University Corporation Basic Life and AD&D

Every benefited employee is covered at $50,000 for Basic Life and AD&D

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

VOLUNTARY LIFE AND AD&D INSURANCE



GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by The Hartford and is also available for your spouse and/or child(ren).

The Hartford Voluntary Life

Employee	Up to 5 times your annual salary amount (varies by employee)
Spouse	$5,000
Child(ren)	$5,000

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by The Hartford

The Hartford Voluntary AD&D

Employee	Up tp 10 times your annual salary amount (varies by employee)

LONG-TERM DISABILITY INSURANCE (LTD)

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Coverage is provided by The Hartford.

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time".

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

ANTHEM EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
1-833-954-1067

Website
anthemEAP.com

Company Code

PRISM

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through **Anthem EAP** can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits per issue per year
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/conflict issues
- Alcohol or drug problems
- Loss and death

FINANCIAL COACHING

- Phone meeting with financial professionals
- Regular business hours; no appointment required
- Free financial resources and budgeting tools online
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- 30-minute phone or in-person meeting
- Discounted fees to retain lawyer
- Free legal resources, forms, and seminars online
- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

DEPENDENT CARE AND DAILY LIVING RESOURCES

- Online information about childcare, adoption, elder care, and assisted living
- Phone consultation with a work-life specialist
- Help with pet sitting, moving, and other common needs

ONLINE RESOURCES

- Well-being articles, podcasts, and monthly webinars
- Self-assessment tools for emotional health issues

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

THE HARTFORD EMPLOYEE ASSISTANCE PROGRAM (EAP)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through **Ability Assist, Hartford EAP,** can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and elder care resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 3 visits per issue per year
- Unlimited web access to helpful articles, resources, and self-assessment tools

CONTACT THE EAP

Phone
1-800-964-3577

Website
guidanceresources.com

To register follow the following steps:

1. In the Company/Organization field use: HLF902
2. In the Company Name field use: ABILI
3. Select Username and Password

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Substance abuse
- Stress, anxiety, and depression

FINANCIAL COACHING

- Money management
- Debt management
- Retirement
- Tax issues

LEGAL CONSULTATION

- Debt and bankruptcy
- Guardianship
- Buying a home
- Power of attorney
- Divorce

HEALTHCARE NAVIGATION SERVICES

- One-on-one review of your health concerns
- Preparation for upcoming doctor's visits
- Answers regarding diagnosis and treatment options
- Coordination with appropriate health care plan provider(s)
- Explanation on what's covered and what's not
- Cost estimation
- Guidance on claims and billing issues
- Fee/payment plan negotiation

TIME AWAY FROM WORK

Paid time off policies

There is no perfect, one-size-fits-all balance between work and home. We provide time off so you can take some "me time" to relax, recover from illness, and take care of personal and family business. Our time off benefits include:

- Flexible work schedules
- Paid time off for vacation and illness
- Time off for jury duty and voting
- Bereavement leave
- Maternity, paternity and adoption leave.

Refer to your employee handbook for information on eligibility and specific leave policies.

2026 Paid Holidays

University Corporation provides 14 paid holidays per year for all full-time, benefit eligible employees. Additional holidays may be designated at the company's discretion.

New Year's Day	January 1st
MLK Day	January 20th
Cesar Chavez Day	March 31st
Memorial Day	May 25th
Juneteenth	June 19th
Independence Day	July 4th
Labor Day	September 7th
Veterans' Day	November 11th
Thanksgiving	November 26th
Christmas	December 25th
Lincoln's Birthday	December 28th
Washington's Birthday	December 29th
CA Admission Day	December 30th
Indigenous Peoples Day	December 31st

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy No.
FSA	BCC	800-685-6100	www.benxcel.net	N/A
Medical	Kaiser	800-464-4000	www.kp.org	SoCal – 233977 NorCal - 605957
Medical	Anthem	800-967-3015	www.anthem.com/ca	175075
Dental	Delta Dental	800-765-6003	www.deltadentalins.com	DPPO – 19589
Vision	VSP	800-877-7195	www.vsp.com	30105867
Life	The Hartford	800-523-223	www.thehartfordwork.com	
Disability	The Hartford	800-523-223	www.thehartfordwork.com	
Rx	Navitus	855-847-1035	https://benefitplans.Navitus.com/NVPSM	NVPSM

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die.
Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network

In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance

An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance

Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order

A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment

The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network

Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost

A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care

Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy

A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non- preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services

Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)

The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

GLOSSARY

S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone.
Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.