This brochure highlights certain features of the TSRI benefits program. It does not include all plan rules and details and is not to be considered a certificate of coverage. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be any inconsistencies between this brochure and the legal plan documents, the plan documents are the final authority.
Dear TSRI Benefit Plan Participant:

The annual Open Enrollment period is **October 23, 2017 through November 3, 2017**. This booklet is provided as a summary of your benefit options for the 2018 plan year. A quick review found on the following pages highlights information regarding each benefit plan. Information regarding 2018 healthcare benefits is also available on the TSRI website under Human Resources, Benefits.

Health care costs continue to be a challenge for many employers and TSRI’s health plans are no different. In order to effectively manage costs in the current funding environment, TSRI has chosen to implement the following changes:

- The California Aetna HMO Deductible will transition to Anthem Blue Cross Select HMO.
- The Anthem Blue Cross Select HMO plan will see slightly higher employee premiums.
- The Comprehensive Choice POS plan deductible and out-of-pocket maximums will increase. The employee premium will remain the same.
- TSRI will introduce an employer contribution towards the Health Savings Account ($1,000 for Employee Only and $3,000 for Employee + Dependent(s)) for participants who enroll in the HDHP PPO Plan. Individuals ineligible for the HSA will be enrolled in a Health Reimbursement Arrangement (HRA) to receive the employer contribution.
- TSRI will also introduce a concierge service for HDHP participants through Compass Pro Health at no cost.

As a reminder, preventive care will still be covered at 100% on the HMO plan and when using in-network providers on the PPO plans. Essentially, this means you will not have to pay any copay, coinsurance or meet a deductible when obtaining care considered and submitted for payment as preventive. Therefore, we encourage you to take advantage of free annual exams to maintain your health. The key to keeping health expenses to a minimum is by staying healthy!

**An important message:** If you participate in the **2017** Dependent Care Spending Account or Health Savings Account (if applicable), you need to re-enroll for **2018**. This means you must log on and elect a **2018 deferral amount** for the new plan year. If you do not log on, re-enroll and elect a 2017 deferral amount, you will not be enrolled in the 2018 Flexible Spending Account or Health Savings Account. The Dependent Care Spending Account limit remains $5,000. For Health Savings Account limits, please refer to page 16.

**Voluntary Life Insurance** and **Voluntary Accidental Death & Dismemberment** enrollments still require paper applications to be completed. Please plan accordingly and log on early when the system opens on October 23 to allow time to complete your enrollment choices and obtain the necessary paper applications.

It is important to note too, if you do not log on and make changes, your coverage will remain the same for the 2018 plan year, and your Flexible Spending Account or Health Savings Account will end with the 2017 plan year. After the open enrollment period ends, changes to your coverage may only be made if you experience a qualified status change during the plan year.

Finally, the online system is accessible from any computer with internet access. If you are traveling during Open Enrollment and will **not** have internet access, please contact Human Resources to make arrangements to complete a paper enrollment by the November 3, 2017 deadline. Benefits Administration is available for questions and if you wish to request hard copy applications; contact us at 858-784-8487 or **benefits@scripps.edu**.

Sincerely,

Christy P. Attebury, Director of Compensation & Benefits
### Benefit Change Highlights

#### Comprehensive Choice POS II Highlights

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Non-Network</th>
<th>In-Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Deductible</strong></td>
<td>$750 Individual $2,250 Family</td>
<td>$1,500 Individual $4,500 Family</td>
<td>$900 Individual $2,700 Family</td>
<td>$1,800 Individual $5,400 Family</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-Pocket Maximum</strong></td>
<td>$2,000 Individual $4,000 Family</td>
<td>$4,000 Individual $8,000 Family</td>
<td>$2,250 Individual $4,500 Family</td>
<td>$4,500 Individual $9,000 Family</td>
</tr>
</tbody>
</table>

#### California Aetna HMO Deductible Plan to Anthem Blue Cross Select HMO

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>Effective January 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Plan Carrier</strong></td>
<td>Aetna</td>
<td>Anthem Blue Cross</td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td>HMO Deductible (CA members only)</td>
<td>Select HMO</td>
</tr>
<tr>
<td><strong>Hospice Care</strong></td>
<td>Inpatient – 90% after deductible Outpatient – 100% after deductible</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Live Health Online</strong></td>
<td>N/A</td>
<td>$10 Copay</td>
</tr>
</tbody>
</table>

*You will be required to re-elect your Primary Care Physician (PCP) via the Open Enrollment system or by contacting Anthem at 800.888.8288.

#### HDHP Aetna Choice POS II Plan

<table>
<thead>
<tr>
<th></th>
<th>2017</th>
<th>Effective January 1, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HSA Employer Contribution</strong></td>
<td>N/A</td>
<td>Employee: $1,000 Employee &amp; Dependent(s): $3,000</td>
</tr>
<tr>
<td><strong>HRA Fund</strong> (For those ineligible to open HSA)</td>
<td>N/A</td>
<td>Employee: $1,000 Employee &amp; Dependent(s): $3,000 (administered by PayFlex)</td>
</tr>
<tr>
<td><strong>Concierge Service</strong></td>
<td>N/A</td>
<td>Compass Pro Health</td>
</tr>
</tbody>
</table>
## 2018 Benefit Premiums

### Monthly Medical Premiums

<table>
<thead>
<tr>
<th>Coverage Plan</th>
<th>RA/EG Contribution</th>
<th>TSRI Contribution</th>
<th>Total Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comprehensive Choice POS II Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA/EG</td>
<td>$74</td>
<td>$606</td>
<td>$680</td>
</tr>
<tr>
<td>RA/EG + Spouse/DP</td>
<td>$260</td>
<td>$1,100</td>
<td>$1,360</td>
</tr>
<tr>
<td>RA/EG + Child(ren)</td>
<td>$198</td>
<td>$938</td>
<td>$1,136</td>
</tr>
<tr>
<td>RA/EG + Family*</td>
<td>$386</td>
<td>$1,431</td>
<td>$1,817</td>
</tr>
<tr>
<td><strong>Anthem Select HMO Deductible Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA/EG</td>
<td>$49</td>
<td>$388</td>
<td>$437</td>
</tr>
<tr>
<td>RA/EG + Spouse/DP</td>
<td>$252</td>
<td>$709</td>
<td>$961</td>
</tr>
<tr>
<td>RA/EG + Child(ren)</td>
<td>$181</td>
<td>$605</td>
<td>$786</td>
</tr>
<tr>
<td>RA/EG + Family*</td>
<td>$387</td>
<td>$967</td>
<td>$1,354</td>
</tr>
<tr>
<td><strong>HDHP Aetna Choice POS II Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA/EG</td>
<td>$0</td>
<td>$573</td>
<td>$573</td>
</tr>
<tr>
<td>RA/EG + Spouse/DP</td>
<td>$0</td>
<td>$1,228</td>
<td>$1,228</td>
</tr>
<tr>
<td>RA/EG + Child(ren)</td>
<td>$0</td>
<td>$1,069</td>
<td>$1,069</td>
</tr>
<tr>
<td>RA/EG + Family*</td>
<td>$20</td>
<td>$1,533</td>
<td>$1,553</td>
</tr>
</tbody>
</table>

### Monthly Dental Premiums

<table>
<thead>
<tr>
<th>Coverage Plan</th>
<th>RA/EG Contribution</th>
<th>TSRI Contribution</th>
<th>Total Monthly Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental PPO Plan</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RA/EG</td>
<td>$0</td>
<td>$39</td>
<td>$39</td>
</tr>
<tr>
<td>RA/EG + Spouse/DP</td>
<td>$20</td>
<td>$58</td>
<td>$78</td>
</tr>
<tr>
<td>RA/EG + Child(ren)</td>
<td>$14</td>
<td>$51</td>
<td>$65</td>
</tr>
<tr>
<td>RA/EG + Family*</td>
<td>$32</td>
<td>$72</td>
<td>$104</td>
</tr>
</tbody>
</table>

*Family coverage includes child(ren) and either your spouse or your domestic partner.

RA = Research Associate   EG = External Graduate   DP = Domestic Partner

### Voluntary Life Insurance Premiums

Rates and an application are available for download from the online system.

### Voluntary Accidental Death and Dismemberment Insurance Premiums

Rates and an application are available for download from the online system.
Informing You of Health Care Reform

Most U.S. citizens and legal residents are subject to a federal tax penalty if they do not have qualifying health insurance coverage.

To avoid paying the penalty you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as a State Health Insurance Exchange.

All TSRI medical plans meet the minimum essential coverage under the Health Care Reform standards, and therefore, you may not be eligible for any Federal subsidies. The State Health Exchange Notice is available for employees through TSRI’s Benefits website at www.scripps.edu/hr/benefits.

For more information regarding Health Care Reform, please contact Benefits Administration at 858-784-8487 or benefits@scripps.edu. You may also visit www.ccio.cms.gov. To review information specific to the Covered California State Health Insurance Exchange, please visit www.coveredca.com.
Welcome to Open Enrollment

Open Enrollment for TSRI benefits program is officially underway. You have from now until October 23, when the online Open Enrollment system opens, to:

√ Assess your personal coverage needs, including those of your dependents;
√ Learn about your plan options;
√ Make your decisions for the upcoming plan year; and
√ Decide whether to enroll in the Dependent Care Flexible Spending Account or Health Savings Account, if you are eligible.

The online Open Enrollment system closes at 5:00 p.m. Pacific time on Friday, November 3, 2017.

This booklet highlights your benefit plan options, outlines steps to change your coverage elections for 2018, and informs you of where you can receive more information if you have questions.

Open Enrollment Meetings & Events

The choices you make during Open Enrollment must remain in effect for the full plan year, January 1 through December 31, 2018. Please take this opportunity to read this booklet, review your options and make your decisions with care. If you have questions, please contact Benefits Administration at 858-784-8487 or benefits@scripps.edu.

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting/Event</th>
<th>Location &amp; Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 24th</td>
<td>Benefits Informational Meeting</td>
<td>Keck Amphitheater 2:30 p.m. – 3:30 p.m.</td>
</tr>
<tr>
<td>October 25th</td>
<td>Benefits Fair</td>
<td>Immunology Building/ Breezeway 10:00 a.m. – 1:00 p.m.</td>
</tr>
<tr>
<td>October 27th</td>
<td>Benefits Informational Meeting</td>
<td>HR Training Room, 3050 Science Park, 2nd Floor 10:00 a.m. – 11:00 a.m.</td>
</tr>
<tr>
<td>October 30th</td>
<td>Benefits Informational Meeting</td>
<td>MB Committee Lecture Hall 2:30 p.m. – 3:30 p.m.</td>
</tr>
<tr>
<td>November 1st</td>
<td>Benefits Informational Meeting</td>
<td>HR Training Room, 3050 Science Park, 2nd Floor 1:00 p.m. – 2:00 p.m.</td>
</tr>
</tbody>
</table>
Which Medical Plan is Best for Me?

All of the TSRI medical plans protect you financially by providing coverage for catastrophic medical events. The plans differ, however, in their deductible, copayment and coinsurance amounts. They also differ in how and where you may access care. To select the plan that best meets your personal needs and budget, it is important that you understand how each plan works.

**Comprehensive Plan**

The Comprehensive Choice POS II Plan is a Preferred Provider Organization (PPO) Plan that utilizes the Aetna Choice POS II (Open Access) Network. It allows you to choose Aetna network or non-network providers each time you need care. Network providers have contracted with the plan to provide services at lower rates, so using these providers will save you money. With network providers, your annual deductible is $900 per person ($2,700 maximum per family), and the plan then pays 80% of the cost for most covered services. With non-network providers, your deductible is $1,800 per person ($5,400 maximum per family), and the plan then pays 60% of the cost for most covered services. Preventive care through network providers is covered at 100% and not subject to deductible. Claims are administered by Aetna.

**Is this plan for you?** The Comprehensive Choice POS II Plan offers comprehensive coverage, provider choice and complete flexibility. If these features are high on your priority list and you do not mind paying higher out-of-pocket expenses, this option may be worth considering. To receive the highest level of benefits with the Comprehensive Plan you must always use Aetna network providers. Please note that providers include doctors, hospitals, urgent care clinics, laboratory and x-ray facilities. It is important to check that your doctor has referred you to a network facility in order for lab or x-ray services to be considered in-network. Often, doctors will utilize several lab services and you can request to be sent to an in-network facility.

**How to Find a Provider**

Network providers may be found by visiting www.aetna.com/docfind and following these steps:

1. Search for a physician by name, provider type, specialty, or location. Once you have made your selections, click on **Search**. Please remember to turn off pop-up blockers.

2. This will prompt you to select a plan. Under “Aetna Open Access® Plans,” select **Aetna Choice® POS II (Open Access)**. Click on **Continue**.
### Comprehensive Choice POS II Plan Highlights

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$900/ person</td>
<td>$1,800/ person</td>
</tr>
<tr>
<td></td>
<td>$2,700/ family</td>
<td>$5,400/ family</td>
</tr>
<tr>
<td>Out-of-Pocket Max (per calendar year)</td>
<td>$2,250/ person</td>
<td>$4,500/ person</td>
</tr>
<tr>
<td></td>
<td>$4,500/ family</td>
<td>$9,000/ family</td>
</tr>
</tbody>
</table>

The out-of-pocket max does not apply to prescription meds.

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th>Coinsurance (Subject to deductible unless otherwise noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits</td>
<td>80% 60%</td>
</tr>
<tr>
<td>Surgery</td>
<td>80% 60%</td>
</tr>
<tr>
<td>Lab/ X-rays</td>
<td>80% 60%</td>
</tr>
</tbody>
</table>

### Hospital Services

| Hospital Charges                             | 80% 60%                                                   |
|                                              | An additional $200 copay will apply if not pre-authorized |

| Emergency Services                           | 80% 60%                                                   |

### Other Services

| Well Baby Care                                | 100% (deductible waived) Cancer screenings only |
| Routine Exam (one annually)                   | 100% (deductible waived) Cancer screenings only |
| Diagnostic X-ray & Lab                        | 80% 60%                                                   |
| Physical Therapy                              | 80% 60%                                                   |

Up to 39 visits/year combined In- and Out-of-Network

| Chiropractic                                  | 80% 60%                                                   |

Up to 20 visits/year combined In- and Out-of-Network

| Acupuncture                                   | 80% 60%                                                   |

Up to 20 visits/year combined In- and Out-of-Network

| Maximum Benefit                               | Unlimited                                                 |

### Mental Health/Substance Abuse through OptumHealth

| Deductible                                    | Combined with medical plan |
| Out-of-Pocket Max (per calendar year)         | Combined with medical plan |

| Inpatient                                     | 80% 60%                                                   |

An additional $200 copay will apply if not pre-authorized

| Outpatient                                    | 80% 60%                                                   |

### Prescription Drugs through OptumRx*

| Annual Rx Deductible for Brand Names          | $100/ person $200/ family |
| Annual Rx Out-of-Pocket Maximum               | $2,000/ person $4,000/ family |
| Retail (30-days)                              | $10/ $35/ $60 |
| Mail Order through the OptumRx Mail Order Pharmacy (90 days) | $20/ $70/ $120 |

*Amounts show Generic / Brand / and Non-Formulary copayments.

Aetna is the claims administrator and the network is Aetna Choice POS II (Open Access).
 Anthem Blue Cross Select HMO

The Anthem Blue Cross Select HMO provides comprehensive coverage, including wellness and preventive care, for services provided by Anthem Blue Cross Select HMO physicians and hospitals. This means when you enroll, you agree to use ONLY Anthem Blue Cross Select HMO doctors, facilities and medical groups for ALL of your medical care. You must complete the appropriate information in the online system to select a Primary Care Physician (PCP) for each covered family member in order to manage each person’s care and for referrals to specialists as needed. Primary Care specialties include Family Practice, General Practice, Pediatrics and Internal Medicine. The PCP will only refer a patient to specialists who are members of the PCP’s Participating Medical Group (PMG). However, each family member may change to another Anthem Blue Cross Select HMO PCP or PMG in your service area. If the member requests the change between the 1st through the 15th of the month, then the change is effective first of the following month. If the member requests the change on the 16th through the 31st, then the change is effective the 1st of the subsequent month. Any care you receive from physicians, hospitals, facilities or medical groups not affiliated with the HMO (or that is not referred by your PCP) is not covered.

The HMO features the Anthem Blue Cross Select HMO network. Anthem is also the plan administrator. To find a network provider, visit www.anthem.com/ca. Next, “Search by Selecting a Plan or Network”, select “Medical”, select “CA”, and select “Select HMO”. You may also call Anthem member services at (800) 888-8288.

Some medical groups and Individual Practice Associations (IPA) that are in the Anthem Blue Cross Select HMO are:

- Rady Children’s Health Network
- Scripps Physicians Medical Group
- Sharp Community Medical Groups IPA
- Sharp Rees-Stealy Medical Group
- UCSD Medical Group

This is subject to change at any time. Please check with your provider before scheduling your appointment or receiving services to confirm he or she is participating in Anthem’s network.

Please note, Scripps Clinics, Scripps Coastal, and Mercy Physicians Medical Group IPA are not members of the Select HMO network. If your current provider is part of the Mercy Physicians Medical Group IPA, please see if your provider belongs to another Select HMO medical group or enroll in another medical plan. However, most physicians affiliated with the other hospitals in San Diego County are members of a Participating Medical Group that contracts with the Select HMO network.

Your current Aetna PCP designation will not automatically carry over to Anthem Blue Cross. Please contact Anthem to assign your PCP, or log onto the Open Enrollment system at https://eo.scripps.edu.

The HMO plan has a $100 (Individual) / $200 (Family) Annual Deductible. The deductible must be met before the coinsurance benefits apply. Benefits with a coinsurance will be subject to the deductible unless otherwise noted. Preventive care and many wellness resources are included in your coverage and are covered at 100%.

Is the HMO for you? To help you decide, first consider location. Is the HMO convenient to where you live and/or work? Are providers available for dependents attending school out of the area? If you have a chronic condition that requires frequent medical attention, you might appreciate the HMO’s broad coverage and small copays. You may have to change doctors if your current physician is not affiliated with the HMO. Keep in mind that the HMO requires that your Primary Care Physician act as “gatekeeper” to manage your care. If you value provider choice and flexibility more than you value lower out of pocket costs, the HMO may not be the best choice for you.
## Select HMO Plan Highlights

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible</td>
<td>$100/ person</td>
</tr>
<tr>
<td></td>
<td>$200/ family</td>
</tr>
<tr>
<td>Out-of-Pocket Max (per calendar year)</td>
<td>$2,500/ person</td>
</tr>
<tr>
<td></td>
<td>$5,000/ family</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### Outpatient Services

- **PCP Office Visit**: $30 copay
- **Specialist Office Visit**: $40 copay
- **Surgery**: Hospital–90% after deductible, Freestanding–$250 copay after deductible
- **Diagnostic Lab**: 100% covered
- **Diagnostic X-ray**: $40 copay
- **Complex X-ray**: $150 copay
- **Physical Therapy**: $40 copay

### Hospital Services

- **Emergency Room**: $100 copay after deductible
- **Inpatient Maternity Care**: 90% after deductible
- **Other Hospital Services**: 90% after deductible

### Other Services

- **Well Baby Care**: 100% (deductible waived)
- **Adult Periodic Exam & Well Woman Care**: 100% (deductible waived)
- **Chiropractic**: $15 copay up to 20 visits per year
- **Acupuncture**: Excluded

### Mental Health / Substance Abuse

- **Inpatient**: 90% after deductible
- **Outpatient**: 100% (deductible waived)

### Prescription Drugs through Express Scripts*

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Rx Deductible (Applies to Brand Formulary and Non-Formulary Drugs)</td>
<td>$100/ person</td>
</tr>
<tr>
<td></td>
<td>$200/ family</td>
</tr>
<tr>
<td>Retail (30-days)</td>
<td>$10/ $35/ $60</td>
</tr>
<tr>
<td>Mail Order (90 days)</td>
<td>$20/ $70/ $120</td>
</tr>
</tbody>
</table>

*Amounts show Generic / Brand / and Non-Formulary copayments.

Anthem Blue Cross Select HMO is the HMO provider network and claims administrator for medical and mental health/substance abuse under the HMO Plan.
HMO Q&A’s

How do I access a specialist under the HMO plan?

You must get a referral from your Primary Care Physician (PCP) to see a specialist. In addition, your PCP will only refer you to specialists who are members of the PCP’s Participating Medical Group (PMG). However, some medical groups like Sharp Rees-Stealy allow direct access to some specialties. For mental health and substance abuse treatment, you do not need a referral from your PCP. Contact Anthem directly for a referral to a therapist who has contracted with Anthem. The telephone number is (800) 888-8288. It will also be on your ID card.

For chiropractic treatment, you do not need a referral from your PCP. Go to Anthem’s website for the names of participating chiropractors (www.anthem.com/ca). You may also contact Anthem member services at (800) 888-8288.

Can I self refer to an OB-GYN of my choice for my annual well woman exam?

You do not need a referral from your PCP for your annual well-woman exam or for any obstetrical or gynecological care; however, the OB-GYN must be a member of the same Participating Medical Group as your PCP.

I currently see a private practice therapist for my mental health. Will I be able to continue to see this provider if I switch to the HMO?

Anthem has Transition of Care Request forms which you should submit directly to Anthem to apply for continuation of treatment with your existing therapist. The forms will be available at the Open Enrollment meetings and from Human Resources. Anthem commonly approves a temporary continuation of treatment with your existing therapist, provided the therapist agrees to accept Anthem’s normal level of reimbursement. Transition of Care is also available for completion of covered services for pregnancy, acute conditions, and terminal illnesses.

What is the prescription drug formulary?

A preferred drug list or formulary is a list of prescription medications generally covered under the pharmacy benefit plans subject to applicable limits and conditions. Anthem's formulary includes brand name and generic drugs that have been approved by the FDA as safe and effective.

A preferred drug list or formulary helps provide access to quality, affordable prescription drug benefits. Drugs chosen for the formulary have gone through an extensive review process. The formulary selection process is structured so that there are internal and external physicians and pharmacists offering clinical input about the medications under consideration. The drugs listed on the preferred drug list either represent an important therapeutic advance, or are clinically equivalent and possibly more cost effective than other drugs not on the preferred drug list.

How do I determine what tier copay my prescriptions will be covered under?

You may look up your particular medications to see what copay will apply by going to www.anthem.com/ca/pharmacyinformation. Click on National Drug List 3 Tier (searchable). Either enter your medication name or search via alpha order.

The search will provide information on your particular medication. Your copay will be based on the tier your medication falls. Brand-Formulary and Non-Formulary drugs are subject to the prescription deductible before copays apply. Tier one is a $10 copay, tier two is a $35 copay and tier three is a $60 copay. This screen will also tell you if your particular medication requires precertification, step therapy or quantity limits. It will also provide generic alternatives if the medication is a brand name. Please note for the most updated and accurate prescription information, it is recommended you log into your Anthem online account at www.anthem.com/ca.
**HDHP Aetna Choice POS II Plan Highlights**

**Service** | **In-Network** | **Non-Network**
---|---|---
Annual Deductible | Employee Only: $2,000 | Employee + Dependent(s): $6,000
Out-of-Pocket Max (per calendar year) | EE Only: $4,500 | EE+ Dep(s): $6,750
| EE Only: $6,750 | EE+ Dep(s): $10,125
Includes deductible | Family OOP applies to all members
**Outpatient Services**
Office Visits (PCP/Specialist) | 80% | 60%
Surgery | 80% | 60%
Lab/X-rays | 80% | 60%
**Hospital Services**
Hospital Charges | 80% | 60% (additional $200 copay applies if not pre-authorized)
Emergency Room | 80% | 80%
**Other Services**
Preventive Care | 100% (deductible waived) | Cancer screenings only
Diagnostic X-ray & Lab | 80% | 60%
Physical Therapy | 80% | 60% (up to 39 visits/year)
Chiropractic | 80% | 60% (up to 20 visits/year)
Acupuncture | 80% | 60% (up to 20 visits/year)
Maximum Benefit | Unlimited | Unlimited

**Mental Health/ Substance Abuse through OptumHealth**

**Deductible** | Combined with Medical Plan
Out-of-Pocket Max (per calendar year) | Combined with Medical Plan
Inpatient | 80% | 60% (additional $200 copay applies if not pre-authorized)
Outpatient | 80% | 60%

**Prescription Drugs through OptumRx**

Retail (30-days) | $10/ $35/ $60
Mail Order through OptumRx Mail Order Pharmacy (90 days) | $20/ $70/ $120

* Amounts show Generic / Brand / and Non-Formulary copayments.

**Using the HDHP Aetna Choice POS II Plan**

The HDHP Aetna Choice POS II Plan allows you to take control of your health plan and how you spend your health care dollars. The savings in premium can help offset the cost of your healthcare. While the High Deductible Health Plan (HDHP) enforces a relatively larger deductible than traditional health plans, it has a lower payroll deduction. These medical plans encourage you to closely analyze your health care decisions and the type of care utilized. The HDHP Aetna Choice POS II Plan operates as follows:

- You are financially responsible for all eligible expenses, such as doctor’s or specialist’s visits, prescriptions and lab charges, until the deductible has been met.
- Regardless if you have satisfied the deductible, several types of screenings, immunizations, and other forms of in-network preventive care will be covered at 100%.
- Once the deductible is met, the plan pays a large percentage of eligible expenses until the out-of-pocket maximum is reached.
- Similar to a traditional PPO plan, you may use the provider of your choice, but the plan will pay more if you see in-network physicians or facilities.
- After reaching the out-of-pocket maximum, covered expenses are paid at 100% for the remainder of the plan / calendar year.
- This can be paired with a Health Savings Account (HSA) to help pay for qualified health care expenses.
- The Annual Medical Deductible accrues toward the Out-of-Pocket Maximum.

- If you are enrolled under Employee + 1 or more Dependents, the Family Deductible must be met before the coinsurance applies.
- If you enroll in an HSA, you cannot participate in the regular Health Care Flexible Spending Account (this includes having any money in your FSA account from the previous year).
- TSRI will now contribute towards your HSA with $1,000 for Employee Only and $3,000 for Employee & Dependent(s). Employer contributions will be made on a quarterly basis.

Claims are administered by Aetna and the plan utilizes the Aetna Choice POS II (Aetna HealthFund) network. PayFlex will administer your HSA account through convenient payroll deductions. Please be aware that if you choose to open an HSA, you are not eligible to participate in a Health Care Flexible Spending Account. The following pages provide detailed information regarding the use of a Health Savings Account (HSA).

J Visa Holders are not eligible for this plan.
Compass Professional Health Services

Compass PHS is a patient advocacy firm providing a personal concierge (a Health Pro) to Aetna HDHP plan members. Services include:

• Unlimited access to a health care expert
• Researching generic or clinical alternative prescription options
• Unbiased doctor recommendations based on quality and cost
• Coordinating care, scheduling doctor appointments
• Coordinating transfer of medical records
• Reviewing bills and charges
• Resolving billing issues with Aetna, hospitals, and provider billing offices
• Explanation of insurance processes and TSRI benefit plans
• Comparing service costs, cost estimates

Compass Health Pro services are available to you at no cost.

You can get in touch with TSRI’s dedicated Health Pro today via:

Phone: 800.513.1667
Email: answers@compassphs.com
Website: www.compassphs.com
Health Savings Account (HSA)

By enrolling in the High Deductible Health Plan, you can choose to open a Health Savings Account, which provides tax advantages and can be used to pay for qualified health care expenses.

HSA Overview

Administered by an authorized financial institution, a Health Savings Account (HSA) accumulates funds that can be used to pay current and future health care costs. An HSA works in conjunction with qualified High Deductible Health Plans (HDHP) and essentially can reduce your federal income taxes while enabling you to pay certain health-related expenses on a tax-deductible basis.

When you incur costs while enrolled in a HDHP, you can utilize HSA dollars to help pay the deductible as well as copayments and other qualified medical, dental and vision out-of-pocket expenses, subject to funds availability. After satisfying the deductible, the plan may provide coverage for covered medical expenses.

- The funds an employee contributes to the HSA are tax-deductible on your tax return if contributed post-tax
- Distributions are tax-free for qualified expenses
- The amount in an HSA rolls over from year-to-year
- Because the employee owns the HSA, the monies in the account will remain with you if you leave the company or the work force
- Money accumulates with tax-free interest until retirement, only outside of AL, CA and NJ

Advantages of an HSA

HSAs encourage consumers to purchase health care wisely, simply for the reason that you are utilizing personal funds to pay health-related expenses. Although an HSA comes with this responsibility, HDHP with an HSA may also lend several advantages including:

- Lower payroll deductions than traditional PPO medical plans
- Reduced taxable income and tax-free withdrawals when paying for qualified expenses

- A vehicle to save for future health needs, such as long term care premiums or health care after retirement

Qualifying for an HSA

The IRS has set guidelines regarding who qualifies for an HSA. An individual is considered eligible if:

- You are covered under a qualified HDHP
- You do not have health insurance outside of your HDHP
- You are not enrolled in Medicare
- You are not claimed as a dependent on someone else’s tax return
- You are not enrolled in a general Health Care FSA
- You are under the age of 65
Activating an HSA

When you’re ready to activate your HSA through PayFlex, you can do so by following these directions:

**Step 1:** Go to [www.PayFlex.com](http://www.PayFlex.com).

**Step 2:** Click on Register Now and enter your Member ID # (or SSN) and Zip Code.

**Step 3:** Follow the prompts to verify your Tax ID or SSN and review and accept the listed terms and conditions.

Once the HSA is activated, you can manage and access your account at any time by visiting [www.PayFlex.com](http://www.PayFlex.com). You may not be able to view the account balance, transactions, make contributions or receive claim reimbursements from the HSA until the account is set up.

Questions regarding account activation? Contact PayFlex by calling 888.678.8242 or visiting their website, [www.PayFlex.com](http://www.PayFlex.com).

Using HSA Funds

The most convenient way to pay for qualified HSA expenses is to utilize PayFlex’s HSA Debit Card / checks. You can also use your own cash or a personal credit card and reimburse yourself by making a withdrawal from your HSA at an ATM / writing yourself a check from the HSA. It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS.

Keep in mind, the IRS only allows HSA funds to pay for qualified medical, dental and vision costs incurred by the plan member or dependent(s) and will not allow for reimbursement for claim dates prior to the HSA account being open. Such examples include:

- Out-of-pocket expenses such as the high deductible and copayments
- Qualified health care expenses for services not covered under the high deductible health plan
- Some dental expenses, including braces, mouth guards and more
- Some vision expenses, including LASIK eye surgery, glasses, contacts and more
- Lab fees, X-rays and more

Explicit guidelines for determining eligible expenses have not been provided by the Internal Revenue Service (IRS); for a list of potential eligible expenses that may be covered by a Health Savings Account (HSA) visit Internal Revenue Code (IRC) section 213 (d). Also, IRS Publication 502 (Medical and Dental Expenses) may be used as a guide for what expenses may be considered by the IRS to be for medical care; however, these guidelines should be used with caution when trying to determine what expenses are reimbursable under an HSA.

Please note: This is informational only and not intended to serve as legal, tax, or financial advice. Participants in an HSA should consult their tax advisor before making any changes to their plan.
HSA Year-to-Year Illustration

Because HSAs are employee-owned and there are no “use it or lose it” provisions, any unused funds remain in your account for future use. In the example below you’ll learn just how your HSA can benefit you year after year.

YEAR 1: Amanda contributed $1,500 and TSRI contributed $1,000 into her HSA. As shown in the chart to the right, she used $580 from her HSA to pay her Year 1 medical expenses.

Amanda was not required to take any money out of her own pocket. And, because she only used $580 in Year 1, she will carry over $1,920 to Year 2.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>YEAR 1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,500 in HSA Fund</td>
</tr>
<tr>
<td>Preventive Care Exam</td>
<td>$0</td>
</tr>
<tr>
<td>Physicians Services</td>
<td>$400</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$180</td>
</tr>
<tr>
<td>Total Medical Expenses</td>
<td>$580</td>
</tr>
<tr>
<td>Paid by HSA Funds</td>
<td>$580</td>
</tr>
<tr>
<td>Paid by Amanda</td>
<td>$0</td>
</tr>
<tr>
<td>Remaining HSA Funds</td>
<td>$1,920</td>
</tr>
</tbody>
</table>

YEAR 2: Amanda had $1,920 remaining in her HSA from Year 1 and an additional $2,500 was contributed in Year 2 for a total of $4,420.

Amanda used $85 from her HSA to pay for her Year 2 expenses. Again, she was not required to pay any money out of pocket. Now, a total of $4,335 will carry over to Year 3, which allows her to continue using funds for future eligible expenses.

<table>
<thead>
<tr>
<th>Service Type</th>
<th>YEAR 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,500 in HSA Fund</td>
</tr>
<tr>
<td>Preventive Care Exam</td>
<td>$0</td>
</tr>
<tr>
<td>Office Visit for Cold</td>
<td>$77</td>
</tr>
<tr>
<td>Generic Prescription</td>
<td>$8</td>
</tr>
<tr>
<td>Total Medical Expenses</td>
<td>$85</td>
</tr>
<tr>
<td>Paid by HSA Funds</td>
<td>$85</td>
</tr>
<tr>
<td>Paid by Amanda</td>
<td>$0</td>
</tr>
<tr>
<td>Remaining HSA Funds</td>
<td>$4,335</td>
</tr>
</tbody>
</table>

Please Note: This example does not reflect your plan’s coverage and does not take into consideration any possible payroll deduction for the HDHP. It simply provides you an illustration of how HSA funds rollover from year-to-year to be used towards future health care expenses.

Additional HSA Information

Additionally, the U.S. Department of Treasury and IRS can inform individuals on what is new regarding HSAs, qualified medical expenses, qualifying for HSAs, contributions, distributions, balances, death of an account holder, forms required and more. They have also provided a comprehensive listing of Frequently Asked Questions regarding HSAs.

Call 800.829.1040 or visit [www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx](http://www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx) for more information.
Contributing to the HSA

Eligible employees, individual’s family members, and any other person can make financial contributions towards an individual’s HSA. The chart below outlines the maximum allowed amounts and other taxation information.

<table>
<thead>
<tr>
<th>Contribution Amounts</th>
<th>Important Contribution Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aggregate contributions in the 2018 calendar year cannot exceed:</td>
<td></td>
</tr>
<tr>
<td>• $3,450 for Employee Only</td>
<td></td>
</tr>
<tr>
<td>• $6,900 for an Employee covering Dependent(s)</td>
<td></td>
</tr>
<tr>
<td>• $1,000 catch-up contribution only for individuals 55+ years of age</td>
<td></td>
</tr>
<tr>
<td>Employer contributions for 2018 will amount to:</td>
<td></td>
</tr>
<tr>
<td>• $1,000 for Employee Only</td>
<td></td>
</tr>
<tr>
<td>• $3,000 for an Employee covering Dependent(s)</td>
<td></td>
</tr>
</tbody>
</table>

This amount makes up part of the aggregate contribution listed above. TSRI’s contributions will be made on a quarterly basis.

• Aggregate funds include those made by any contributing source
• The maximum aggregate contribution is adjusted each year to align with inflation
• A catch-up contribution is an amount in addition to the HSA maximum aggregate contribution
• Post-tax deductions are also acceptable and you will receive a tax deduction on federal and state income tax, excluding AL, CA and NJ up to the applicable maximum contribution
• Contributions are excluded from the employee’s income, up to the maximum contribution limit
• Contributions are not federally taxable to the employee
• State taxes apply to AL, CA and NJ for employers
• Annual amounts are prorated based on the employee’s month of enrollment

Please note: Consult your tax advisor for additional taxation information or advice.

Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA) is an IRS-approved employer provided fund used to pay for eligible out-of-pocket health care expenses. Our benefits program offers an HRA fund to pay for your eligible health care expenses, up to a specified dollar amount for those employees ineligible for Health Savings Account (HSA) contributions.

HRA Overview

Our Health Reimbursement Arrangement (HRA) is administered by PayFlex and works in conjunction with the Aetna HDHP Choice POS II medical plan, OptumRx prescription plan, and Optum Behavioral Health, which provides coverage for in network and out of network services.

You can use HRA dollars for eligible health care expenses like your deductible, copayments and other qualified out-of-pocket expenses until your HRA balance is depleted.

HRA Contributions

TSRI makes contributions to your HRA based on your coverage tier (individual or family) on a quarterly basis.

• If you have individual (employee-only) coverage, the annual contribution maximum to your HRA is $1,000

• If you have Employee & Dependent(s) coverage, the annual contribution maximum to your HRA is $3,000

• In order to qualify for the higher family HRA contribution, your dependent(s) must meet the Health Plan’s definition of an eligible dependent and be enrolled in the Aetna HDHP Choice POS II medical plan

• Your HRA fund amount is pro-rated if your coverage level (individual or Family) changes during the plan year

• Per IRS regulations, employees may not contribute to an HRA, as an HRA must be solely funded by an employer
If you enroll after the beginning of the plan year, the annual HRA contribution is pro-rated based on the number of quarters you are enrolled in the HRA during the plan year. Your pro-rated HRA contribution will be 1/4 for each quarter enrolled in the plan.

**Using the HRA**

HRAs encourage individuals to purchase health care more wisely, which allows your HRA fund to go further!

- If covered expenses exceed the funds available in your HRA, you pay any remaining out-of-pocket expenses.
- Once the individual or family health care plan annual out-of-pocket maximum (which includes the deductible) is met, the plan pays 100% of a covered eligible expenses for the remainder of the plan year.
- The annual deductible and out-of-pocket maximums are based upon a calendar year regardless of your effective date in the HRA.
- Unused funds do roll over to the following year if you are still enrolled.
- Because the HRA is owned by TSRI, HRA funds are forfeited if you leave the company or terminate the HRA plan; however, you may be eligible to continue using your HRA funds if you enroll in COBRA.

**Receiving HRA Funds**

PayFlex is the administrator of our Health Reimbursement Arrangement. The HRA will be set-up automatically upon enrollment. You will receive a debit card to use for paying for qualified health care expenses. Once your funds are available in your account, you may register and log on at www.PayFlex.com to track your HRA fund.

**Important Notes on the Prescription Drug Plan through OptumRx**

The prescription benefit under both the Comprehensive Choice POS II and HDHP Aetna Choice POS II Medical Plans have the following copay arrangement. Under the Comprehensive Choice POS II Plan, there is a $100 (Individual) / $200 (Family) Annual Deductible applied to brand name drugs before the copay applies. There is also a separate Out-of-Pocket Maximum of $2,000 (individual) / $4,000 (family) for prescription drugs under the Comprehensive Choice POS II plan. Under the HDHP Aetna Choice POS II Plan, prescriptions (other than preventive medications) are subject to the medical plan deductible before the copays apply. Generic drugs are covered at a $10 copay, brand name formulary drugs are covered at a $35 copay, and brand name non-formulary drugs are covered at a $60 copay for a 30-day supply.

A preferred drug list or formulary provides access to quality, affordable prescription drug benefits. Drugs chosen for the formulary have gone through an extensive review process. The drugs listed on the preferred drug list either represent an important therapeutic advance, or are clinically equivalent and possibly more cost-effective than other drugs not on the preferred drug list. The formulary is typically updated every three months to provide a clinically appropriate list of medicines to meet participants’ needs. To determine if your brand name prescriptions are considered formulary or non-formulary and subject to the third tier copay log onto optumrx.com/myCatamaranRx or call OptumRx at 855-395-2022.

In the event that a generic is available but the pharmacy dispenses the brand per the member’s request, the Plan Member will pay the generic copay plus the difference in cost between the brand and the generic. If a physician writes “dispense as written” or “do not substitute” on the prescription, then the applicable brand copay should apply in that instance.
If you are enrolled in a TSRI medical plan (Comprehensive Choice POS II, HMO Deductible, or HDHP Aetna Choice POS II HSA plans), you receive vision benefits through MESVision. MES offers a broad panel of ophthalmologists, opticians, and optometrists located throughout the United States. You may use any vision care provider, but if you use MES providers, you receive higher coverage and are only required to pay a copayment at the time of service. With non-MES providers, you must pay the bill in full and file a claim for reimbursement.

For a list of MESVision providers, visit their website at www.mesvision.com.

**Please note:** Enrollment in the vision plan is automatic when enrolling in a medical plan.

<table>
<thead>
<tr>
<th></th>
<th>MES Provider</th>
<th>Non-MES Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Copay/Deductible</strong></td>
<td>$10 Copay/ Person</td>
<td>$10 Deductible/ Person</td>
</tr>
<tr>
<td><strong>Eye Exam</strong></td>
<td>Plan pays 100%</td>
<td>$40 allowance</td>
</tr>
<tr>
<td><em>One every 12 months</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Standard Lenses</strong></td>
<td>Plan pays 100%</td>
<td>Single Vision: $30</td>
</tr>
<tr>
<td><em>One pair every 12 months in lieu of contact lenses</em></td>
<td></td>
<td>Bifocal: $50</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trifocal: $65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lenticular: $125</td>
</tr>
<tr>
<td><strong>Standard Frame</strong></td>
<td>Plan pays 100% up to a $110 retail cost allowance</td>
<td>$40 allowance</td>
</tr>
<tr>
<td><em>One every 24 months</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td>Plan pays 100%</td>
<td>$250 allowance</td>
</tr>
<tr>
<td><em>Medically Necessary:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>One pair every 12 months in lieu of lenses &amp; frames</em></td>
<td></td>
<td>$100 allowance, plus up to $40 for a contact lens fitting fee</td>
</tr>
<tr>
<td><em>Cosmetic or Convenience:</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>One pair every 12 months in lieu of lenses &amp; frames</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
TSRI offers you dental coverage through Delta Dental. You may use any of the following:

- Delta Dental PPO Preferred Dentists
- Delta Dental Premier Dentists
- Dentists who have not contracted with Delta

To receive the highest level of coverage, select a Delta PPO Preferred dentist. These dentists offer significant discounts from their normal fees, and the plan provides 100% coverage for Diagnostic and Preventive services with no deductible. The table below highlights how benefits compare using different dental providers.

For a list of Delta Dental PPO and Premier providers, visit their website at www.deltadentalins.com.

<table>
<thead>
<tr>
<th></th>
<th>PPO Dentist</th>
<th>Delta Premier Dentist</th>
<th>All Other Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible</td>
<td></td>
<td>$50/ Person*</td>
<td></td>
</tr>
<tr>
<td>General Dentistry Annual</td>
<td></td>
<td>$1,500/Person/Calendar Year</td>
<td></td>
</tr>
<tr>
<td>Orthodontia Lifetime Maximum</td>
<td></td>
<td>$1,500/Person/Lifetime</td>
<td></td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive Services</td>
<td>100% Deductible waived</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Exams, cleanings, bite-wing X-rays, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Extractions, fillings, endodontia, periodontia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Services</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Bridges, crowns, implants, dentures, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia*</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>(To age 19)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Deductible does not apply to Orthodontia services.

Delta Premier Dentist and All Other Provider network charges are based off of reasonable and customary rates.
The Dependent Care Flexible Spending Account (FSA) allows you to use pre-tax dollars to pay for certain dependent care expenses. When you contribute to this account you pay fewer taxes and save money. This plan is administered by Tri-Ad.

You may contribute up to $5,000 annually to the Dependent Care Flexible Spending Account (or up to $2,500 annually if you are married and file separate tax returns). Please note that External Graduate Students and Research Associates in a Stipend Pay Status (Division 7) are not eligible to participate in the Dependent Care FSA.

**The new plan year for the FSAs begins January 1. You must re-enroll if you wish to participate.**

The Dependent Care FSA can be used for dependent care and elder care expenses that enable you (or you and your spouse, if you are married) to work and/or attend school full-time. Eligible expenses include daycare, preschool programs and after school care for qualifying children and qualifying relatives under age 13. They also include elder care or care for qualifying dependents and qualifying relatives of any age who are not capable of self-care.

**Important:** The IRS has a “use it or lose it” rule that applies to the FSA. Any funds set aside but not used for eligible expenses by December 31, 2018 for the Dependent Care Spending Account must be forfeited, so be conservative when estimating your contributions.
Voluntary Life Insurance

You may purchase Voluntary Life Insurance from a minimum of $10,000, up to a maximum of $500,000 for yourself and/or your spouse/domestic partner. Eligible dependent children may be covered to a maximum of $10,000 each.

You may enroll yourself for up to $100,000 of coverage, pre-approved regardless of health and with no medical questionnaire and your spouse for up to $50,000 guarantee issue during your first Open Enrollment. You may enroll your spouse regardless of whether you enroll yourself for coverage. Coverage for amounts over the guarantee issue amounts require you to complete a short medical questionnaire. Rates and an application are available for download via the online Open Enrollment system.

Voluntary AD&D Insurance

You may purchase Voluntary Accidental Death and Dismemberment Insurance in increments of $50,000 up to a maximum of $500,000 for yourself, your spouse/domestic partner, and/or your unmarried dependent children under the age of 26. You are eligible for this benefit if you are under the age of 70, and work at least 20 hours per week in a benefit eligible position. Rates are available for download via the online Open Enrollment system.

Please note: New enrollees under the Voluntary Life and/or AD&D must complete a Prudential Beneficiary Form.
PLAN GUIDELINES / EVIDENCE OF COVERAGE

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan’s Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members’ medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan’s network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan’s Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

LEGAL INFORMATION REGARDING YOUR PLANS

Required Notices

Women’s Health & Cancer Rights Act

The Women’s Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer’s plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents’ other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) 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 a 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. Other midyear election changes may be permitted under your plan (refer to “Change in Status” section). To request special enrollment or obtain more information, contact your Human Resources Representative.
“HIPAA Special Enrollment Opportunities” include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage⁽¹⁾
- Acquisition of a new spouse or dependent through marriage⁽¹⁾, adoption⁽¹⁾, placement for adoption⁽¹⁾ or birth⁽¹⁾
- Loss of state Children’s Health Insurance Program coverage (e.g., Healthy Families) (60-day notice)⁽¹⁾
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

“Change in Status” Permitted Midyear Election Changes

Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved “change in status” as defined by the IRS.

Examples of permitted “change in status” events include:

- Change in legal marital status (e.g., marriage⁽²⁾, divorce or legal separation)
- Change in number of dependents (e.g., birth⁽²⁾, adoption⁽²⁾ or death)
- Change in eligibility of a child
- Change in your / your spouse’s / your state registered domestic partner’s employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse’s / your state registered domestic partner’s benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- Loss of other coverage⁽²⁾
- Change in employment status where you have a reduction in hours to an average below 20 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage.
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

⁽¹⁾ Indicates that this event is also a qualified “Change in Status”
⁽²⁾ Indicates this event is also a HIPAA Special Enrollment Right
⁽³⁾ Indicates that this event is also a COBRA Qualifying Event
The Scripps Research Institute Group Health and Welfare Plan

NOTICE OF PRIVACY RIGHTS – HEALTH CARE RECORDS

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

This Notice is provided as required by the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act"), and regulations issued at 45 CFR Parts 160 through 164 ("Privacy Regulations"). This Notice is provided to participants and beneficiaries in The Scripps Research Institute (TSRI) health plans designated as an organized health care arrangement and identified in Appendix C to The Scripps Research Institute Group Health and Welfare Plan (collectively referred to herein as the “Plan”).

As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan’s privacy procedures with respect to your “Protected Health Information.” “Protected Health Information” is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care. This notice is intended to inform you about:

- the Plan’s use or disclosure of your Protected Health Information;
- your privacy rights with respect to the Plan’s use and disclosure of your Protected Health Information;
- the Plan’s duties with respect to your Protected Health Information;
- your right to file a complaint with the Plan’s Privacy and Complaint Officer or with the Office for Civil Rights of the U.S. Department of Health and Human Services about the Plan’s privacy practices; and
- the Plan’s Privacy and Complaint Officer along with such Officer’s contact information.

The Plan is required by law to provide you with this Notice about your rights and the Plan’s legal duties and privacy practices with respect to your Protected Health Information. The Plan must follow the terms of this Notice currently in effect. Some of the uses and disclosures described in this Notice may be limited by applicable state laws that are more stringent than the federal standards.

You may also receive notices about the use and disclosure of health information from others, such as from other health care plans, insurers (including HMOs) and providers. As a result, you may, in addition to this Notice, receive other notices of your privacy rights.

How the Plan May Use and Disclose Your Protected Health Information

The Plan may use and disclose your Protected Health Information for different purposes. The examples below are provided to illustrate the types of uses and disclosures the Plan may make without your authorization for treatment, payment and health care operations.

- **Treatment.** The Plan may use and disclose your Protected Health Information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, the Plan may disclose to one treating physician the name of another treating physician for records or other information needed for diagnosis or treatment.

- **Payment.** The Plan may use and disclose your Protected Health Information in order to pay for your covered health expenses. For example, the Plan may use your Protected Health Information to enroll you for coverage and the Plan may use or disclose such information to determine if a claim for benefits is covered under the Plan (e.g., is medically necessary, experimental, etc).

- **Health Care Operations.** The Plan may use and disclose your Protected Health Information in order to perform Plan activities, such as quality assessment and improvement activities, reviewing competence or qualifications of health care providers, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. Such activities also include disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program. Notwithstanding the foregoing, the Plan is prohibited from using or disclosing Protected Health Information that is your genetic information for underwriting purposes.

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1. The Plan includes the following component plans: TSRI Health Care Spending Account Plan; TSRI Medical Plans; TSRI Dental Plan; TSRI Vision Plan; TSRI Prescription Drug Plan; TSRI Long-Term Care Insurance Plan; TSRI Mental Health Plan; TSRI Employee Assistance Program; or any other insured or self-insured major medical plan, group dental plan, or other health plan as may be sponsored by TSRI and designated as part of the TSRI Organized Health Care Arrangement.

2. Discussions within the TSRI Counseling and Psychological Services Program will continue to be held in the strictest confidence in accordance with professional ethics and state/federal law. All records are maintained separately from medical and personnel/department files and are not released without your consent.
• **Plan Sponsor.** The Plan discloses your medical information to The Scripps Research Institute, which sponsors the Plan, for Plan administration purposes that are described in the document that governs the specific Plan. The Scripps Research Institute will be required to certify to the Plan that it will use your medical information in accordance with the Privacy Regulations.

• **Component Plans.** The Plan’s component plans may share your Protected Health Information for payment and health care operations.

• **Enrolled Dependents and Family Members.** The Plan will mail explanation of benefits forms and other mailings containing Protected Health Information to the address the Plan has on record for the employee who is enrolled in the health plan.

**Other Permitted or Required Disclosures**

• **To Your Family Member, Other Relative or Close Personal Friend.** The Plan may disclose Protected Health Information to your family member, other relative, close personal friend, or other person you identify, provided such Information is directly relevant to such person’s involvement in your health care or payment, or to notify them of your location, general condition or death. The Plan will not make any such disclosure unless you are given a reasonable opportunity under the circumstances to object and did not, in fact, object. If you are not present or able to agree to these disclosures of your Protected Health Information, then using professional judgment, the Plan may determine whether the disclosure is in your best interest.

• **As Required by Law.** The Plan must disclose Protected Health Information about you when required to do so by law.

• **Public Health Activities.** The Plan may disclose Protected Health Information to public health agencies for reasons such as preventing or controlling disease, injury or disability. This includes disclosures necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

• **Immunizations.** The Plan may disclose Protected Health Information limited to proof of immunization to a school if you are a student or prospective student of the school and the school is required by law to have such proof of immunization prior to admission. The Plan must obtain your agreement (or the agreement of a parent, guardian, or other person acting in the place of a parent if you are an unemancipated minor) before making any such disclosure to a school.

• **Victims of Abuse, Neglect or Domestic Violence.** The Plan may disclose Protected Health Information to government agencies about abuse, neglect or domestic violence if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such disclosure has been or will be made. Disclosure may generally be made to the minor’s parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor’s Protected Health Information.

• **Health Oversight Activities.** The Plan may disclose Protected Health Information to government oversight agencies (e.g., U.S. Department of Labor) for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs.

• **Judicial and Administrative Proceedings.** The Plan may disclose Protected Health Information in response to a court or administrative order. The Plan may also disclose Protected Health Information about you in certain cases in response to a subpoena, discovery request or other lawful process. In such case, the Plan will require satisfactory assurances that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

• **Law Enforcement.** The Plan may disclose Protected Health Information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect or witness; or to provide information about the victim of a crime. Such disclosures include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual’s agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual’s agreement, and disclosure is in the best interest of the individual as determined by the Plan in its sole discretion.

• **Coroners, Funeral Directors, Organ Donation.** The Plan may release Protected Health Information to coroners or funeral directors as necessary to allow them to carry out their duties. The Plan may also disclose Protected Health Information in connection with organ or tissue donation.
• **Plan Information and Programs.** The Plan may contact you to provide appointment reminders or information about alternative treatment programs or other health-related benefits and services that may be of interest to you.

• **Research.** Under certain circumstances, the Plan may disclose Protected Health Information about you for research purposes, provided certain measures have been taken to protect your privacy.

• **To Business Associates.** The Plan may disclose Protected Health Information to a "business associate", provided that such person or entity enters into an agreement as described in the Privacy Regulations. A "business associate" is a vendor that provides certain services (typically Plan administration services) to or on behalf of the Plan.

• **To Limited Data Recipients.** The Plan may disclose Protected Health Information to a "limited data recipient", provided that such person or entity enters into an agreement as described in the Privacy Regulations. A "limited data recipient" is a person or entity that receives Protected Health Information that is partially de-identified in accordance with the Privacy Regulations and used for purposes of research, public health or health care operations.

• **Marketing.** The Plan may use Protected Health Information for purposes of marketing where it is face-to-face or involves a promotional gift of nominal value.

• **To Avert a Serious Threat to Health or Safety.** The Plan may disclose Protected Health Information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person; provided, however, that any such disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

• **Special Government Functions.** The Plan may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

• **Workers’ Compensation.** The Plan may disclose Protected Health Information to the extent necessary to comply with state law for workers’ compensation programs or similar programs established by law.

• **Incidental to Another Permitted Use.** The Plan may disclose Protected Health Information as permitted by the Privacy Regulations to be incidental to another permitted use.

• **Decedents.** The Plan may disclose to your family member, other relative, close personal friend, or other person you identify, who were involved in your care or payment for health care prior to your death, Protected Health Information that is relevant to their involvement, unless doing so is inconsistent with any prior expressed preference known to the Plan. Your individually identifiable health information remains Protected Health Information for a period of 50 years following your death.

### Other Uses or Disclosure Require an Authorization

Except as otherwise indicated by this Notice, other uses or disclosures of your Protected Health Information will be made only with your written authorization subject to your right to revoke any such authorization. The types of uses and disclosures of Protected Health Information that may not be made without your written authorization include the following:

• **Psychotherapy Notes.** The Plan must obtain an authorization to use or disclose psychotherapy notes subject to certain limited exceptions or as may be required by law.

• **Marketing.** The Plan must obtain an authorization to use or disclose Protected Health Information for marketing if the Plan receives financial remuneration in exchange for making such communication subject to certain limited exceptions. If the marketing involves financial remuneration to the Plan, the authorization must state that such remuneration is involved.

• **Sale of Protected Health Information.** The Plan must obtain an authorization for any disclosure of Protected Health Information in exchange for direct or indirect remuneration from or on behalf of the recipient of the Protected Health Information. Such authorization must state that the disclosure will result in remuneration to the Plan.

You may revoke an authorization at any time in writing, except to the extent that the Plan has already taken action on the information disclosed or your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself. Such revocation will be effective upon the Plan’s receipt of your written notice of cancellation or modification of the authorization.

### Your Rights Regarding Your Protected Health Information

You have certain rights regarding Protected Health Information that the Plan maintains about you.

• **Right To Notification In The Event Of A Breach Of Your Unsecured Protected Health Information.** You have the right to be notified of any impermissible acquisition, access, use or disclosure of your unsecured Protected Health Information that compromises the security or privacy of the Protected Health Information. Should such a breach of your unsecured Protected Health Information occur, the Plan or its authorized representative will notify you without unreasonable delay after the date the Plan discovers the breach.
Unsecured Protected Health Information is Protected Health Information that has not been rendered unusable, unreadable or indecipherable by means of encryption or destruction.

- **Right To Access Your Protected Health Information.** You have the right to review or obtain copies of your Protected Health Information contained in a “designated record set” with some limited exceptions. A designated record set includes the medical and billing records about individuals maintained by or for a covered health care provider. This includes enrollment, billing, claims payment and case or medical management records maintained by or for the Plan. Your request to review and/or obtain a copy of Protected Health Information contained in your designated record set must be made in writing. The Plan may charge a fee for the costs of producing, copying and mailing your requested information, but the Plan will tell you the cost in advance.

You also have the right to obtain a copy of any “electronic health record” maintained by the Plan with respect to your Protected Health Information in electronic format. An “electronic health record” is an electronic record of health-related information on an individual that is created, gathered, managed and consulted by authorized health care clinicians and staff.

The Plan will provide the requested information within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To access your Protected Health Information contained in a designated record set, you or your personal representative must complete the appropriate form and return it using the contact information identified at the end of this Notice.

- **Right To Amend Your Protected Health Information.** If you believe that Protected Health Information or a record about you in a designated record set maintained by the Plan is incorrect or incomplete, you may request that the Plan amend the information. Your request must be made in writing and must include the reason you are seeking a change. The Plan may deny your request if, for example, you ask the Plan to amend information that was not created by the Plan, as is often the case for health information in the Plan’s records, or you ask to amend a record that is already accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with such deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement of disagreement with the Plan’s decision and have that statement included with any future disclosures of your Protected Health Information.

To amend your Protected Health Information contained in a designated record set, you or your personal representative must complete the appropriate form providing the reason for such request and return it using the contact information identified at the end of this Notice.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures the Plan has made of your Protected Health Information. Such accounting will not include Plan disclosures related to your treatment, the Plan’s payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as disclosures incident to a use or disclosure otherwise permitted or required under the Privacy Regulations.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years.

You may obtain an accounting of any disclosures of Protected Health Information in the form of an electronic health record for purposes of treatment, payment or health care operations within the three years immediately preceding your request for an accounting of disclosures.

Your request for an accounting should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional accountings within the same time period, the Plan may charge for providing the accounting, but the Plan will tell you the cost in advance.

If the Plan cannot provide the accounting within 60 days, an additional 30 days is allowed if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

To request an accounting of disclosures the Plan has made of your Protected Health Information, you or your personal representative must complete the appropriate form and return it using the contact information identified at the end of this Notice.
• **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that the Plan restrict or limit how the Plan uses or discloses your Protected Health Information for treatment, payment or health care operations. *The Plan may not agree to your request.* If the Plan does agree, the Plan will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you or your personal representative must tell the Plan (1) what information you want to limit; (2) whether you want to limit how the Plan uses or discloses your information, or both; and (3) to whom you want the restrictions to apply.

Notwithstanding any other provision of this Notice, and except as required by law, the Plan will comply with your request not to disclose your Protected Health Information to a health plan for payment or health care operations (but not carrying out treatment) if the Protected Health Information pertains solely to a healthcare item or service for which the health care provider involved has been paid in full by you or by someone other than the Plan on your behalf.

To request that the Plan restrict or limit how it uses or discloses your Protected Health Information, you or your personal representative must complete the appropriate form and return it using the contact information identified at the end of this Notice.

• **Right To Receive Confidential Communications.** You have the right to request that the Plan use a certain method to communicate with you about the Plan or that the Plan send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from the Plan could endanger you. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

To request confidential communications, you or your personal representative must complete the appropriate form and return it using the contact information identified at the end of this Notice.

• **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy. To request a paper copy of this Notice, you must use the contact information identified at the end of this Notice.

• **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by using the contact information identified at the end of this Notice.

**Personal Representatives**

Your personal representative may exercise your rights. Such representative must produce evidence of his/her authority to act on your behalf before that person will be given access to your Protected Health Information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- the parent of a minor child.

The Plan may deny access to your Protected Health Information to a personal representative in order to protect certain individuals who depend on others to exercise their rights under the Privacy Regulations and who may be subject to abuse or neglect including minors.

**Changes to this Notice**

The Plan reserves the right to change the terms of this Notice at any time, effective for Protected Health Information that the Plan already has about you as well as any information that the Plan receives in the future. Whenever the Plan makes a material change to the privacy practices described in this Notice, the Plan will promptly revise the Notice and post a copy of the new Notice on the Plan’s intranet site and otherwise distribute the new Notice in accordance with the Privacy Regulations.

**Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy and Complaint Officer identified at the end of this Notice and/or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, based on the region where the alleged violation took place, or by email to OCRComplaint@hhs.gov. All complaints to the Plan must be made in writing and sent to the contact listed at the end of this Notice.

The Plan supports your right to protect the privacy of your Protected Health Information. *The Plan will not retaliate against you or penalize you for filing a complaint.*
Effective Date of this Notice

This Notice as updated pursuant to the HITECH Act and final regulations issued thereunder is effective September 23, 2013.

The effective date of the Plan’s first Notice of Privacy Practices was April 14, 2003. The Notice was previously revised in response to the enactment of the HITECH Act effective as of February 17, 2010.

Contact the Plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Privacy and Complaint Officer for The Scripps Research Institute:

TSRI Human Resources
Attention: Benefits Administration
10550 North Torrey Pines Road, SP-211
La Jolla, California 92037
(858) 784-8487

Important Information on How Health Care Reform Affects Your Plan

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office.

For plans and issuers that require or allow for the designation of a primary care provider for a child:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

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

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual’s preexisting condition, regardless of the individual’s age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

Continuation Coverage Rights Under COBRA

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 the same coverage that the plan gives to other participants or beneficiaries who aren’t getting continuation coverage. Each “qualified beneficiary” (described below) who elects COBRA continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan.

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 [choose and enter appropriate information: must pay or aren’t required to 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.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The Scripps Research Institute, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
• Commencement of a proceeding in bankruptcy with respect to the employer; 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 after the qualifying event occurs. You must provide this notice to anyone covered under the Plan who are spouses, dependent children, or anyone else eligible for COBRA continuation coverage under the Plan.

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) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

**Employee Rights & Responsibilities under the Family Medical Leave Act**

**Basic Leave Entitlement**

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;

(continued on next page)
• To care for the employee's child after birth, or placement for adoption or foster care;

• To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or

• For a serious health condition that makes the employee unable to perform the employee's job.

**Military Family Leave Entitlements**

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.

**Benefits & Protections**

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

**Eligibility Requirements**

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

**Definition of Serious Health Condition**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**Use of Leave**

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of Paid Leave for Unpaid Leave**

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

**Employee Responsibilities**

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer Responsibilities**

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.
Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

(1) The FMLA definitions of “serious injury or illness” for current servicemembers and veterans are distinct from the FMLA definition of “serious health condition”

(2) Special hours of service eligibility requirements apply to airline flight crew employees

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.


Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:
Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to “service in the uniformed services.”

- “Uniformed services” means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

- “Service in the uniformed services” or “service” means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from The Scripps Research Institute, but are unable to afford the premiums, the State of California may have a premium assistance program that can help pay for coverage. Funds from the Medicaid or CHIP programs are used to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in the State of California, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS-NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

To contact the California Department of Health Care Services http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

To Contact the U.S. Department of Health and Human Services, Centers of Medicare and Medicaid Services: http://www.cms.gov/
Phone: 1-866-444-EBSA (3272) or 1-877-267-2323, Ext. 61565
Please read this notice carefully and keep it where you can find it.

This notice has information about your current prescription drug coverage with The Scripps Research Institute and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. The Scripps Research Institute has determined that the prescription drug coverage offered by OptumRx and Aetna HMO Deductible Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE PRESCRIPTION DRUG PLAN?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer’s group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact TSRI Benefits Administration for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.
WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with The Scripps Research Institute and don’t join a Medicare prescription 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 TSRI Benefits Administration at (858) 784-8487 for further information or email benefits@scripps.edu.

NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through The Scripps Research Institute 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: October 2017

Name of Entity/Sender: The Scripps Research Institute

Contact—Position/Office: Christy Attebury/ Director, Compensation & Benefits

Address: 10550 North Torrey Pines Road
La Jolla, CA 92037

Phone Number: (858) 784 - 8487
If You Have Questions

Benefits Administration
10550 North Torrey Pines Rd., SP-211
La Jolla, CA 92037

(858) 784-8487 – phone
(858) 784-8071 – fax
benefits@scripps.edu