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Western University of Health Sciences is committed to providing its employees with a competitive benefits program that gives you and your family a comprehensive level of coverage and protection. Your benefits package includes the following programs:

- Medical/Prescription
- Vision
- Long Term Disability
- Basic Life and AD&D
- Employee Assistance Program
- Travel Assist
- Dental
- Flexible Spending Account
- Health Savings Account
- Long Term Care
- Discount Programs
- Wells Fargo At Work℠

Benefit Plan Eligibility

You are eligible to participate in Western University of Health Sciences’ benefits program if you are classified as a regular, full-time or part-time employee working 30 or more hours per week. Certain plans also permit you to cover your eligible dependents. Your eligible dependents include your:

Legal spouse;

Registered domestic partner (with State Certificate): same sex partner over age 18 or opposite sex partner where one is over age 62 and entitled to Social Security benefits;

Dependent children to age 26 regardless of marital status, student status, level of support provided, or residency. Married adult dependent children are not eligible for dental coverage.

Initial Eligibility Period

You are eligible to participate in the Western University of Health Sciences’ benefits program on the first day of the month following or coincident with the date of hire. You have up to 30 days from your date of hire to apply for coverage.

Annual Enrollment

Each year Western University of Health Sciences holds an Annual Enrollment period during which time eligible employees have the opportunity to evaluate their elections to be sure their healthcare needs are met.

If you are changing your benefit elections during the Annual Enrollment period, those changes will take effect on March 1st unless you are not actively at work. If you are not actively at work on the day coverage is approved, the coverage will be pended until the first day you return to an actively at work, benefit eligible status.
Late Enrollment

A “Late Enrollee” is a person (including yourself) for whom you do not elect coverage within 30 days of the date the person becomes eligible for such coverage. You may elect coverage for a Late Enrollee only during the Annual Enrollment period established by Western University of Health Sciences or when a Qualifying Life Event occurs.

Making Changes During the Year

Enrollment changes outside the Annual Enrollment period are not permitted unless you experience a Qualifying Life Status Event (QLSE) as defined by the Internal Revenue Service (IRS). Examples of Qualifying Life Status Events include:

- Marriage, divorce or legal separation;
- Birth, adoption or placement for adoption of a child;
- Death of a spouse or dependent;
- A change in employment status for you or your spouse affecting health care coverage (such as changing from full-time to part-time employment (i.e. a reduction in hours) or your spouse ending or starting employment);
- COBRA coverage under another health plan is exhausted;
- A dependent child satisfies or ceases to satisfy plan requirements (such as age limitations);
- Entitlement to, or loss of, Medicare or Medicaid benefits;
- A change in place of residence for you, your spouse or your dependent that affects healthcare coverage; or,
- Termination of other health coverage.

Any changes to your election must be made within 30 days* of the event and must be consistent with the event. If you do not change your coverage within 30 days* of the event, you will have to wait until the next open enrollment period to make a change.

*The deadline to change your elections and provide documentation is 60 days for qualifying life events involving Medicare, Medicaid or State Children’s Health Plan.

You must provide information and documentation that is necessary to verify your qualified change in status as required by Western University of Health Sciences.
Qualifying Life Events

Below is a partial list of common Qualifying Life Events and how you can update your benefits mid-year:

<table>
<thead>
<tr>
<th>Qualified Life Events</th>
<th>Medical / Dental / Vision</th>
<th>Health Care FSA</th>
<th>Dependent Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>Enroll self, spouse and newly acquired child(ren) in all plans</td>
<td>Enroll, drop, increase or decrease</td>
<td>Enroll, drop, increase or decrease</td>
</tr>
<tr>
<td>Death of Spouse</td>
<td>Enroll self and or child(ren) in all plans and drop spouse</td>
<td>Enroll, drop, increase or decrease</td>
<td>Enroll or increase coverage</td>
</tr>
<tr>
<td>Birth / Adoption / Placement for Adoption</td>
<td>Enroll self and/or child(ren) in all plans</td>
<td>Enroll or increase coverage</td>
<td>Enroll or increase coverage</td>
</tr>
<tr>
<td>Divorce/Legal Separation/Annulment</td>
<td>Enroll self and/or child(ren) in all plans and drop spouse</td>
<td>Enroll, drop, increase or decrease</td>
<td>Enroll, drop, increase or decrease</td>
</tr>
<tr>
<td>Significant Change in Benefits</td>
<td>Enroll self and/or child(ren) in all plans</td>
<td>No change allowed</td>
<td>No change allowed</td>
</tr>
</tbody>
</table>

Required Documentation for Eligible Dependents

You may be required to provide verification of dependent eligibility when enrolling. You will be asked to provide supporting documentation for adding your dependents (e.g. marriage certificate when adding spouse, birth certificate when adding a child and domestic partner registration when adding a domestic partner).

If you do not provide the required documentation within your designated enrollment window, your dependent will be considered ineligible and unable to enroll in Western University of Health Sciences’ benefit program.

When Coverage Ends

Coverage for you and your dependents ends on your last day of the month of active employment or the last day of the month you no longer meet the plan’s eligibility requirements. Coverage for your dependents may also end on the last date of the month they no longer meet the definition of an eligible dependent. Under certain circumstances, you may be able to continue some benefit coverages for yourself and/or your dependents through COBRA or the portability/conversion provisions of the plans.
COST FOR COVERAGE

Western University of Health Sciences offers a benefits program that is not only comprehensive, but cost-effective for you and your family. The following benefits are provided by Western University of Health Sciences at no premium cost to you:

- DMO if coverage is elected
- Core Long-Term Disability Insurance
- Basic Life and Accidental Death and Dismemberment (AD&D) Insurance
- Employee Assistance Programs

You and Western University of Health Sciences share in the cost of your and your dependent’s medical, dental and vision benefits. You pay for your share through the convenience of payroll deductions. Any contributions you make for healthcare coverage (e.g., Medical/Rx, Dental) and Flexible Spending Accounts are deducted from your paycheck pre-tax – before federal, Social Security, state and local taxes are withdrawn. This reduces your taxable income.

<table>
<thead>
<tr>
<th>EMPLOYEE/EMPLOYER MONTHLY CONTRIBUTIONS</th>
<th>Kaiser HMO</th>
<th>Blue Shield HMO</th>
<th>Blue Shield PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WesternU</td>
<td>$383.89</td>
<td></td>
<td>$453.60</td>
</tr>
<tr>
<td>Employee</td>
<td>$70.42</td>
<td>$49.77</td>
<td>$55.66</td>
</tr>
<tr>
<td>Employee+One</td>
<td>$362.82</td>
<td>$623.03</td>
<td>$379.12</td>
</tr>
<tr>
<td>Employee+Family</td>
<td>$502.57</td>
<td>$499.57</td>
<td>$517.14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MetLife DPO</th>
<th>MetLife DMO</th>
<th>VSP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WesternU</td>
<td>$38.98</td>
<td>$11.02</td>
</tr>
<tr>
<td>Employee</td>
<td>$8.19</td>
<td>$0</td>
</tr>
<tr>
<td>Employee+One</td>
<td>$65.73</td>
<td>$4.16</td>
</tr>
<tr>
<td>Employee+Family</td>
<td>$65.73</td>
<td>$9.94</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VSP</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WesternU</td>
<td>$11.02</td>
<td>$3.15</td>
</tr>
<tr>
<td>Employee</td>
<td>$0</td>
<td>$3.76</td>
</tr>
<tr>
<td>Employee+One</td>
<td>$9.94</td>
<td>$9.33</td>
</tr>
<tr>
<td>Employee+Family</td>
<td>$3.15</td>
<td>$3.15</td>
</tr>
</tbody>
</table>
Western University of Health Sciences offers you three options for medical coverage. Benefits are provided through Blue Shield of California and Kaiser. The plans are designed to assist you and your covered dependents by paying a portion of eligible expenses incurred for a wide range of medical services. Review the benefit summaries and plan documents carefully before deciding which plan is best for you and your dependents.

**Blue Shield and Kaiser HMO** – The HMO (Health Maintenance Organization) plan requires members to select a primary care physician (PCP), a doctor who acts as a "gatekeeper" to direct access to medical services. PCPs are usually internists, pediatricians, family doctors, or general practitioners (GPs). Except for a medical emergency, patients need a referral from the PCP in order to see a specialist or other doctor. There is no coverage outside of the network.

**Blue Shield PPO (HDHP)** – The PPO plan has an extensive network that allows you to choose a physician from within or outside of the network. All maximums included in this Plan are combined maximums between In-Network and Out-of-Network, where applicable, unless specifically stated otherwise. Calendar Year Deductible – This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. Allowable Amounts – When receiving services from Out-of-Network providers, any charges above Allowable Amounts are your responsibility. Charges above Allowable Amounts will not apply to your deductible or out-of-pocket maximum.

**Health Savings Account (HSA)** – If you enroll in the Blue Shield PPO (HDHP), you have an option to participate in a Health Savings Account (HSA). An HSA is a personal savings account created from pre-tax employee contributions to be used for qualified medical expenses. An HSA can also be used as an investment tool. The maximum annual contribution is $3,350 per individual and $6,650 per family. If you are 55 years of age or older, there is a catch-up contribution amount of $1,000.

When electing the HSA option during annual enrollment, you need to select from one of the two options: 1) Wells Fargo or 2) Other financial institution. Pre-tax contributions will be deducted from your paycheck if Wells Fargo is selected as the HSA financial institution. After enrollment you will receive a Welcome Kit from Wells Fargo. Please follow the instructions in this kit to activate your HSA. If Wells Fargo is not used, HSA contributions will be on an after-tax basis. If contributions are made on an after-tax basis, the contributions can be claimed on your federal income tax return. If you are also enrolled in a Health Care FSA, eligible expenses under the FSA will be reimbursed on a limited purpose basis. Limited purpose FSA reimbursements are those expenses not reimbursed under an HSA; such as dental or vision.

If you are enrolled in Medicare, you are not eligible to participate in an HSA.
<table>
<thead>
<tr>
<th>Benefit</th>
<th>Kaiser HMO Plan</th>
<th>Blue Shield HMO Plan</th>
<th>Blue Shield PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>In-Network¹</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Out-of-Network¹</td>
</tr>
<tr>
<td>Deductible</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>$1,500/Member</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$3,000/Family</td>
</tr>
<tr>
<td>Out-of-Pocket Max</td>
<td>$3,000/Member</td>
<td>$1,500/Member</td>
<td>$3,000/Member</td>
</tr>
<tr>
<td>(OOPM) (Calendar Year)</td>
<td>$6,000/Family</td>
<td>$3,000/Family</td>
<td>$6,000/Family</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$12,000/Family</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Coinurance</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP: $30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist: $30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered; ded.</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
<td>waived</td>
</tr>
<tr>
<td>Routine Child &amp; Well</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered; ded.</td>
</tr>
<tr>
<td>Baby</td>
<td></td>
<td></td>
<td>waived</td>
</tr>
<tr>
<td>Women Preventive</td>
<td>100% covered</td>
<td>100% covered</td>
<td>100% covered; ded.</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td></td>
<td>waived</td>
</tr>
<tr>
<td>Maternity Office Visits</td>
<td>100% covered</td>
<td>100% covered</td>
<td>90% covered</td>
</tr>
<tr>
<td>(Pre-Natal &amp; Post-Natal)</td>
<td></td>
<td></td>
<td>60% covered</td>
</tr>
<tr>
<td>Diagnostic X-rays and Laboratory</td>
<td>Preventive: 100% covered</td>
<td>100% covered</td>
<td>Preventive: 100% covered</td>
</tr>
<tr>
<td></td>
<td>Non-Preventive: $10</td>
<td></td>
<td>Non-Preventive: $25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>per visit then 90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>covered²</td>
</tr>
<tr>
<td>Advanced Imaging</td>
<td>$50</td>
<td>100% covered</td>
<td>$100 then 90% covered</td>
</tr>
<tr>
<td></td>
<td>$20</td>
<td></td>
<td>60% covered²</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>$5</td>
<td>$20</td>
<td>90% covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60% covered</td>
</tr>
<tr>
<td>Hospital Expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$500 per day copay</td>
<td>$250 per admission</td>
<td>$100 then 90% covered</td>
</tr>
<tr>
<td></td>
<td>copay</td>
<td>copay</td>
<td>60% covered³</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$250 per procedure</td>
<td>Ambulatory Surgical</td>
<td>90% covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Center: $100</td>
<td>60% covered⁴</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital: $150</td>
<td></td>
</tr>
<tr>
<td>Emergency Health Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room (per visit copay waived if admitted)</td>
<td>$150</td>
<td>$100</td>
<td>$100 then 90% covered</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$30</td>
<td>$20</td>
<td>90% covered</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$150 per trip</td>
<td>$100 per trip</td>
<td>90% covered</td>
</tr>
<tr>
<td>Professional Services</td>
<td>100% covered</td>
<td>100% covered</td>
<td>90% covered</td>
</tr>
</tbody>
</table>
## MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Kaiser HMO Plan</th>
<th>Blue Shield HMO Plan</th>
<th>Blue Shield PPO (HDHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network</strong></td>
<td><strong>Out-of-Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation</strong></td>
<td>$30</td>
<td>$20</td>
<td>90% covered</td>
</tr>
<tr>
<td>(Physical &amp; Occupational)</td>
<td></td>
<td></td>
<td>50% covered</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td>$30</td>
<td>$20</td>
<td>90% covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60% covered</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>50% covered</td>
<td>80% covered</td>
<td>90% covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60% covered</td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td>100% covered</td>
<td>100% covered</td>
<td>90% covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>60% covered</td>
</tr>
<tr>
<td><strong>Family Planning Benefits</strong></td>
<td>50% covered; All services related to covered infertility treatment</td>
<td>Counseling &amp; Consulting: No charge; 50% covered for infertility services; diagnosis and treatment of cause of infertility</td>
<td>No charge; Counseling and consulting</td>
</tr>
<tr>
<td><strong>Prescription Retail</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-day supply</td>
<td>30-day supply</td>
<td>After satisfying plan deductible:</td>
<td></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>$15</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10+25%</td>
</tr>
<tr>
<td><strong>Brand Formulary</strong></td>
<td>$35</td>
<td>$25</td>
<td>$25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$25+25%</td>
</tr>
<tr>
<td><strong>Brand Non-Formulary</strong></td>
<td>$35</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$40+25%</td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td>100-day supply</td>
<td>90-day supply</td>
<td>90-day supply</td>
</tr>
<tr>
<td>After satisfying plan deductible:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>$30</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Brand Formulary</strong></td>
<td>$70</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$50</td>
</tr>
<tr>
<td><strong>Brand Non-Formulary</strong></td>
<td>$70</td>
<td>$80</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Specialty Drugs</strong></td>
<td>$35</td>
<td>80% covered</td>
<td>70% covered</td>
</tr>
<tr>
<td>(30 day supply)</td>
<td></td>
<td>(up to $200 copay maximum per prescription)</td>
<td>(up to $200 copay maximum per prescription)</td>
</tr>
<tr>
<td><strong>Mental Health / Substance Abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>$500 per day copay</td>
<td>$250 per admission copay</td>
<td>$100 then 90% covered</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>$30 per individual visit; Group Visit: MH: $15 &amp; SA: $5</td>
<td>$20 per visit</td>
<td>90% covered</td>
</tr>
</tbody>
</table>

¹ Unless otherwise specified, copayments/coinsurance are calculated on allowable amounts. Participating providers agree to accept Blue Shield’s allowable amount plus the plan’s and any applicable member’s payment as full payment for covered services. Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments/coinsurance plus any amount that exceeds Blue Shield’s allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your calendar-year deductible accrue toward the out-of-pocket maximum.

² Participating non-hospital based (“freestanding”) lab or radiology centers may not be available in all areas. Lab and radiology services may also be obtained from a hospital or from a lab and radiology center that is affiliated with a hospital, and paid according to the benefit under your health plan’s hospital benefits.

³ The maximum allowed charge for non-emergency hospital services received from a non-participating hospital is $600/day. Members are responsible for 40% of this $600/day plus all charges in excess of $600. Payments that exceed this allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be owed after the maximum is reached.

¹ The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-participating hospital is $350/day. Members are responsible for 40% of this $350/day plus all charges in excess of $350.

³ Limited to office visits and consultations only. To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health services must be provided by a MHSA network participating provider.
HEALTH SAVINGS ACCOUNT

What is an HSA?

A Health Savings Account (HSA) is an account that you can use to pay healthcare expenses. Eligibility requires that an employee must be enrolled in a high deductible health plan (HDHP), and not entitled (eligible or enrolled) to Medicare.

2015 IRS contribution limits:

✓ $3,350 for individual coverage
✓ $6,650 for family coverage
✓ $1,000 catch-up for employees age 55 or older

Advantages of an HSA

✓ HSA is voluntary, not mandatory
✓ Employee owns the account; portable
✓ Triple Tax Advantage
  - Contributions pre-tax (federal and most state)
  - Earned interest or investment income accrue tax free
  - Disbursement tax free; as long as used for medical expenses (pay income tax + 20% penalty if disbursement is used for non-medical expense)
✓ No claim or expense substantiation required
  - Retain receipts
  - Wells Fargo Visa debit card; ATM withdrawal
✓ HSA funds to pay for eligible medical expenses
  - IRC Section 213(d), same as FSA
  - Medicare/LTC premium
✓ HSA funds roll over from year to year
  - No use it or lose it provision like FSA
  - Although you must be insured in an HDHP to contribute into an HSA, you don't have to be enrolled in an HDHP to use HSA funds
  - Funds must be available in the account to access

Note: If you enroll in the HDHP and open an HSA you will be eligible to participate in the Limited Purpose Health Care Flexible Spending Account.

2015 HSA Account Fees

Fees may apply for additional services. Contact Wells Fargo at 866-884-7374 or www.wellsfargo.com/hsa

HSA Questions

Wells Fargo HSA Customer Service can help you maximize the value of your HSA. Contact Wells Fargo at 866-884-7374 or www.wellsfargo.com/hsa
HEALTH SAVINGS ACCOUNT

HSA/FSA Comparison Chart

<table>
<thead>
<tr>
<th></th>
<th>Health Savings Account</th>
<th>Limited Purpose Health Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>An employee schedule to work at least 30 hours per week and enrolled in HDHP. Not enrolled in Medicare. Not eligible to be claimed as a dependent on another individual's tax return. Not covered by any other medical plan that is not an HSA-compatible health plan.</td>
<td>An employee scheduled to work at least 30 hours per week. No medical enrollment required.</td>
</tr>
<tr>
<td>Contribution Methods</td>
<td>Pre-tax deduction through WesternU if Wells Fargo is selected as the financial institution.</td>
<td>Pre-tax contribution through WesternU payroll deduction.</td>
</tr>
</tbody>
</table>
| Annual Contribution Limits | Individual: Up to $3,350  
Family: Up to $6,650 | Up to $2,550 maximum                                                                              |
| Catch-Up Contributions  | Available for participants age 55 and above by year-end who are not enrolled in Medicare. Catch-up contribution is $1,000 for each individual. | No. Employees can only contribute up to plan’s maximum amount.                                   |
| Annual Rollover         | Yes. Automatic rollover and unlimited carryover to the following year.                  | Yes, up to $500.                                                                                |
| Investment Income       | Yes.                                                                                   | Not applicable.                                                                                 |
| Portability             | Yes.                                                                                   | Not portable.                                                                                  |
| Reimbursement of Non-qualified Health Expenses | Yes. If funds are used for non-section 213(d) expenses the amount will be considered taxable income and a 20% penalty will apply, except for those over 65, deceased or disabled. | No. Health Care FSA must only be used for qualified health care expenses as identified by Section 213(d) of the IRS code. |
| Use of Funds            | Funds must be in account before they can be used.                                       | Funds can be used upfront before full annual contributions have been made.                      |
| Administration          | Self-administered.                                                                     | Administered by a third-party carrier.                                                          |

Convenient Access

With a swipe of your Wells Fargo Visa HSA debit card, you can pay for prescriptions, doctor’s visits, dental expenses, hearing aids, eye glasses and more. Each time you use your HSA debit card, expenses are automatically deducted from your HSA. You can also make withdrawals from your HSA by visiting any Wells Fargo branch or Wells Fargo ATM.

Investment Opportunity

Once you reach a minimum balance in your FDIC-insured deposit account, you have the option to invest in a diverse range of mutual funds. It’s easy to find funds that meet a variety of long-term investment strategies. Tools are available to help you research, manage, and optimize your investment opportunities at the HSA Investment Center. And, through the relationship with Wells Fargo Advantage Funds, investment professionals are available to assist you.
Kaiser Resources

My Health Manager

When you’re a registered member on kp.org, you get a one-stop resource for managing your health online. It offers time-saving features 24 hours a day, seven days a week. With My Health Manager, you can:

✓ Email your doctor’s office
✓ View most lab results
✓ View your immunization record
✓ View past visit information
✓ Make/cancel appointments
✓ View list of ongoing health conditions
✓ Refill prescriptions
✓ Get maps, directions and contact information to our facilities
✓ Mobile app available

Health Guides A to Z

Health Encyclopedia
In-depth information on health conditions, related symptoms, and treatment options at kp.org/health.

Symptom Checker
Interactive visual aid to assess your symptoms. Click on the part of the body that’s troubling you and learn what to do next at kp.org/symptoms.

Drug Encyclopedia
Look up detailed descriptions of thousands of drugs at kp.org/medications. Find out how to use a medication, its possible side effects, and any precautions you should take. You can search by drug name or medical condition.

Natural Medicines Comprehensive Database
Visit kp.org/naturalmedicines to find answers to your questions about dietary supplements, vitamins, minerals and other natural products.

Look, Listen and Learn
Get your health information to go. Download guided imagery audio programs and other wellness recordings at kp.org/listen. Or take in one of our health videos at kp.org/watch.

Interactive Tools and Calculators
Take a quiz or enter your information into one of our calculators to learn more about your health. Go to kp.org/calculators to find these interactive tools.

Kaiser Healthy Lifestyle Programs

Kaiser Permanente invites you to take an active role in improving your health with free, customized online programs that are designed to help you succeed in creating a healthier lifestyle. These programs are brought to you in collaboration with HealthMedia®, and focus on your total health-mind, body and spirit. They’ll help you evaluate your daily routines and discover what steps you should take to get your life headed in a healthier direction.

To select the program you want, sign on to kp.org/healthylifestyles. To use these programs for the first time, all you need to do is register at kp.org/register. Then sign on with your user ID and password.

Fill out the online questionnaire and you’ll receive a customized guide to the program you specify. You can start measuring your success within weeks of completing your program. For programs in Spanish, go to kp.org/vidasana.
MEDICAL BENEFITS

Discount Programs to Help You Stay Healthy

Now you have another way to feel good, healthy and strong – for less. As a Kaiser Permanente member, you now have access to a variety of new programs to help you stay healthy. Provided by American Specialty Health (ASH), you can get discounts and preferred rates on:

- Chiropractic, acupuncture and massage therapy
- Fitness club memberships
- Health tools and health products

You have a choice of chiropractors, acupuncturists and massage therapists from across the country. As a Kaiser Permanente member, you receive a 25% discount off a provider’s regular rates. You don’t need a referral from your personal physician to request an appointment for these services and there’s no limit on how many times you see a provider.

To select a chiropractor, acupuncturist or massage therapist, go to kp.org/healthyroads to view American Specialty Health (ASH)’s directory of providers, or call the toll-free customer service line at 1-877-335-2746. Once you’ve made your selection, call the provider directly to make an appointment. When you go for your appointment, be sure to show your Kaiser Permanente identification (ID) card to receive your 25% discount. You’ll pay the practitioner directly; no money is sent to Kaiser Permanente.

Get preferred membership rates at fitness clubs near you and get active. You’ll receive the lowest membership rates for the type of program you select at participating fitness clubs. To join a fitness club, go to kp.org/healthyroads or call 1-877-335-2746 to find a facility near you. Receive the preferred rate when you register by showing your Kaiser Permanente ID card.

In addition to the health resources you receive at Kaiser’s web site, you can link to the Healthyroads’ web site, kp.org/healthyroads, to find:

- A directory of ASH’s contracted providers and fitness clubs
- Educational information on complementary health
- An online store with more than 2,400 quality brand name health products at discounts of 15% or more off the suggested retail price, plus free shipping
- Online health assessment tools and more than 35 health trackers to log what you eat, when you exercise and more

Kaiser Permanente Health Education Services

Health education classes offer information on self-care skills, caring for others, and making healthier lifestyle choices. In each of our local service areas, you can sign up for classes that discuss:

- Asthma
- Cardiovascular disease
- Depression
- Diabetes
- Chronic conditions
- Perinatal and postnatal care
- Smoking cessation
- Stress reduction
- Weight management
Classes are open to Kaiser Permanente members and their families; some are open to nonmembers. Many classes are offered at no charge.

**MEDICAL BENEFITS**

**Blue Shield Resources**

With your Blue Shield membership, you’ll get more with a website created just for you. You’ll have access to a variety of online resources around the clock:

- My Health Plan – benefits, claims, forms
- The pharmacy – information about drugs and generics, mail service prescriptions, locations
- Condition Management Tool
- Ask & Answer – ask your questions to other members and Blue Shield clinicians
- Find a provider
- Health & Wellness programs and information
- Hospital Comparison Tool
- Ratings & Reviews – give candid feedback about your plans and services

**Healthy Lifestyle Rewards**

Healthy Lifestyle Rewards is an interactive online program that gives you the resources, motivation, and support you need to eat healthy, get fit, manage stress, quit smoking, and more. This is your chance to make progress toward your personal wellness goals.

Get support in these areas:

- Stress reduction
- Smoking cessation
- Emotional wellness
- Weight management
- Exercise
- Nutrition

To get started, go to [blueshieldca.com/hlr](http://blueshieldca.com/hlr) to register!

**Case Management**

Case managers help ensure members have access to the right care at the right time. Case managers provide education, care coordination, and personal support to members when they need it most. Programs include:

- Transplant Program
- Neonatal Intensive Care Unit (NICU) Case Management Program
- Chronic Complex Case Management Program
- High-Risk Case Management Program
- High-Risk Maternity Case Management Program

**NurseHelp 24/7**

Call NurseHelp 24/7 toll-free at 877-304-0504 and talk with a registered nurse anytime you have health-related questions.
Experienced nurses can help you figure out how you can care for yourself, evaluate treatment options, and help you determine whether to see a doctor.
### MEDICAL BENEFITS

#### Wellness Discount Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Description/Discount</th>
</tr>
</thead>
</table>
| **Diet and Exercise**    | • Discounts on membership fees and gym fees, including waived enrollment and processing fees  
                              • Special pricing on membership rates for local meetings, at-home kits, and online program savings                                                                 |
| 24-Hour Fitness, ClubSport, and Renaissance ClubSport |                                                                                                                                             |
| Weight Watchers          |                                                                                                                                             |
| **Non-prescription drugs** | • 5% off non-prescription drugs  
                              • 15% off herbal vitamins and supplements in the natural supplements line  
                              • 15% discount for contact lenses (first-time customers) and 5% discount for any subsequent orders  
                              • 5% back in rewards for every dollar spent (with participation in the drugstore.com dollars program)                                              |
| Drugstore.com            |                                                                                                                                             |
| **Alternative Care**     | • 25% discounts for services                                                                                                                                                        |
| Acupuncture              |                                                                                                                                             |
| Chiropractic             |                                                                                                                                             |
| Massage Therapy          |                                                                                                                                             |
| **Vision**               | • 20% discount at participating providers  
                              • 15% discount on LASIK laser vision correction surgery through the TLCVision provider network in California                                                                 |
| Exams, lenses, and frame discounts and LASIK |                                                                                                                                                  |

#### Other Programs Include

- **Prevention Program** – Log on to blueshieldca.com or call the Member Services number on your Blue Shield member ID card.

- **Prenatal Education** – Join by logging on to blueshieldca.com/prenatal or calling 1-877-371-1511.

- **Disease Management** – Log on to [blueshieldca.com](http://blueshieldca.com) or call the Member Services number on your Blue Shield member ID card.

- **CareTips** – Notifies your physician of any gaps in your care.

- **LifeMAP and Guided Imagery Program** to help you prepare for and inform you of upcoming surgery. Log on to blueshieldca.com and click on *Surgery: Before and After* in Condition Management of the Health & Wellness section, or email guidedimagery@blueshieldca.com

- **Life Referrals 24/7** – Access to support and advice from experienced professionals. Call any time at 1-800-985-2405.

- **Online Pharmacy Resources** – Online drug resources that include: a drug database and formulary, drug interactions tool, ask the pharmacist, find a pharmacy and mail service pharmacy. Log on to blueshieldca.com and click on *Pharmacy*. 
DENTAL BENEFITS

Dental Overview

The dental coverage offered by Western University of Health Sciences is designed to assist you and your covered dependents by paying a portion of eligible expenses incurred for a wide range of dental services. The dental plan is insured through MetLife and they offer two comprehensive dental options: the DMO plan and the DPO plan.

Remember, if you enroll in the DMO plan, you will need to select a Primary Care Dentist (PCD) for dental care. Services from specialists will require your PCD’s referral and authorization from MetLife. If a PCD is not selected during enrollment, MetLife will select one for you. If you select the DPO plan, you may select and access any dentist you choose – however, if your dentist is not in the MetLife network, your benefits may be reduced.

The College of Dental Medicine is an in-network provider for the DPO Plan.

Benefit Summaries

<table>
<thead>
<tr>
<th>Benefits</th>
<th>DMO¹</th>
<th>DPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>N/A</td>
<td>$25</td>
</tr>
<tr>
<td>Family Deductible</td>
<td>N/A</td>
<td>$75</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>Unlimited</td>
<td>$1,500 per person</td>
</tr>
<tr>
<td>Preventive (exams, x-rays,</td>
<td>$0 copay</td>
<td>100% Covered;</td>
</tr>
<tr>
<td>cleaning, fluoride, sealants)</td>
<td></td>
<td>Deductible waived</td>
</tr>
<tr>
<td>Basic Restorative (fillings,</td>
<td>$0 to $175 copay</td>
<td>90% covered after</td>
</tr>
<tr>
<td>extractions, oral surgery,</td>
<td></td>
<td>deductible</td>
</tr>
<tr>
<td>endodontics, periodontics)</td>
<td></td>
<td>80% of R&amp;C* covered after deductible</td>
</tr>
<tr>
<td>Major Restorative (crowns,</td>
<td>Copays as listed in the Schedule of Copayment</td>
<td>60% covered after deductible</td>
</tr>
<tr>
<td>dentures, bridges)</td>
<td></td>
<td>50% of R&amp;C* covered after deductible</td>
</tr>
<tr>
<td>Dental Implants</td>
<td>Not covered</td>
<td>60% covered after deductible</td>
</tr>
<tr>
<td>Orthodontia (Adults and Child(ren))</td>
<td>$1,695 copay</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*R&C – Reasonable and Customary charge is a charge which falls within the common range of fees billed by a majority of dentists for a procedure in a given geographic region as determined by MetLife.

¹ Please refer to Schedule of Copayment for further detail for covered services and applicable copays.

If enrolling in MetLife’s DMO, an ID card will be issued to you. For DPO, generic ID cards can be downloaded at the Benefit Resource Center (BRC) at [https://hrportal2.plansource.com/entities/24017/pub_nodes/1019](https://hrportal2.plansource.com/entities/24017/pub_nodes/1019).
DENTAL BENEFITS

Dental Resources

Provider Search

1. Open up your web browser and type in the following web address: www.metlife.com/dental
2. On the right-hand side of this homepage, you will select either ‘Dental PPO’ or ‘Dental HMO,’ depending on what plan you’re enrolled in. You will also need to key in a 5-digit zip code.
3. Once these two steps have been completed, click ‘GO.’
   a. If you are on the DPO, this search will pull the first 50 results within the 5-digit zip code. At the bottom of this page, the member has the option to further refine this search by clicking on ‘More Search Options,’ which will allow the member to search by Dentist Last Name, Dental Practice Name, or Specialty.
   b. If you are on the DMO, the secondary screen requires that you select your Plan Name (SGX150A) within the drop down box provided.
4. Please note that you do have the option to e-mail or print results with the icons shown on the webpage after results have loaded.
5. Should you have issues with accessing our website, you may also contact MetLife customer service at 1-800-275-4638.

MyBenefits Registration Overview

MyBenefits provides you with a personalized, integrated and secure view of your MetLife-delivered benefits. You can take advantage of a number of self-service capabilities as well as a wealth of easy to access information including planning tools and oral health awareness material. MetLife is able to deliver services to you that empower you to manage your benefits. As a first time user, you will need to register on MyBenefits.
**VISION**

### Vision Overview

Welcome to VSP® Vision Care. VSP will help keep you and your eyes healthy through personalized care from a doctor you can trust. Your eyes say a lot about you and can even tell your VSP doctor about you. During your WellVision® Exam, your VSP doctor will look for vision problems and signs of health conditions too.

### Benefit Summary

<table>
<thead>
<tr>
<th>Benefit</th>
<th>VSP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Copay</strong></td>
<td>$10 Exam copay and $25 Materials copay</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td>Once every 24 months</td>
</tr>
<tr>
<td>Frame</td>
<td>Once every 24 months</td>
</tr>
<tr>
<td>Contacts (in lieu of glasses)</td>
<td>Once every 24 months</td>
</tr>
<tr>
<td>Exam</td>
<td>Covered</td>
</tr>
<tr>
<td>Lenses</td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>Covered</td>
</tr>
<tr>
<td>Lined Bifocal</td>
<td>Covered</td>
</tr>
<tr>
<td>Lined Trifocal</td>
<td>Covered</td>
</tr>
<tr>
<td>Frames</td>
<td></td>
</tr>
<tr>
<td>Covered up to $130 then 20% discount above allowance</td>
<td>Up to $70</td>
</tr>
<tr>
<td>Contacts</td>
<td>Covered up to $130</td>
</tr>
</tbody>
</table>

### Vision Resources

- Find the right VSP doctor for you. You’ll find plenty to choose from at vsp.com or by calling 1-800-877-7195.
- Already have a VSP doctor? Make an appointment today and tell them you’re a VSP member.
- Check out your coverage and savings. Visit vsp.com to see how much you saved with VSP after your appointment.

That’s it! VSP will handle the rest – no ID card necessary or claim forms to complete.

### Extra discounts and savings

- Average 35-40% savings on lens options, i.e. tints, scratch and anti-reflective coatings.
- 20% off additional glasses and sunglasses within 12 months of your last eye exam.
- Contacts - 15% off cost of contact lens exam (fitting and evaluation).
- Laser Vision Correction - Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

The College of Optometry is an in-network provider.
LIFE AND ACCIDENT

Life Insurance is designed to provide a level of financial protection to your family in the event of your death. Accidental Death and Dismemberment (AD&D) Insurance provides an additional benefit if your death results from an accident, or if an accident causes certain serious injury.

Actively at Work

If you are absent from work due to injury, sickness, or leave of absence, you are not considered actively at work. If you are not actively at work on the day the coverage is approved, the coverage will be pended until the first day you return to an actively at work, benefit eligible status.

Basic Life and AD&D Benefits

Western University of Health Sciences provides you with Basic Life and AD&D coverage at no cost to you. You are automatically enrolled for Basic Life and AD&D insurance on the date of eligibility.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Unum - Basic Life/AD&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td>1x annual earnings, rounded to the next higher $1,000 – plus $10,000</td>
</tr>
<tr>
<td>Maximum Benefit Amount</td>
<td>$260,000</td>
</tr>
<tr>
<td>Accelerated Death Benefit</td>
<td>75%, maximum of $500,000</td>
</tr>
<tr>
<td>Age Reduction Schedule</td>
<td></td>
</tr>
<tr>
<td>Age 70</td>
<td>65% of original amount</td>
</tr>
<tr>
<td>Age 75</td>
<td>50% of original amount</td>
</tr>
</tbody>
</table>

Supplemental Life

You may elect to purchase through payroll deduction supplemental life for yourself, your spouse/registered domestic partner and your eligible dependent children.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Unum – Supplemental Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Amount</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>1, 2, or 3x your annual earnings to a maximum of $500,000 (Basic and Supplemental Life combined)</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,000 increments up to maximum of $250,000; not to exceed 50% of employee’s supplemental life amount</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>Birth to 6 months: $1,000; 6 months to age 21: $10,000</td>
</tr>
</tbody>
</table>

Guaranteed Issue

<table>
<thead>
<tr>
<th>Benefit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Lesser of 3x annual earnings plus $10,000 or $410,000 (Basic and Supplemental Life combined)</td>
</tr>
<tr>
<td>Spouse</td>
<td>$50,000</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$10,000</td>
</tr>
</tbody>
</table>
Supplemental Life Rates

Supplemental Life Rates: For each $1,000 of Supplemental Life Insurance, the monthly premium rate shall be determined in accordance with employee’s age as follows:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rates</th>
<th>Age Group</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 30</td>
<td>$0.043</td>
<td>55-59</td>
<td>$0.522</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.051</td>
<td>60-64</td>
<td>$0.846</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.077</td>
<td>65-69</td>
<td>$1.351</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.128</td>
<td>70-74</td>
<td>$2.103</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.197</td>
<td>75+</td>
<td>$3.634</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.299</td>
<td>Dependents Family Unit</td>
<td>$0.15/$1,000</td>
</tr>
</tbody>
</table>

Spouse’s monthly premium is calculated based on employee’s age.

$$\frac{\text{Elected Benefit Amount}}{1,000} \times \text{Rate Above} = \text{Your Monthly Cost}$$

Evidence of Insurability is required for supplemental life if you:

- Are already enrolled and increasing your and/or your spouse/registered domestic partner’s coverage regardless of the amount; or
- Previously waived coverage and are electing supplemental life coverage for the first time regardless of the amount.

**Update your Beneficiary!**

Please remember to keep your beneficiary designations up to date. This will guarantee that your loved ones will be protected. Please contact Human Resources as soon as possible if you would like to update or check on your beneficiaries.
LIFE AND ACCIDENT

Conversion (Applies to life coverage only)

When coverage ends under the plan, you and your dependents can convert your coverage to individual life policies without evidence of insurability. Converted insurance is an individual, whole-life, premium plan. You can convert any time coverage is lost for any reason, such as:

- Termination of employment,
- Becoming ineligible for benefits due to a reduction in hours,
- The ported coverage ends, or
- Western University of Health Sciences’ policy is cancelled and coverage is not provided through a successor carrier (total loss of coverage) or replacement coverage is less than what you had in force (lost amounts can be converted).

Coverage for your spouse or child can be converted when coverage is lost due to divorce, reaching the maximum age of coverage for the group plan, reaching the age of majority (child) or the subscriber’s employment is terminated. You and/or your dependents may convert up to the in force amount lost and coverage amount cannot be increased. Evidence of Insurability is not required.

You and your dependents must apply for individual life insurance under this life conversion and pay the first premium within 31 days after termination of group coverage.

Portability (Applies to life and AD&D coverage only)

In addition to conversion, you also have the option to port your life and/or AD&D coverage if your employment ends or you retire from Western University of Health Sciences; or you are working less than the minimum number of hours required to be benefit eligible. You may elect portable coverage for yourself and your dependents.

The portable insurance coverage will be the current coverage and amounts that you and your dependents are insured for under Western University of Health Sciences’ group plan. The coverage limit is outlined below:

<table>
<thead>
<tr>
<th>The amount of portable coverage for you will not be more than:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee</strong></td>
</tr>
<tr>
<td>✓ The highest amount of life insurance available for the employees; or</td>
</tr>
<tr>
<td>✓ 5x your annual earnings; or</td>
</tr>
<tr>
<td>✓ $750,000 from all Unum group life and AD&amp;D plans combined; whichever is less.</td>
</tr>
<tr>
<td><strong>Spouse/Registered Domestic Partner</strong></td>
</tr>
<tr>
<td>✓ The highest amount of life insurance available for spouse under the plan; or</td>
</tr>
<tr>
<td>✓ 100% of your amount of portable coverage; or</td>
</tr>
<tr>
<td>✓ $750,000 from all Unum group life and AD&amp;D plans combined; whichever is less.</td>
</tr>
<tr>
<td><strong>Child</strong></td>
</tr>
<tr>
<td>✓ The highest amount of life insurance available for spouse under the plan; or</td>
</tr>
<tr>
<td>✓ 100% of your amount of portable coverage; or</td>
</tr>
<tr>
<td>✓ $20,000 from all Unum group life and AD&amp;D plans combined; whichever is less.</td>
</tr>
</tbody>
</table>

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after the date your coverage ends or you retire from Western University of Health Sciences; or you work less than the minimum number of hours required to be in a benefit eligible class.
Long Term Disability

Would you be able to meet your financial responsibilities if you were ill or injured and could not work for a period of time? Western University of Health Sciences provides core Long Term Disability benefits at no cost to you, to protect you and your family in the event of serious illness or injury. You may elect to purchase through payroll deduction, voluntary Buy-Up LTD coverage at group rates on an after tax basis. Benefits are provided through Unum.

| Benefit                  | Core LTD | Buy-Up LTD  
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>($0.40 per $100 of monthly income)</td>
</tr>
<tr>
<td>% of Covered Salary</td>
<td>60%</td>
<td>66.67%</td>
</tr>
<tr>
<td>Maximum Monthly Benefit</td>
<td>$4,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Minimum Monthly Benefit</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Elimination Period</td>
<td>180 days</td>
<td>180 days</td>
</tr>
<tr>
<td>Definition of Disability</td>
<td>2 year “own occupation”</td>
<td>2 year “own occupation”</td>
</tr>
<tr>
<td>Benefit Duration</td>
<td>Normal retirement age</td>
<td>Normal retirement age</td>
</tr>
</tbody>
</table>
LONG TERM CARE BENEFITS

Long Term Care is defined as the type of care received either at home or in a facility when someone needs assistance with activities of daily living, or suffers severe cognitive impairment due to an accident, an illness or advancing age. Long Term Care insurance pays benefits when a physician certifies that you are unable to perform (without substantial assistance from another individual), two of six Activities of Daily Living (ADLs), for a period that is expected to last at least 90 days, or that you require Substantial Supervision by another individual to protect yourself and others from threats to health of safety due to Severe Cognitive Impairment. Benefits may be paid if loss of ability occurs on or after the coverage effective date. The treatment and services you receive for your Chronic Illness must be provided pursuant to a Plan of Care developed by a Licensed Health Care Practitioner, your physician of a multi-disciplinary team.

The ADLs are: bathing, dressing, toileting, transferring, continence and eating.

This benefit is available to you and your family members. Family members are your spouse/registered domestic partner, adult children, siblings, parents (in-law) and grandparents (in-law) ages 18 to 80 must satisfy the Application for Long Term Care Insurance.

<table>
<thead>
<tr>
<th>Benefit Duration</th>
<th>3 Years</th>
<th>6 Years</th>
<th>Unlimited Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Benefit Amount (In Increments of $1,000)</td>
<td>$3,000 to $8,000</td>
<td>$3,000 to $8,000</td>
<td>$3,000 to $8,000</td>
</tr>
<tr>
<td>Residential Care Facility</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Lifetime Maximum Per $1,000 Increments</td>
<td>$36,000</td>
<td>$72,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Home and Community-Based Care</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Home, Community-Based and Immediate Family Member Care – Option</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inflation Protection – Options</td>
<td>Compounded Uncapped</td>
<td>Compounded Uncapped</td>
<td>Compounded Uncapped</td>
</tr>
</tbody>
</table>

*Please refer to Unum Enrollment Packet for further detail

Evidence of Insurability

You may enroll without Evidence of Insurability (EOI) when you first become eligible (e.g. when you are hired or go from benefit ineligible to eligible status). EOI is required by Unum when you enroll in LTC outside of your initial enrollment period.
FLEXIBLE SPENDING ACCOUNTS

This program allows you the opportunity to set aside money from your paycheck on a pre-tax basis to pay for health care expenses not covered by your medical, dental or vision plan, and expenses incurred in taking care of a qualified dependent child or adult.

Health Care FSA

Effective 3/1/15, the Health Care FSA maximum contribution amount is increasing from $2,500 to $2,550.

The Health Care FSA is a supplement to our benefit menu and is not intended as a replacement to the medical plan. The debit card will be loaded with the value of your annual Health Care FSA election and allow you to pay qualified out-of-pocket health care expenses not covered by insurance such as:

- Health plan copays, coinsurance, and deductibles;
- Prescription copays;
- Out-of-pocket dentist, orthodontic, or other provider fees;
- Lasik surgery and eyeglasses;
- Balance due notices from eligible providers.

Save your receipts. While most Health Care FSA expenses can be verified automatically, you may be required to substantiate the expense. You may also be required to submit a completed claim form for reimbursement. An Explanation of Benefits (EOB) statement that outlines the expense must accompany claim forms for health care expenses. You will be reimbursed up to the amount you have elected to contribute for the Plan Year (March 1 through end of February). Any unsubstantiated claims from debit card swipes are subject to tax implications on your W-2 and/or additional withholdings from future paychecks.

Please note that if you are contributing to an HSA, your Health Care FSA must be a limited purpose FSA. Under the limited purpose FSA, your reimbursements will be limited to your out-of-pocket vision, dental, and other expenses after you meet your deductible under the PPO (HDHP) plan. The plan election maximum is $2,550.

$500 Carryover Provision

If you have money remaining in your Health Care FSA at the end of the plan year (2/28/15), you can carryover a maximum of $500 to the next plan year. The amount you carryover will not apply to the maximum contribution amount of $2,550.

Online tools to help you maximize your Card — available on www.benesyst.net

Can I get reimbursed for this Over-The-Counter (OTC) item?
Log in to your account for a reference guide of all eligible OTC FSA expenses. It also lists ineligible expenses. You will not be able to charge ineligible expenses.

Is my pharmacy a Participating Paperless Merchant?
This list of participating merchants is updated daily.
**FLEXIBLE SPENDING ACCOUNTS**

**Dependent Care FSA**

You may contribute up to $5,000 each plan year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum amount you may contribute is $2,500 each plan year. If your spouse’s employer offers a Dependent Care FSA, you and your spouse can contribute a combined maximum of $5,000 to your accounts each plan year.

You can use your Dependent Care Account to pay for eligible expenses during the year such as:

- Day care provided by individuals inside or outside of your home;
- Day care at a licensed nursery school, day camp (not sleep-away camp) or day care center;
- Day care for an elderly dependent; and
- A nanny who cares for your eligible dependents.

If you participate in the Dependent Care FSA, you will need to provide the taxpayer identification number (or Social Security number) of the caregiver. An eligible dependent means; your child under age 13; or a mentally or physically disabled spouse, parent or other relative who spends at least eight hours a day in your home. In addition, you must claim the person as a dependent on your federal income tax return.

**How to File a Claim**

You can obtain a reimbursement request form at [www.benesyst.net](http://www.benesyst.net).

**Claim Filing Deadline**

The deadline to file claims for Health Care and/or Dependent Care FSA is 90 days following the close of the Plan Year (i.e. for 2014/2015 Plan Year, the deadline to file claims will be May 29, 2015).

If your employment is terminated, the following deadlines apply:

- **Health Care FSA:** 90 days following the close of Plan Year
- **Dependent Care FSA:** 90 days following the close of Plan Year

**Use it or Lose it!**

Carefully review your personal situation before enrolling in any reimbursement account – the IRS requires that you forfeit any unused money remaining in your reimbursement accounts at the end of the plan year.

Keep in mind that for Health Care FSA, you can rollover up to $500 to the next plan year if you have a balance remaining in the account at the end of the plan year.
FLEXIBLE SPENDING ACCOUNTS

Important FSA Guidelines

If you elect to participate in these accounts, you must enroll each year in order to continue participating. Enrollment is never automatic.

As with any tax-advantaged program, there are some rules in exchange for the tax break:

- You cannot transfer money between your Health Care and/or Dependent Care FSA;
- You cannot change the amount you originally elect to contribute during the year – unless you have a qualifying life event;
- You cannot claim expenses on your federal income tax return if you’ve already been reimbursed for them through a FSA;
- You must spend all monies set aside in each account during the plan year;
- The IRS regulates that any monies left in your account cannot be carried over and will be forfeited (excludes the $500 rollover amount); and
- If you have questions about claiming expenses on your tax return vs. reimbursement through the FSA, consult your tax adviser.

This means planning for upcoming Health Care and/or Dependent Care expenses carefully. **Once you’ve finished the enrollment, enjoy your tax break!**

Online tools to help you maximize your FSA — available on www.benesyst.net

**How much should I contribute? / How much can I save?**

The FSA Calculator will help you determine how much you should contribute to an FSA and how much you can save if you do contribute.

**Can I get reimbursed for this item?**

Log in to your account for a reference guide of all eligible expenses for both Health and Dependent Daycare FSAs. It also lists *ineligible* expenses. You will not be able to charge ineligible expenses.

**How much do I have left in my account?**

Log in to your account to see your remaining balance and other valuable information.

Mobile Tools for your FSA — MyTASC Mobile App

Use the mobile app capabilities for quick and easy access to your account(s) anytime, anywhere. The MyTASC Mobile App is a free download from the Apple iStore® and Android Market™ for smartphones and tablets. Once downloaded, you can log in with your username and password.

Through the App, you can:

- Submit reimbursement requests for FSA expenses
- Upload pictures of receipts with your phone camera
- View real-time account balances and transactions for FSA plans and your MyCash account
- Review FSA plan information and annual contributions
- Enable login memory for faster access

For more information on MyTASC Mobile tools, please visit: [www.tasconline.com/mobile](http://www.tasconline.com/mobile).
EMPLOYEE ASSISTANCE PROGRAM

Western University of Health Sciences' Employee Assistance Program is provided by Optum. It is designed to help you maximize your health and effectiveness at home and at work. Through this plan, you receive confidential, personal support for a wide range of issues, from everyday concerns to serious problems. Western University of Health Sciences provides this program for you and your family at no cost to you.

Optum provides phone counseling and up to 5 face-to-face sessions per incident per year, with a professional at no cost to you and your family members who may experience:

- Marital or relationship difficulties
- Financial worries
- Substance abuse problems
- Parenting issues
- Elder care responsibilities
- Other family or work difficulties

In addition, Unum's EAP program provides 3 face-to-face sessions for each problem (not just per year). This service is completely confidential.
ADDITIONAL BENEFITS

Vacation and Sick Days

Western University of Health Sciences offers a generous vacation and sick pay package, plus 10 paid holidays per year.

Travel Assist

The worldwide emergency travel assistance services program is available through Unum and can help you obtain quality medical care when you have a health emergency while traveling 100 miles or more from home or in another country. The program arranges and pays for services such as doctor referrals, hospital admission guarantee*, help refilling lost or forgotten prescriptions, emergency medical evacuation, care of minor children and more when you are away from home in unfamiliar surroundings, legal/interpreter referral, return of mortal remains and much more, whether on business or for pleasure. This program is offered to employees as well as your spouse and dependent children. Extended family members are not considered members of the travel assistance services program. Spouse business travel – trips taken by the spouse on behalf of his or her employer – is excluded.

For a complete description of services, consult your membership brochure or visit www.unum.com/travelassistance

*May require a validation of your medical insurance or an advance of funds to the foreign medical facility. You must repay any expenses related to emergency hospital admissions to Assist America Inc., within 45 days.

Discounts and Online Marketplace

In partnership with Wells Fargo Insurance Services (WFIS), we are pleased to continue offering the BenefitHub. You have access to BenefitHub where you may log on for valuable online discounts and services.

BenefitHub

BenefitHub offers information and access to voluntary products that you can purchase directly from a carrier. The available plans are:

- Long Term Care Insurance,
- Critical Illness Insurance,
- Final Expense (Permanent Life Insurance), and
- Pet Insurance
- Auto/Home Insurance
- Legal Plans

You also have access to discounts, special offers, and big savings:

- Access to over 100,000 name brands at hundreds of your favorite retailers
- Discounts on concert tickets, theme parks, sporting events and more!
- Special monthly offers from some of the hottest brand names, including: Disney, Dell, 800Flowers, Barnes & Noble and more.
**BenefitHub**

It’s easy to get to the information you need, and it’s all in one place! To get started, you can follow these steps:

1. Go to [https://wfdiscounts.benefithub.com](https://wfdiscounts.benefithub.com)
2. Click on: “Create a new account”
3. Enter Referral Code: D2E7TV
4. Enter your email address
5. Click on “GET AN INVITE”
6. Receive your invite to BenefitHub

**Thousands of deals in every category!**

![Image of various categories: Computer & Electronics, Apparel, Music & Photos, Automotive, Beauty & Fragrance, Health & Wellness, Home, Garden, Pets, Tickets & Events, Food & Beverage]

**Employee Benefits Resource Center**

To view Western University of Health Sciences’ employee benefits and HR communication tool online you may log on to [http://bit.ly/UK9YQT](http://bit.ly/UK9YQT) or follow the link through Western University of Health Sciences’ intranet website under *Benefits At WesternU*. 
ADDITIONAL BENEFITS

Wells Fargo At Work℠

Western University of Health Sciences has partnered with Wells Fargo to offer you the Wells Fargo At Work℠ program — a valuable package of accounts, services and special benefits that may help you reach your financial goals.

Manage and grow your money with the Wells Fargo At Work℠ Package

✓ Earn interest on checking account when your balance is $500 or more
✓ Options to waive, or receive a discount on, the monthly service fees — including direct deposit of your salary²
✓ Many savings account options to help meet short- and long-term savings goals
✓ Benefits on mortgages, home equity and personal loans and lines of credit², ³

Maximize your money with helpful account tools and resources

✓ Access online tools to track spending, create a budget, establish savings goals, and monitor your progress
✓ Attend complimentary financial seminars on various topics including savings, credit, identity theft, and more (where available)
✓ Set up email or text account alerts to get spending limit and payment reminders⁴

Banking in the palm of your hand - Get free⁴ access to Wells Fargo Mobile® banking and you can:

✓ Deposit checks with Mobile Deposit
✓ Check available balances
✓ Pay your bills while on the go
✓ Transfer funds between accounts or to others
✓ Find a nearby Wells Fargo ATM

Enrollment is easy:

✓ Open a Wells Fargo At Work℠ at any Wells Fargo banking location
✓ Sign up for direct deposit or set up another qualifying account or service to help waive your monthly service fee
✓ Take advantage of all your Wells Fargo At Work benefits

To find out more, call 1-800-WFB-OPEN (1-800-932-6736) or stop by any Wells Fargo banking location.

¹ Please talk to a banker for more details — or refer to the Consumer Account Fee and Information Schedule — about minimum opening deposit requirements and how your account may qualify for a waiver of a discount of the monthly service fee.
² Home loans are subject to credit qualification and are originated by Wells Fargo Home Mortgage, a division of Wells Fargo Bank, N.A. Products are not available in all states and are subject to change without notice. You cannot combine these promotions or discounts with other Wells Fargo promotions or discounts.
³ All loans and lines of credit are subject to credit approval, verification and collateral evaluation. Products are not available in all states. Certain restrictions apply. Programs, rates, terms and conditions are subject to change without notice.
⁴ Your mobile carrier’s message and data rates may apply.
This insert contains important information about Western University of Health Sciences’ benefit plans. Please review this information and keep it with your other benefits material for future reference. Should you have any questions about the material in this document, you may contact Human Resources.

Patient Protection

Blue Shield HMO and Kaiser HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in Blue Shield HMO or Kaiser HMO networks and who is available to accept you or your family members. Until you make this designation, Blue Shield or Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Shield at 1-800-424-6521 or Kaiser at 1-800-464-4000.

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

You do not need prior authorization from Blue Shield or Kaiser 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 Blue Shield at 1-800-424-6521 or Kaiser at 1-800-464-4000.

Women’s Health and Cancer Rights Act

As a Plan participant or beneficiary of Western University of Health Sciences’ Health Plan who elects breast reconstruction in connection with a mastectomy you will also be covered for:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

This coverage will be provided after consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

This notice is provided to you for informational purposes. No action is required on your part.

If you have any questions regarding this notice, please contact Member Services at the number found on your Medical ID Card.

Newborns' and Mothers' Health Protection Act

Hospital Stay in Connection with Childbirth:

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
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 your employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs 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 a state listed below, 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.

*If you live in California, you may be eligible for assistance paying your employer health plan premiums. You should contact your state for further information on eligibility.*

<table>
<thead>
<tr>
<th>CALIFORNIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website:</td>
</tr>
<tr>
<td><a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a></td>
</tr>
</tbody>
</table>

If you or your child resides in a state other than ones listed above, contact Human Resources for information on how to contact your state.
Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like a 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. Western University of Health Sciences has determined that the prescription drug coverage offered by the Western University of Health Sciences’ Health and Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Western University of Health Sciences coverage will not be affected. See Pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Western University of Health Sciences coverage, be aware that you and your dependents may not be able to get this coverage back.
LEGAL NOTICES

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 Western University of Health Sciences and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact Rebecca Caballero at 1-909-469-5371 for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Western University of Health Sciences changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

✓ Visit www.medicare.gov

✓ Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help.

✓ Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

This Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of Western University of Health Sciences Employee Welfare Benefit Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

1. your past, present, or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact Western University of Health Sciences’ Privacy Office, Dr. Thomas Fox at 909-469-5270.

Effective Date

This Notice is effective on September 23, 2013.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail, electronically, or by another method permitted under the law.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.
LEGAL NOTICES

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.
LEGAL NOTICES

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:
- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official:
- in response to a court order, subpoena, warrant, summons, or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
LEGAL NOTICES

Research. We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
(2) treating such person as your personal representative could endanger you; and
(3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under “Your Rights”), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:
Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to [Employer Contact]. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to [Employer Contact].

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Office of Human Resources Attn: Rebecca Caballero, Benefits Administration.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to The Office of Human Resources Attn: Rebecca Caballero, Benefits Administration. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.
We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to the Benefits Administration. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to The Office of Human Resources Attn: Rebecca Caballero, Benefits Administration. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

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

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website [http://www.westernu.edu/hr-benefits](http://www.westernu.edu/hr-benefits).

To obtain a paper copy of this notice, contact The Office of Human Resources Attn: Rebecca Caballero, Benefits Administration.

**Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact The Office of Human Resources Attn: Rebecca Caballero, Benefits Administration:

309 E. Second Street  
Pomona, CA 91766  
Phone: 909-469-5371

All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.
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<thead>
<tr>
<th>Plan</th>
<th>Carrier</th>
<th>Phone</th>
<th>Website</th>
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<tbody>
<tr>
<td><strong>Medical</strong></td>
<td>Blue Shield</td>
<td>HMO: 1-800-424-6521 PPO: 1-800-200-3242</td>
<td><a href="http://www.blueshieldca.com">www.blueshieldca.com</a></td>
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<tr>
<td><strong>Medical</strong></td>
<td>Kaiser</td>
<td>1-800-464-4000</td>
<td><a href="http://www.kp.org">www.kp.org</a></td>
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<tr>
<td><strong>Dental</strong></td>
<td>MetLife</td>
<td>1-800-275-4638</td>
<td><a href="http://www.metlife.com/dental">www.metlife.com/dental</a></td>
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<tr>
<td><strong>Vision</strong></td>
<td>VSP</td>
<td>1-800-877-7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td><strong>Life and AD&amp;D</strong></td>
<td>Unum</td>
<td>EOI Status: 1-800-421-0344 Claims: 1-800-445-0402</td>
<td><a href="http://www.unum.com">www.unum.com</a></td>
</tr>
<tr>
<td><strong>Long Term Care</strong></td>
<td>Unum</td>
<td>1-800-693-4988</td>
<td><a href="http://www.unum.com">www.unum.com</a></td>
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<tr>
<td><strong>FSA</strong></td>
<td>Benesyst, A TASC Company</td>
<td>1-800-670-7131</td>
<td><a href="http://www.benesyst.net">www.benesyst.net</a></td>
</tr>
<tr>
<td><strong>EAP</strong></td>
<td>Optum</td>
<td>1-800-234-5465</td>
<td><a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> Access Code: WesternU</td>
</tr>
<tr>
<td><strong>EAP</strong></td>
<td>Unum</td>
<td>1-800-854-1446</td>
<td><a href="http://www.lifebalance.net">www.lifebalance.net</a> User ID &amp; Password: lifebalance</td>
</tr>
<tr>
<td><strong>Health Savings Account (HSA)</strong></td>
<td>Wells Fargo</td>
<td>1-866-884-7374</td>
<td><a href="http://www.wellsfargo.com/hsa">www.wellsfargo.com/hsa</a></td>
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<tr>
<td><strong>BenefitHub</strong></td>
<td>Wells Fargo Insurance</td>
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<td><a href="https://wfdiscounts.benefithub.com">https://wfdiscounts.benefithub.com</a> Referral Code: D2E7TV</td>
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<tr>
<td><strong>Employee Benefits Resource Center</strong></td>
<td>Western University of Health Sciences</td>
<td>N/A</td>
<td><a href="http://bit.ly/UK9YQT">http://bit.ly/UK9YQT</a></td>
</tr>
<tr>
<td><strong>Retirement Plan</strong></td>
<td>Mutual of America</td>
<td>1-800-468-3785 Tracey Smith: 1-562-983-0407</td>
<td><a href="http://www.mutualofamerica.com">www.mutualofamerica.com</a></td>
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