AZUSA PACIFIC
UNIVERSITY

2025 Employee Benefits

Effective January 1, 2025 through December 31, 2025

AZUSA PACIFIC
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Dear APU Community,

Thank you for the significant contribution you make at APU on a daily basis. The university strives to provide affordable, high-quality health insurance options for employees as an important part of APU's compensation package. Doing so is a tangible way to express our appreciation for all that you do to advance the university's mission and contribute to our legacy of transformation.

APU's open enrollment period for selection of 2025 health coverage is November 1-15. This year enrollment is required for **all benefit-eligible employees**–whether adding a spouse or dependent child, switching between plans, or even selecting the same benefits you had in 2024.

Medical Plans: Our core medical plans are Anthem Classic Select HMO and Kaiser HMO, with APU bearing approximately 80% of the cost for each. Despite cost pressures in the broader healthcare marketplace, APU's premium increases for 2025 are low, and we are able to maintain the current plans without increases in copays or deductibles.

Medical Four-Tier Structure: The medical plans are moving from the previous three-tier premium structure to a four-tier structure. You will have the option of *employee-only, employee+spouse, employee+child(ren), or employee+family* (employee plus spouse and child(ren)) coverage. Because the cost to insure one or more children is less than the cost to insure a spouse, those of you who only insure yourself and a child (or children) in 2024 and elect to do so again in 2025 will see only a small increase in cost, or even a substantive decrease. If you cover just a spouse and yourself, you will see an increase (less than ten percent) in cost, varying by plan. The new tier structure provides a good opportunity to review your options, including if your spouse has other options for coverage.

Lower Cost Options: With the multiple plans, there are choices available for those seeking to reduce their premium. As has been the case, those in the Anthem Classic HMO may want to consider the Classic Select HMO, which has a narrower network of providers but the same copays, deductibles, and plan design. Those in the Classic PPO may want to consider one of the three HMO plans APU offers or the high-deductible PPO (HDHP) with HSA; for the latter plan, APU will continue to contribute generously to the employee's HSA–$750 for those with *employee-only coverage, $1,250 for employee+spouse or employee+child(ren), and $1,750 for employee+family*.

Dental: Both the Delta Dental DHMO and Premier PPO options remain for 2025 with no plan design changes. Cost for the DHMO and PPO options will increase by under four percent and under six percent respectively, depending on tier.

Life Insurance: APU is changing life insurance carriers this year, which provides a one-time opportunity to review optional life insurance coverage opportunities and purchase up to $280,000 for yourself and up to $50,000 for your spouse on a guarantee-issue (i.e., no medical underwriting) basis.

For your convenience, Human Resources is hosting optional virtual workshops focused on maximizing your benefit choices. We encourage you to attend one of the sessions listed on page 21. We also invite you to join us at the Annual Health and Wellness Fair on Tuesday, November 5 from 11 am-1 pm on the West Campus lawn, where APU HR representatives, insurance carriers, and other benefits providers will be present to answer questions.

You may view Anthem network providers here. If you have any questions about the information outlined in this letter or in the rest of this brochure, please contact Phonetrya Yupiter, benefits manager, at 626.815.4686 or at pyupiter@apu.edu.

Blessings,

John Baugus
Associate Vice President of Human Resources

Aaron Dahlke
Vice President for Finance and Administration,
Chief Financial Officer

Special Points of Interest

- Make your benefit changes and confirm your elections via the APU online enrollment site by 9pm on November 15, 2024.
- APU's contribution to the HSA for those electing the HDHP will continue in 2025. See page 8 for additional information.
- See page 20 for employee premium information.
- See page 5 and 6 for medical plan comparisons.
- We will host 4 virtual open enrollment webinars. Please see page 21 for dates and times.

Open Enrollment 2025

Please take a look at all of the benefit materials included within this guide and use the resources available to you to make an educated decision about the benefit plans that are best for you and your family. Open enrollment occurs one time each year in November. This year, open enrollment is from November 1-15, 2024. During this time, you may add or delete dependents from your coverage, change your coverage level, or change your benefit elections without experiencing a qualifying event. The benefits and coverage you select during this enrollment period will take effect on January 1, 2025 and remain in effect through the plan year ending on December 31, 2025.
Please Note: This year's Open Enrollment is an Active Enrollment. If you do not make online enrollments, you will not have benefits for 2025.

Can I make changes during the year?

During the year, you can change your benefit elections only if you experience a qualifying event. You must notify Human Resources within 30 days from the time of your qualifying event. Qualifying events are:

- Marital status change (marriage, divorce, legal separation)
- Birth or adoption of a dependent child; or child reaches maximum age
- Employment status change (part-time to full-time, or full-time to part-time)
- Eligibility status change (change in hours, job loss, a new job, become entitled to Medicare or Medicaid)

Who is Eligible?

Full-Time Employees: regular, full-time employees regularly scheduled to work 30 hours or more per week are eligible upon the first day of the month following date of hire.
You may also elect coverage for you and your:

- Legal Spouse;
- Dependent children until the age of 26 regardless of student status;
- Dependent children over the carrier age limits who are physically or mentally incapable of self-support.

Accessing the APU Online Enrollment System

FIRST TIME USER:
Please contact benefits@apu.edu for a PRC code. Then go to workforcenow.adp.com and set up a new account as a New User with the personal registration code (PRC). Once registered, log back into personal registration code and go to Myself > Benefits > Open Enrollment to begin the process.

PREVIOUSLY REGISTERED:
Please go to workforcenow.adp.com and enter user ID: FLastname@azusa and password, then go to Myself > Benefits > Open Enrollment to begin the process.

Insurance Basics

Medical HMO

An HMO is a plan that offers coverage within a specific network of doctors and hospitals. Coverage under an HMO is only available through providers and facilities that are in-network. If you visit a doctor that is not in the HMO network, you are responsible for 100% of the cost of services.

WHAT KIND OF PERSON SHOULD OPT FOR A HMO?
Someone who is looking to pay reduced premiums, lower copays, and no coinsurance for in-network and covered services. HMOs are also great for patients who want a doctor dedicated to coordinating their care. Under an HMO plan, your primary care doctor (also called a primary care provider) will provide referrals when a specialist visit is necessary. An HMO could be a good option if your providers are contracted in the HMO network. An HMO plan may limit your ability to see doctors that you've seen in the past if they are not in-network

Medical PPO

PPO plans typically have premiums and deductibles that are higher compared to HMO plans. They also offer greater flexibility, such as expanded networks and no referral requirements.

WHAT KIND OF PERSON SHOULD OPT FOR A PPO?
If you are looking for greater flexibility to book appointments with providers who are in the PPO network (as well as those out-of-network) without a referral. It's important to note that you may pay a higher rate if you choose to go out-of-network. If you travel often, a PPO plan might be a better fit since they tend to be more flexible– which can be especially helpful if something unexpected happens and you need urgent care.

Dental HMO (DHMO)

If you elect coverage in this plan, you must select a primary care dentist from the DHMO contracted provider list. All care must be provided by the primary dentist. A referral is required in order to visit a specialist. You may change dentists once each month. Changes made prior to the 15th of the month will take effect on the first of the following month.

Dental PPO (DPPO)

Similar to a medical PPO plan, a dental PPO allows you to choose an in-network or out-of-network provider. Remember, going out-of-network will be more costly than visiting an in-network dentist. If you need services or treatments that will cost $300 or more, it is strongly recommended to ask for a predetermination of benefits from your dentist to understand the cost of services. Please be advised that ID cards are not necessary, and DPPO members may not receive ID cards.

Medical Coverage

The following charts summarize the benefits for the medical plan offered to all eligible employees of Azusa Pacific University. As an eligible employee, you may choose to enroll in one of the plans or waive coverage.

For the 2025 plan year, you will have the option to enroll in the Kaiser HMO, Anthem Classic Select HMO (Select Network), Anthem Classic HMO (California Care Network), Anthem Classic PPO, or Anthem PPO with HSA. Kaiser coverage includes vision, and the Anthem plans include VSP vision plan coverage.

Kaiser HMO & Anthem HMO side-by-side comparison:

	Kaiser $20 Copay HMO	Anthem Classic Select HMO	Anthem Classic HMO
Deductible Individual / Family	None	None	None
Out of Pocket Maximum Indidividual / Family	$2,000 / $4,000	$2,000 / $4,000	$2,000 / $4,000
Lifetime Benefit Max	Unlimited	Unlimited	Unlimited
Physician Services			
Primary Care	$20 Copay	$20 Copay	$20 Copay
Specialist Visits	$20 Copay	$40 Copay	$40 Copay
Preventive Care	Plan Pays 100%	Plan Pays 100%	Plan Pays 100%
Telehealth	Plan Pays 100%	$20 Copay	$20 Copay
Diagnostic X-Ray & Lab			
Complex Imaging	$50 Copay	$100 Copay	$100 Copay
Lab & X-Ray	$10 Copay	No Copay	No Copay
Hospital Services			
Inpatient Hospitalization	$250 Copay / Admit	$250 Copay / Admit	$250 Copay / Admit
Outpatient Surgery	$100 Copay	$125 Copay	$125 Copay
Urgent / Emergency Care Visits			
Urgent Care	$20 Copay	$20 Copay	$20 Copay
Emergency Room (Waived if Admitted)	$100 Copay	$125 Copay	$125 Copay
Other Covered Services			
Chiropractic Care	$15 Copay (30 Visits / Year)	$20 Copay (20 Visits / Year)	$20 Copay (20 Visits / Year)
Prescriptions			
Generic	$15 Copay	1a: $5 Copay 1b: $15 Copay	1a: $5 Copay 1b: $15 Copay
Brand Name	$30 Copay	$40 Copay	$40 Copay
Non-Brand Name	NA	$60 Copay	$60 Copay
Specialty	30% up to $250	30% up to $250	30% up to $250
Mail Order Service*	$30 / $60 / N/A / Not Covered	$12.50 / $37.50 / $120 / $180	$12.50 / $37.50 / $120 / $180

* Kaiser's mail order prescriptions provide a 100 day supply. Anthem's mail order prescriptions provide a 90 day supply/30 day supply for Specialty.

Medical Coverage (Continued)

The Anthem Classic PPO and Anthem PPO with HSA plans are both PPO plans, meaning that they provide both in-network and out-of-network coverage. The Anthem PPO with HSA is unique in that it has a high deductible in place. If you enroll in this plan, you may be eligible to open a Health Savings Account (HSA) which will allow you to set aside pretax dollars for health related expenses. For those who enroll and open an HSA, APU will contribute to your HSA as follows:

$750 for *Employee Only*, $1,250 for *Employee + Spouse* and *Employee + Child(ren)*, $1,750 for *Employee + Family*

Anthem PPO & High Deductible (HDHP with HSA) side-by-side comparison

	Anthem Classic PPO 500/20/40		Anthem PPO with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual / Family	$500 / $1,500	$1,500 / $4,500	$3,500 / $7,000	$10,500 / $21,000
Out of Pocket Maximum Indidividual / Family	$3,500 / $7,000	$10,500 / $21,000	$5,500 / $11,000	$16,500 / $33,000
Lifetime Benefit Max	Unlimited	Unlimited	Unlimited	Unlimited
Physician Services				
Primary Care	$20 Copay	40%*	20%*	50%*
Specialist Visits	$40 Copay	40%*	20%*	50%*
Preventive Care	Plan Pays 100%	40%*	Plan Pays 100%	50%*
Telehealth	$20 / $40 Copay	40%*	20%*	50%*
Diagnostic X-Ray & Lab				
Complex Imaging	20%*	40%*	20%*	50%*
Lab & X-Ray	20%*	40%*	20%*	50%*
Hospital Services				
Inpatient Hospitalization	20%*	40%*	20%*	50%*
Outpatient Surgery	20%*	40%*	20%*	50%*
Urgent / Emergency Care Visits				
Urgent Care	$20 Copay	40%*	20%*	50%*
Emergency Room (Waived if Admitted)	$150 Copay+ 20%*	Same as In-Network	20%*	Same as In--Network
Other Covered Services				
Chiropractic Care	$20 Copay (30 Visits/Year)	40%* (30 Visits/Year)	20%* (30 Visits/Year)	50%* (30 Visits/Year)
Prescriptions				
Generic	1 a: $5 Copay 1b: $15 Copay	50% up to $250	1a: $5 Copay* 1b: $15 Copay*	50% up to $250
Brand Name	$40 Copay	50% up to $250	$40 Copay*	50% up to $250
Non-Brand Name	$60 Copay	50% up to $250	$60 Copay*	50% up to $250
Specialty	50% up to $250	50% up to $250	30% up to $250*	50% up to $250
Mail Order Service	$12.50 / $37.50 / $120 / $180	Not Covered	$12.50 / $37.50 / 120 / $180	Not Covered

* This is the amount you would pay after deductible has been met. If the deductible has not yet been met, you would be responsible for the full amount of the service.

Kaiser - Special Features

TELEHEALTH CONSULT:
Now, you can get care from a doctor wherever you are! Do you have a minor health condition? If it doesn't require an in-person medical exam, you may be able to address it with a doctor by phone. You'll get great care, save time and money! Contact your Kaiser location for availability.

MYSTRENGTH:
myStrength is a personalized program via a downloadable phone app that helps you improve your awareness and change behaviors. Kaiser Permanente members can explore interactive activities, in-the-moment coping tools, community support, and more at no cost.

- Mindfulness and meditation activities
- Tailored programs for managing depression, stress, anxiety, and more
- Tools for setting goals and preferences, tracking current emotional states and ongoing life events, and viewing your progress

CALM:
A research-based meditation and mindfulness app that can help users develop self-care skills:

- Lower stress
- Reduce anxiety
- Improve sleep quality
- Practice mindfulness and meditation

Anthem - Special Features

TELEHEALTH CONSULT: LIVEHEALTH ONLINE
When you're not feeling well, you want to feel better fast. Or, you may be feeling anxious or having trouble coping on your own and need some support. LiveHealth Online lets you stay home and have a phone call or video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer. This is a great, cost effective solution for ailments such as pinkeye, a cold, the flu, a sinus infection or another common health condition. Sign up for LiveHealth Online today – it's quick and easy. Go to livehealthonline.com or download the app and register on your phone or table.

24/7 NURSE LINE:
Anytime day or night you can call the Anthem 24/7 NurseLine at 800.224.0336. The call is free to you! Registered nurses are ready and waiting to help you over the phone with your health concerns.

HSA Quick Facts

WHAT IS A HEALTH SAVINGS ACCOUNT?
A Health Savings Account (HSA) is an account that works in conjunction with a High-Deductible Health Plan (HDHP). The account allows you to put money aside on a pre-tax basis and reimburse yourself for health-related expenses. Unspent funds accumulate tax-free and roll over from year-to-year. (There is no "use it or lose it" rule as with flexible spending accounts).
An HSA gives you the freedom to spend the funds today or save them for the future. The HSA is your account. You own it. You fund it. And you can take it with you wherever you go, including into retirement.

WHO IS OUR HSA VENDOR?
Our HSA account is administered by Anthem, while WealthCare Saver is the HSA Custodian. If you have had an HSA in the past. You can contact them to rollover your funds into your Act Wise account! You can call them at: 844.860.3535

HOW CAN I CAN REVIEW MY ACCOUNT AND/OR SUBMIT CLAIMS?
Download Anthem's Sydney app! In doing so, you will be able to:

- See all of your account and claims information.
- Take a photo of a receipt and upload it for reimbursement.
- Manage and send payments from your HSA.
- Find care wherever you are, 24/7.

HOW MUCH CAN I CONTRIBUTE?
Contributions you make to your HSA are tax-deductible. The limits are set by the IRS each year.
For 2025, you can contribute up to the following amounts after APU's contribution:

- $3,550 for Employee only
- $7,300 for Employee + Spouse
- $7,300 for Employee + Child(ren)
- $6,800 for Employee + Family

Employees aged 55 and above may make an additional "catch-up" contribution of $1,000.

WHO IS ELIGIBLE FOR AN HSA?
You are eligible for an HSA if you are covered only by a compatible High-Deductible Health Plan (HDHP). At APU, that is the Anthem HDHP. Other rules and restrictions apply, including:

- You are not covered by other health insurance
- You are not enrolled in Medicare (Part A or Part B)
- You are not listed as a dependent on someone else's tax return
- You do not participate in APU's health care Flexible Spending Account
- Your spouse is not enrolled in a health care Flexible Spending Account

Anthem

Focus on your well-being and earn rewards up to $200

The more activities you complete, the greater your reward.

Your whole health matters, and we want to reward you for taking care of it. The Wellbeing Solutions program, sponsored by your employer, connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $200 in rewards. Don't wait, use your Sydney Health app or Anthem.com to learn more.

Activity type	Activities	Amount
Preventive care measures **How you earn:** Receive your reward when claims are processed	Complete a colorectal cancer screening (45 years and older)	$25
	Complete a routine mammogram (women 40 to 74)	$25
	Complete an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Get an annual flu shot	$20
	Have an annual eye exam[2]	$25
Condition management programs **How you earn:** Reach certain benchmarks or complete a program	ConditionCare program: Work one-on-one with your health coach for a chronic condition and earn rewards for participating in and completing the program[3]	Up $50 ($20 participation/$30 completion)
	Future Moms program: Moms-to-be can receive support from a registered nurse and earn rewards for completing initial, interim, and postpartum assessments[4]	Up to $40 ($20 initial/$10 interim/$10 postpartum assessments)
	Wellbeing Coach Telephonic – Weight Management Program: Receive one-on-one support and lifestyle coaching for weight management. Complete your goal to earn a reward[5]	$25
	Wellbeing Coach Telephonic – Tobacco Cessation Program: Receive one-on-one support and lifestyle coaching for tobacco cessation. Complete your goal to earn a reward[6]	$25
Digital Wellness activities **How you earn:** Complete activities in the Sydney Health℠ app or on anthem.com	Complete action plans around eating healthy, weight management, physical activity, and more	Up to $25 ($5 per action plan)
	Complete a health assessment and receive tailored health recommendations	$20
	Complete Well-being Coach Digital daily mission check-ins[7]	Up to $20 ($4 per milestone)
	Connect a fitness or lifestyle device	$5
	Log in to your Anthem account	$5
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Update your contact information	$10

Well-being Coach can help you meet your goals

Well-being Coach offers multiple options to help you meet your health goals. Our digital coaching app offers personalized 24/7 support on the go. Well-being Coach combines smart technology and proven behavioral therapy techniques to help you maintain a healthy weight, quit tobacco, and improve your nutrition, activity, mindfulness and sleep. Well-being Coach is powered by Lark and accessible from the Sydney Health app.

If you prefer a helping hand and would like additional support meeting your health goals for high-risk weight management and tobacco cessation, Well-being Coach gives you access to a certified health coach by phone. You and your health coach will identify healthy habits and develop custom action plans to achieve your health goals. No matter how you connect, you can earn rewards with Well-being Coach.

How to redeem your rewards

When you're ready to redeem your rewards, open the **Sydney Health app** or go to **anthem.com**. Then go to *My Health Dashboard*, select **Redeem Rewards**, and use your rewards credit toward an electronic gift card.

You choose from popular retailers including MasterCard, Amazon, Bed Bath & Beyond, Gap (all brands), Staples, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.

Open the **Sydney Health app** or log into **anthem.com** anytime to explore the electronic gift card options available to you.

If you'd like more information about any of the Wellbeing Solutions activities, call the Member Services number on the back of your ID card

1 Annual cholesterol test eligibility: men 35 years and older, women 40 years and older with a full cholesterol (Lipid) panel
2 Routine Annual eye exam reward is available if employer provides vision coverage through Anthem.
3 Adult members identified as moderate or high risk are eligible for ConditionCare and may receive a reward for participation in 1 of 5 ConditionCare programs and completion for 1 of 5 ConditionCare programs: (Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Asthma, Diabetes, and Congestive Heart Failure (CHF).
4 Future Moms assessments completion dates: Initial assessment must be completed by day 97; Interim assessment must be completed by 1 day prior to delivery; Postpartum Assessment must be completed by 56 days after delivery.
5 Well-being Coach Weight Management program (telephonic) is available for members who are identified as high risk based on a BMI of 30 or higher.
6 Well-being Coach Tobacco Cessation program (telephonic) is available for members who are identified as high risk based on any tobacco usage.
7 Members may earn rewards for completing quarterly Well-being Coach Digital milestones while logging daily mission check-in activities on the digital coaching app: daily Mission check-ins: 1st check-in: $4, next 15 check-ins during 1sr quarter: $4, 25 check-ins for quarters 2-4: $4 each quarter) The digital coaching app download is available using Sydney Health or anthem.com. Well-being Coach Digital is provided by Lark Health.

All preventive care activities are claims-based. Medical waivers apply to all claim-based activities.

Rewards eligibility applies to only employees and their spouse/domestic partner. Members must be active on the plan and activity must take place during the plan effective year. It may take a little time once you complete a wellness activity before you see the reward amount in your account.

Subscriber and spouse/domestic partner may earn rewards when eligible activities are completed and, in some instances, are verified by an Anthem claim. Anthem claims are required for claims-based activity rewards and may take up to 60 days to adjudicate.

Product availability may vary. The reward amount redeemed may be considered income to you and/or your spouse/domestic partner and subject to state and federal taxes in the tax year it is paid. You and/or your spouse/domestic partner should consult a tax expert with any question regarding tax obligations.

The list of retailers available for electronic gift card rewards redemption is subject to change. Open the Sydney Health app or log on to anthem.com or to explore the electronic gift card options available to you.

Engagement Package 200 MEM 09/21

Dental Coverage

Dental insurance is an important part of your overall health benefits. APU will continue to provide in 2025 two options for your dental coverage: DeltaCare USA HMO and Delta Premier Plus PPO Plan.

	DeltaCare USA HMO (DeltaCare USA Network)	Delta Premier Plus PPO (PPO Premier Plus Network)	
		In-Network	Out-of-Network
Annual Deductible (Waived for Preventive Care)	None	$25 Individual / $75 Family	$25 Individual / $75 Family
Annual Maximum Benefit	Unlimited	$2,000	$2,000
Preventive & Diagnostic Services (Deductible Waived)			
Prophylaxis (Cleaning) D1110	Plan pays 100%	Plan pays 100%	Plan pays 100%
Bitewing X-rays D0272	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services			
Amalgam Restoration (Filling) One Surface D2140	Plan pays 100%	Plan pays 80%*	Plan pays 80%*
Gingivectomy per Quad (1 to 3 Teeth) D4211	$80 Copay	Plan pays 80%*	Plan pays 80%*
Root Canal, Bicuspid Tooth D3320	$120 Copay	Plan pays 80%*	Plan pays 80%*
Major Services			
Implants D6000-D6199	Not Covered	Plan pays 50%*	Plan pays 50%*
Porcelain Crown D2750	$240 Copay	Plan pays 50%*	Plan pays 50%*
Orthodontic Benefits			
Child D8080	$1,700 Copay	Plan Pays 50%* Lifetime max of $1,500	Plan Pays 50%* Lifetime max of $1,500
Adult D8090	$1,900 Copay	Plan Pays 50%* Lifetime max of $1,500	Plan Pays 50%* Lifetime max of $1,500

* This is the amount you would pay after the deductible has been met.

DENTAL HEALTH MAINTENANCE ORGANIZATION (HMO)

- If you elect coverage in this plan, you must select a contracted dentist from the HMO Provider list. All care must be coordinated through the primary dentist. To search the provider list online, visit deltadentalins.com.
- You may change your dentist one time each month by calling the carrier directly prior to the 15th of the month. The change will then go into effect the 1st day of the following month.
- The HMO features unlimited benefits but does require a copay for each covered procedure. Examples of some copays are provided in the chart above.

DENTAL PREFERRED PROVIDER ORGANIZATION (PPO)

- The Dental PPO allows you to choose an In-Network or Out-of-Network provider. When visiting an Out-of-Network dentist, please remember that you are responsible for amounts in excess of charges above the allowable amounts. Out-of-Network dentists are not contracted with the carrier; therefore, members may expect to pay more for utilizing a dentist outside of the network.
- Search for an In-Network provider online at deltadentalins.com and click on “Find a Dentist”. Enter the search criteria information and click on “Find” to view the results.
- A predetermination of benefits is recommended for any treatment plan that amounts to $300 or greater.
- Your PPO plan utilizes the PPO plus Premier Network. As a result if your dentist happens to be both PPO and Premier network contracted, your out-of-pocket expenses may slightly decrease.

Vision Coverage

Vision insurance is included with your medical insurance if you elect medical coverage from APU. Vision coverage from Kaiser is automatically included for Kaiser participants, and vision coverage from VSP is automatically included for Anthem participants. APU offers employees who otherwise opt out of APU medical coverage the opportunity to elect VSP vision coverage as a standalone benefit.

	Kaiser Vision	VSP	
		In-Network	Out-of-Network
Benefit Frequency			
Eye Exam	Unlimited, Based on Need	Every Plan Year*	Combined with In-Network
Lenses	Every 24 Months	Every Plan Year*	Combined with In-Network
Frames	Every 24 Months	Every Other Plan Year*	Combined with In-Network
Benefits			
Basic Eye Exam	Plan pays 100%	$10 Copay	Up to $45
Frames	$300 Allowance	$130 Allowance+ 20% off Balance	Up to $70
Lenses			
Single	$300 Allowance	Plan pays 100%	Up to $30
Bifocal	$300 Allowance	Plan pays 100%	Up to $50
Trifocal	$300 Allowance	Plan pays 100%	Up to $65
Contact Lenses (In Lieu of Lenses & Frames)			
Medically Necessary	$300 Allowance	Plan pays 100%	Up to $210
Elective	$300 Allowance	$130 Allowance	Up to $105
Contact Fitting and Evaluation	$300 Allowance	Up to $60 Copay	N/A
Diabetic Eyecare Plus Program			
Diabetic Eyecare Plus Program	Incorporated in all Vision Exams	$20 Copay	Not Covered

*Plan year begins January 1st.

IMPORTANT NOTES FOR KAISER VISION

- Please note that the $300 allowance is combined for lenses, frames, contact lenses, and contact fitting and evaluation.
- All Kaiser vision services must be received at a participating plan provider office or at a Kaiser facility.

IMPORTANT NOTE FOR VSP

- The VSP Diabetic Eyecare Plus Program provides coverage for members with type 1 or type 2 diabetes. The program also supports that VSP doctors should be a member's first call for all vision-related concerns, not just for routine eye care.

Provider Search Page

KAISER HMO (MEDICAL)

- Go to kp.org
- Click “Doctors & Locations”

ANTHEM BLUE CROSS (MEDICAL)

- Go to anthem.com/ca/find-doctor/
- Select a plan for basic search
- Enter the required fields-indicate you are searching for “Medical” care in “California” (even if you are out of state) and within “Medical (Employer-Sponsored)” plans
- Choose one of the following under plan/network and click “Continue”
    - Classic Select HMO 20/40/250 admit/125 OP: “Select HMO”
    - Classic HMO 20/40/250 admit/125 OP: “Blue Cross HMO (CACare)”
    - Classic PPO 500/20/40/20: “Blue Cross PPO (Prudent Buyer PPO/EPO)”
    - Lumenos HSA 3500/20: “Blue Cross PPO (Prudent Buyer PPO/EPO)”
- You can then search by Types of Providers, Specialty, Name, NPI/License Number and/or Zip Code (this is where you can enter your true location if you are outside of CA)

DELTADENTAL (DENTAL)

- Go to deltadentalins.com
- Select ‘Find a Dentist’
- Choose one of the following Networks under “Your plan”:
    - DeltaCare USA HMO: “DeltaCare USA”
    - Delta Premier Plus PPO: “Delta Dental PPO Premier”
    - Delta Dental PPO
- You can also choose to search by a Dentist’s name or location and then select “Find dentists”

VSP (VISION)

- Go to vsp.com/eye-doctor
- You can choose to search by Location, Office or Doctor
- Follow the prompts and answer the corresponding questions according to the type of search you choose
- In case it comes up in your search, please note that the APU plan utilizes the “VSP Choice network”

Basic Life / AD&D Coverage

Azusa Pacific University provides Basic Life and Accidental Death and Dismemberment Insurance for each benefit-eligible employee. This benefit provides valuable income protection in the event that you suffer a severe accident or loss of life. An accelerated death benefit is also included. For a complete benefit summary, please contact Human Resources.

Employer Provided Life Insurance	Employer Provided AD&D
$50,000*	$50,000*

*Benefits will reduce to 50% at age 70

You must name a beneficiary for your Life and AD&D benefits. Beneficiary changes can be done through ADP Workforce Now at any time during the plan year.

Long Term Disability

Azusa Pacific University provides you with an employer paid plan for Long Term Disability coverage. This coverage provides financial assistance if you are unable to work for an extended period of time due to an illness or injury.

Coverage Amount	66.67% of monthly salary
Maximum Monthly Benefit	$10,000
Less Any Amount Payable by	Social Security Income (SSI) State Disability Income (SDI)
Elimination Period	180 Days
Benefit Duration	SSNRA - Social Security Normal Retirement Age

Voluntary Life Coverage

As an employee of Azusa Pacific University, you have the option of purchasing additional life insurance for yourself, your spouse, and/or your children. When you enroll yourself and your dependents in this benefit, you pay the full cost through post-tax payroll deductions. Please note that you may need to complete an evidence of insurability form if you elect an amount above the guaranteed issue or if you declined to enroll at your initial eligibility date. **Please Note: For the 2025 enrollment only, all employees have the opportunity to newly elect coverage, or increase previously elected coverage up to the Guarantee Issue without answering medical questions.**

	Employee	Spouse	Child(ren)*
Coverage Option	Increments of $10,000	Increments of $10,000	Increments of $1,000
Guarantee Issue Amount	$280,000	$50,000	$10,000
Maximum Amount	The lesser of 5x employee's salary or $500,000	Spouse election cannot exceed employee's election	$10,000

*Coverage for children from 6 months to 26 years.
Benefits will reduce to 50% at age 70.
Please refer to ADP for rates and coverage options.

Flexible Spending Account (FSA)

Flexible Spending Accounts (FSAs) are valuable tax savings tools. These accounts provide a way for you to set aside pretax dollars from your paycheck in a Health Care Reimbursement Account or a Dependent Care Reimbursement Account. You then use those funds when you have qualified health care or dependent care expenses.

Utilizing your FSA to the fullest extent possible is a powerful way to help offset the increasing cost of health coverage. As you make the election during Open Enrollment for how much you wish to set aside for 2025, we encourage you to carefully estimate your expenses for the year. During the 2025 Open Enrollment, you may elect to set aside up to $3,300 pre-tax dollars in your Health Care Reimbursement Account and up to $5,000 pre-tax dollars in your Dependent Care Reimbursement Account. To submit claims please login to your account at healthequity.com/wageworks. For general questions you can call HealthEquity at 855.692.2959.

Please note if you are enrolled in the High Deductible plan and are making contributions into a Health Savings Account (HSA), you are not eligible to enroll for the Flexible Spending Account.

Important Dates to Remember:

HEALTH CARE REIMBURSEMENT ACCOUNT

- Grace Period: This is an extension of the plan year. In other words you have until 3/15/2025 to incur claims and be reimbursed by funds set aside for the 2024 plan year.
- Runout Period: You have through 3/31/2025 to submit claims incurred between 1/1/2025 - 03/15/2025.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

- Runout Period: You have through 3/31/2025 to submit claims incurred between 1/1/2025 - 3/15/2025.

Please note that termed participants cannot incur claims past their last day worked but have the same run-out period (through 3/31/2025) as an active participant.

Affordable Care Act

APU's employee medical coverage is intended to be "affordable coverage" as defined in the Patient Protection and Affordable Care Act (PPACA, aka ACA) and meets all of the other coverage-specific requirements.

It is important to have health insurance, whether from an employer, directly from an insurance carrier, or through an exchange. California's health insurance marketplace, Covered California, will conduct their annual open enrollment beginning on **November 1, 2024.** You can get more information at 1.800.300.1506 or at coveredca.com. This exchange is run by the state and is open to anyone who would like to purchase health coverage on an individual basis.

You may want to explore options available to you through the California exchange and compare to the coverage offered by APU.

Other helpful information about ACA is available at healthcare.gov and kff.org/health-reform/. If you have other questions about ACA or its implementation at APU, please feel free to contact Phonetrya Yupiter in Human Resources at 626.815.4686.

Insurance Health Mandate

Please note that California has enacted a law that will taxes all CA residents, including dependents, who do not maintain qualifying health insurance. This tax went into effect on January 1, 2020. To avoid paying the tax, all CA residents should have health insurance. For more information regarding amounts and exemptions, please consult a tax professional. The penalty for a dependent child is half of what it would be for an adult. The penalty is based on your state income and the number of people in your household. For more information, you can visit the State of CA Franchise Tax Board's website at: ftb.ca.gov/about-ftb/newsroom/news-articles/health-care-mandate.html.

TIAA Retirement Plan

Azusa Pacific University invites employees to participate in Azusa Pacific University's Defined Contribution Retirement Plan through TIAA. Eligible employees may contribute a portion of their pay to the plan as a pre-tax or as a Roth deferral. Employer contributions to the plan are discretionary and may be modified or suspended at any time.

Employees may enroll on their own through an online process. To create your TIAA account and enroll, log in to tiaa.org/apu. To change your deferral contribution amount or to view your account, log in to tiaa.org.

FOR MORE INFORMATION, CONTACT:
Phonetrya Yupiter
Benefits Manager
626.815.4686
pyupiter@apu.edu

Voluntary Benefits

Cyberscout Identity Theft

- Provides identity theft protection, credit monitoring and restoration services.
- 24/7 Monitoring of banking and credit card activity
- Potential fraud alerts
- Lost wallet assistance
- White glove ID theft restoration
- Mobile app (IOS and Android) available
- 100% of premium paid by employees

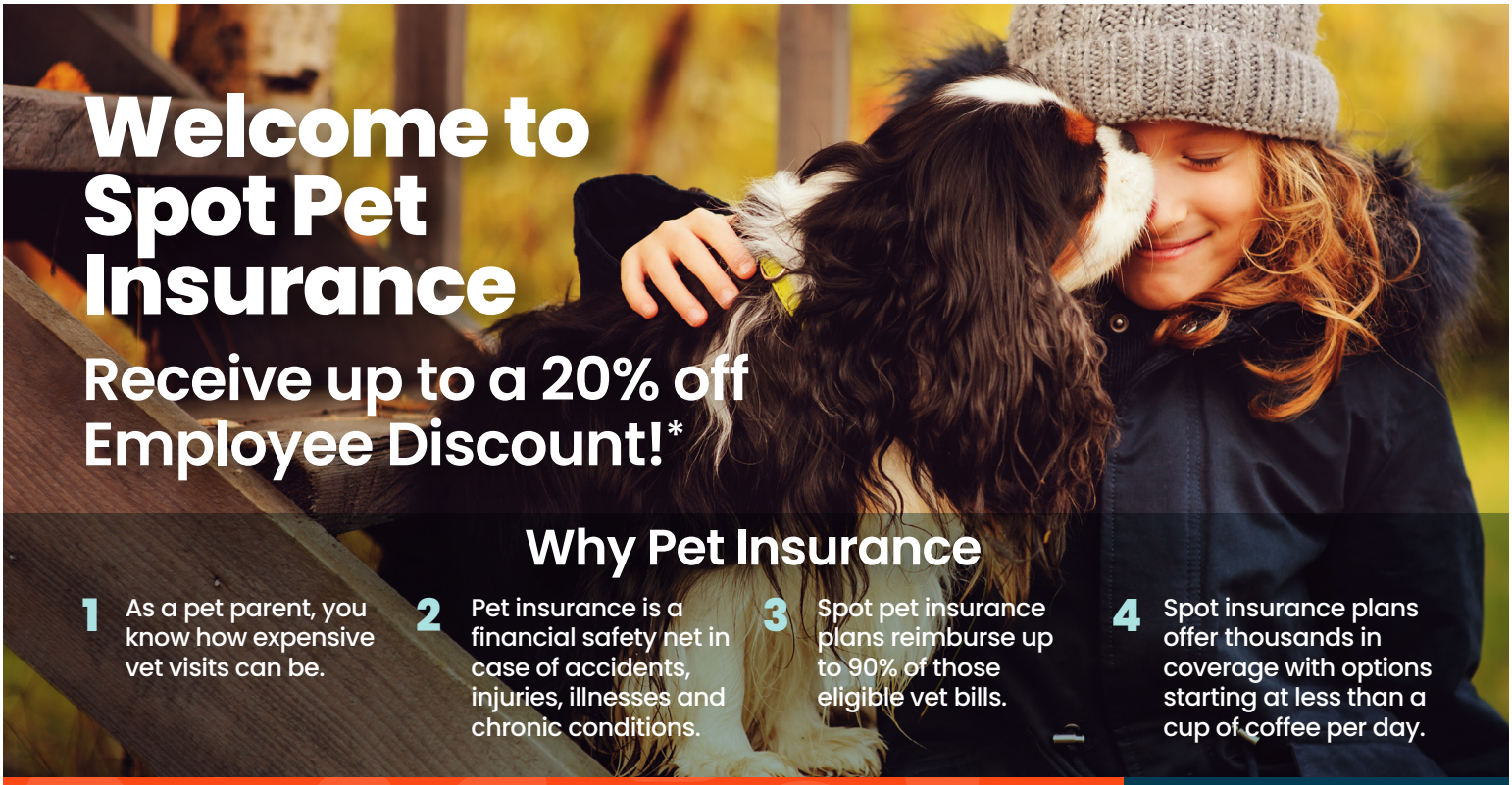
Voluntary Short Term Disability Benefits (only available for employees who reside outside of CA)

- Replaces 60% of your weekly pay
- Maximum weekly benefit of $1,500.
- Payment may be reduced by deductible sources of income & disability earnings.
- Some disabilities may not be covered or may have limited coverage under this plan; pre-existing conditions may apply.
- 8 day waiting period
- 13 week benefit duration
- 100% of premiums paid by employee

EARLY RETIREMENT
APU continues to offer an early retirement benefit. Faculty and staff who are over 62 years of age but not yet 65 and have ten years of full-time APU service are eligible to declare early retirement and continue APU health insurance benefits at the employee rate until the month the employee reaches his/her 65th birthday. See Section 5.5 of the employee handbook for details.

EMPLOYEE ASSISTANCE PROGRAM
APU continues to offer an Employee Assistance Program (EAP), now through Anthem's Resource Advisor. The EAP is a telephonic counseling service provided at no cost to regular, benefit-eligible employees. You and your dependents will receive confidential support and service specifically designed to help with issues that may arise personally or professionally. An EAP counselor is available around the clock for emergency and crisis situations at 888.209.7840.

TRAVEL ASSISTANCE
APU offers 24-hour travel assistance through General Global Assistance, Inc. This coverage assists employees during emergencies while traveling. You can reach them at 866.295.4890.



Welcome to Spot Pet Insurance

Receive up to a 20% off Employee Discount!*

Why Pet Insurance

1. As a pet parent, you know how expensive vet visits can be.
2. Pet insurance is a financial safety net in case of accidents, injuries, illnesses and chronic conditions.
3. Spot pet insurance plans reimburse up to 90% of those eligible vet bills.
4. Spot insurance plans offer thousands in coverage with options starting at less than a cup of coffee per day.

Top Rated Pet Insurance

Spot coverage helps you protect your pet in case of accidents, illnesses, and emergencies. With pet insurance from Spot, you can get coverage for surgery, cancer treatment, prescription medications, microchip implantation, X-rays, behavioral issues, dental disease, and more, for covered conditions!

Up to 20% Discount

As a valued employee, you can get up to 20% off your policy (a 10% employee discount on your first pet, plus another 10% off any additional pets)!

Custom Plans for Any Budget

Avoid overpaying for coverage you don't need. Customize the plan that is best for your pet and it could save you thousands on covered conditions. Spot offers up to 90% reimbursement and a range of annual limits to fit your budget.

30-Day Money Back Guarantee

We want you to be sure this is the right product for you and your furry friend! Give it a try, and if you change your mind within 30 days, get your money back.*

24/7 Pet Tele-health Helpline

As a thank you for enrolling in Spot Pet Insurance, we provide you with immediate access to a 24/7 helpline to ask vets questions about pet health, behavior, and wellness. Get answers and reduce unnecessary vet visits during uncertain times.

Fetch A Free Quote: https://spotpet.link/apu

How It Works

No Networks!
Visit Any Licensed Vet, Emergency Clinic or Specialist.

Submit Your Claim.
Send it in through our app, online, by mail, or by fax.

Get Reimbursed.
We can send a direct deposit or mail a check.

*10% group employee discount on every pet, plus a 10% multi-pet discount on each additional pet. 30-day money-back guarantee is not available if claims have been covered. Not available in NY. Pre-existing conditions are not covered. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit spotpetins.com/sample-policy. Preventive Care reimbursements are based on a schedule. Spot On Coverage reimbursements are based on the invoice. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. Insurance plans are underwritten by United States Fire Insurance Company. Insurance plans are marketed and produced by Spot Pet Insurance Services, LLC. (NPN # 19246385) © 2021 United States Fire Insurance Company. Copyright 2021, Spot Pet Insurance Services, LLC. All Rights Reserved. U03137-RA17. Paid Endorsement.

AZUSA PACIFIC UNIVERSITY

spot pet insurance

Frequently Asked Questions

1. I want my current benefits to remain the same in 2025; do I have to participate in the Open Enrollment process?

Yes! This year's Open Enrollment is an ACTIVE Open Enrollment. This means ALL employees must log into ADP Workforce Now to make benefit elections for the 2025 plan year. If you do not make online elections, your benefits will end on 12/31/2024!

Please also ensure your address and beneficiary information is up to date.

2. Where do I find the online benefit enrollment system?

First Time User:

Please contact benefits@apu.edu for a PRC code. Then go to workforcenow.adp.com and set up a new account as a New User with the personal registration code (PRC). Once registered, log back into workforcenow.adp.com and go to Myself> Benefits > Open Enrollment to begin the process.

Previously Registered:

Please go to personal registration code and enter user ID: FLastname@azusa and password: then go to Myself>Benefits>Open Enrollment to begin the process.

3. I've chosen Kaiser as my medical plan. Can I add VSP for vision?

No; Kaiser vision benefits are included in your Kaiser coverage.

4. How long can I continue to cover my young adult children?

They remain eligible for coverage through the last day of the month in which they turn 26 years of age.

5. What are my choices for medical benefits?

You may choose Kaiser HMO, Anthem Classic Select HMO, Anthem Classic HMO, Anthem Classic PPO, or the Anthem PPO HSA.

6. I reside outside of California. What are my choices for 2025?

If your permanent residence is outside of California, please confirm your status with APU Benefits Team. When identified as out-of-state, you may choose between Anthem PPO or the Anthem High Deductible Plan (HDHP) with HSA, as well as Delta Premier Plus dental and VSP vision coverage.

7. Where can I get information about how high-deductible health plans (HDHP's) and Health Savings Accounts (HSA's) work?

Further information will be available at the open enrollment workshops and on the Human Resources website at: apu.edu/humanresources/additionalresources.

8. Do I need to assign life insurance beneficiaries this year?

Yes. We need everyone to make sure to add beneficiary data to ADP for the Unum Life Plans.

2025 Semi-Monthly Employee Rates

(24 Paychecks per Year)

	Payroll Deductions Per Paycheck			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Medical				
Kaiser HMO with Kaiser Vision	$88.78	$190.21	$184.74	$265.37
Anthem Classic Select HMO with VSP Vision	$85.08	$187.17	$154.74	$263.73
Anthem Classic HMO with VSP Vision	$123.04	$261.72	$223.98	$373.31
Anthem Classic PPO with VSP Vision	$324.86	$698.25	$584.72	$977.91
Anthem PPO HSA (HDHP with HSA) with VSP VIsion	$90.51	$197.76	$184.74	$278.78
Vision				
VSP Vision (Stand-Alone Benefit)	$0.78	$1.86	$1.53	$3.31

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Dental				
DentalCare USA DHMO	$2.27	$8.29	$7.77	$13.27
Delta Dental Premier DPPO	$7.78	$30.50	$31.67	$59.04

2025 Bi-Weekly Employee Rates

(26 Paychecks per Year)

	Payroll Deductions Per Paycheck			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Medical				
Kaiser HMO with Kaiser Vision	$81.95	$175.58	$170.52	$244.96
Anthem Classic Select HMO with VSP Vision	$78.53	$172.77	$142.84	$243.44
Anthem Classic HMO with VSP Vision	$113.58	$241.59	$206.75	$344.59
Anthem Classic PPO with VSP Vision	$299.87	$644.53	$539.74	$902.68
Anthem PPO HSA (HDHP with HSA) with VSP Vision	$83.54	$182.55	$170.52	$257.33
Vision				
VSP Vision (Stand-Alone Benefit)	$0.72	$1.72	$1.41	$3.06

	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Dental				
DentalCare USA DHMO	$2.09	$7.65	$7.17	$12.24
Delta Dental Premier DPPO	$7.18	$28.15	$29.23	$54.50

Benefit Workshops

Human Resources is offering benefit workshops that include a brief presentation on employee benefits for 2025, followed by a time to answer your specific questions.

Thursday, November 7, 2024

Virtual
Webinar

9:00 am – 10:00 am
us02web.zoom.us/j/89831728453

Friday, November 8, 2024

Virtual
Webinar

11:30 am – 12:30 pm
us02web.zoom.us/j/81109750748

Tuesday, November 12, 2024

Virtual
Webinar

1:00 pm – 2:00 pm
us02web.zoom.us/j/86301161931

Wednesday, November 13, 2024

Virtual
Webinar

2:00 pm – 3:00 pm
us02web.zoom.us/j/89017634746

Please refer to HR for the registration links for each of the above webinars.

Carrier Contact Information:

Administrator	Benefit	Phone	Website
Kaiser Permanente	Medical HMO	800-464-4000	kp.org
Anthem Blue Cross	Medical HMO	855-383-7248	anthem.com/ca
Anthem Blue Cross	Medical PPO	855-383-7248	anthem.com/ca
Delta Dental	Dental HMO	800-422-4234	deltadentalins.com
Delta Dental	Dental PPO	800-765-6003	deltadentalins.com
VSP	Vision	800-877-7195	vsp.com
Unum	Basic and Voluntary Life/AD&D	800-888-8288	unum.com
Unum	Long Term Disability	800-232-0113	unum.com
Unum	Voluntary STD	800-232-0113	unum.com
Identity Force	Cyber Insurance	877-694-3367	identityforce.com
Bolton & Company	Broker - Customer Service Line	855-206-1255	customerservice@boltonco.com

Open Enrollment Questions?

Contact APU's health insurance broker, Bolton & Co., at their Customer Service Line at:
1-855-206-1255 | customerservice@boltonco.com

- OR-

Contact APU's Benefit Team in Human Resources at: benefits@apu.edu or 626.815.2172.

This brochure highlights the main features of the Azusa Pacific University benefit plan. It is intended to help you choose the benefits that are best for you. This brochure does not include all plan rules and details. The terms of your benefit plans are governed by legal documents, including insurance contracts.

Important Notices

NOTICE: CMS PART D NOTICE OF CREDITABLE OR NON-CREDITABLE COVERAGE

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
Anthem Classic HMO 20/40/250 admit/125 OP **Anthem Select Classic HMO 20/40/250 admit/125 OP** **Anthem Classic PPO 500/20/40** **Anthem PPO HSA 3500/20** **Kaiser Permanente-CA Traditional HMO** **Kaiser Permanente-OR HMO**	**None (all plans are creditable)**

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at ***shiphelp.org***.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 01/01/2025

Name Of Entity/Sender: Phonetrya Yupiter

Contact—Position/Office: Benefits Manager

Address: 701 E. Foothill Blvd., Building 1 – Suite 222
Azusa, CA 91702

Phone Number: 626.815.4686

NOTICE: SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards the other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

NOTICE: HIPAA NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement and other government requests
- Respond to lawsuits and legal action

YOUR RIGHTS

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 9.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting ***hhs.gov/ocr/privacy/hipaa/complaints***.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what to share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.**

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your Plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: ***hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers***

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect or domestic partner violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research

Comply with the law

- We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: ***hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers***.

NOTICE: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

INTRODUCTION

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

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

You may have other options available to you when you lose group health coverage.

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the contact person shown at the end of these notices.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit ***medicare.gov/medicare-and-you***.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

NOTICE: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

NOTICE (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): PATIENT PROTECTION – PRIMARY CARE DESIGNATION (HMO)

Your group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

NOTICE (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): PATIENT PROTECTION – OBSTETRICS & GYNECOLOGICAL CARE (HMO)

You do not need prior authorization from your group health plan 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, see the contact information at the end of these notices.

NOTICE: PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit ***healthcare.gov***.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) KIDS NOW** or ***insurekidsnow.gov*** to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored Plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer Plan, your employer must allow you to enroll in your employer Plan if you aren't already enrolled. This is called a "special enrollment" opportunity, **and you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer Plan, contact the Department of Labor at ***askebsa.dol.gov*** or call (866) 444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: ***myalhipp.com***

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: ***myakhipp.com/***

Phone: 1-866-251-4861

Email: ***CustomerService@MyAKHIPP.com***

Medicaid Eligibility:
health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: ***myarhipp.com***

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: ***dhcs.ca.gov/hipp***

Phone: 916-445-8322

Fax: 916-440-5676

Email: ***hipp@dhcs.ca.gov***

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: ***healthfirstcolorado.com***

Health First Colorado Member Contact Center:
1-800-221-3943 / **State Relay** 711

CHP+: ***hcpf.colorado.gov/child-health-plan-plus***

CHP+ Customer Service: 1-800-359-1991 / **State Relay:** 711

Health Insurance Buy-In Program (HIBI): ***mycohibi.com***

HIBI Customer Service: 1-855-692-6442

DELAWARE – Medicaid

Website: ***dhss.delaware.gov/dmma***

Email: ***MedicaidInfo@delaware.gov***

Customer Relations: 866-843-7212

Health Benefits Manager: 1-800-996-9969

FLORIDA – Medicaid

Website: ***flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html***

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: ***medicaid.georgia.gov/health-insurance-premium-payment-program-hipp***

Phone: 678-564-1162, Press 1

GA CHIPRA Website: ***medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra***

Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program: ***in.gov/fssa/dfr***

Medicaid Website: ***in.gov/medicaid***

Family and Social Services Administration
Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Iowa Medicaid:
hhs.iowa.gov/programs/welcome-iowa-medicaid

Iowa Medicaid Phone: 1-800-338-8366

Health and Well Kids in Iowa (HAWKI) Website: ***hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki***

HAWKI Phone: 1-800-257-8563

Health Insurance Premium Payment (HIPP) Website: ***hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp***

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: *kancare.ks.gov*

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: *chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx*

Phone: 1-855-459-6328

Email: *KIHIPP.PROGRAM@ky.gov*

KCHIP Website: *kynect.ky.gov*

Phone: 1-877-524-4718

Kentucky Medicaid Website: *chfs.ky.gov/agencies/dms*

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: *mymaineconnection.gov/benefits*

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage: *maine.gov/dhhs/ofi/applications-forms*

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: *mass.gov/masshealth/pa*

Phone: 1-800-862-4840

TTY: 711

Email: *masspremassistance@accenture.com*

MINNESOTA – Medicaid

Website: *mn.gov/dhs/health-care-coverage*

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: *dss.mo.gov/mhd/participants/pages/hipp.htm*

Phone: 573-751-2005

MONTANA – Medicaid

Website: *dphhs.mt.gov/MontanaHealthcarePrograms/HIPP*

Phone: 1-800-694-3084

Email: *HHSHIPPProgram@mt.gov*

NEBRASKA – Medicaid

Website: *ACCESSNebraska.ne.gov*

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: *dhcfp.nv.gov*

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: *dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program*

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: *DHHS.ThirdPartyLiabi@dhhs.nh.gov*

NEW JERSEY – Medicaid and CHIP

Medicaid Website: *state.nj.us/humanservices/dmahs/clients/medicaid/*

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: *njfamilycare.org/index.html*

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: *health.ny.gov/health_care/medicaid*

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: *medicaid.ncdhhs.gov*

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: *hhs.nd.gov/healthcare*

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: *insureoklahoma.org*

Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: *healthcare.oregon.gov/Pages/index.aspx*

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: *pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html*

Phone: 1-800-692-7462

Children's Health Insurance Program (CHIP) Website: *dhs.pa.gov/CHIP/Pages/CHIP.aspx*

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: *eohhs.ri.gov/*

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: *scdhhs.gov*

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: ***dss.sd.gov***

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: ***hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program***

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: ***medicaid.utah.gov/upp***

Email: ***upp@utah.gov***

Phone: 1-888-222-2542

Adult Expansion Website: ***medicaid.utah.gov/expansion***

Utah Medicaid Buyout Program Website: ***medicaid.utah.gov/buyout-program***

CHIP Website: ***chip.utah.gov***

VERMONT– Medicaid

Health Insurance Premium Payment Program Website: ***dvha.vermont.gov/members/medicaid/hipp-program***

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: ***dmas.virginia.gov***

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: ***hca.wa.gov***

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: ***dhhr.wv.gov/bms***

Website: ***mywvhipp.com***

Medicaid Phone:304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: ***dhs.wisconsin.gov/badgercareplus/p-10095.htm***

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: ***health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility***

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on *Special Enrollment Rights,* contact either:

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

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

OMB Control Number 1210-0137 (Expires: 1/31/2026)

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and posted electronically.

FOR MORE INFORMATION, CONTACT:

Name	Phonetrya Yupiter
Title	Benefits Manager
Address:	701 E. Foothill Blvd. Building 1 – Suite 222 Azusa, CA 91702
Phone Number:	626.815.4686
Other Contact Information:	pyupiter@apu.edu

Effective date of this Notice: January 1, 2025

NOTES

This guide describes the benefit plans and policies available to you as an employee of LAPU. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. This guide is meant only to cover the major points of each plan or policy. It does not contain all the details that are included in your Summary Plan Descriptions (as required by ERISA) found in your other employee benefit materials. If there is ever a question about one of these plans and policies, or if there is a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern.
Note: The benefits highlighted and described in this guide may be changed at any time and do not represent a contractual obligation – either implied or expressed – on the part of LAPU.

Office of Human Resources

CULTIVATING DIFFERENCE MAKERS

AZUSA PACIFIC UNIVERSITY