2025
Employee Benefits Program

ST. JOHN'S UNIVERSITY

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The employee benefit programs described in this guide are effective in 2025. The information in this guide is a summary of St. John's University benefits, and every attempt has been made to ensure its accuracy. The actual provisions of each benefit program will govern if there is any inconsistency between the information in this guide and St. John's University's formal plans, programs, policies, or contracts or any subsequent change in such plans, programs, policies, or contracts.

Please refer to the Summary Plan Descriptions for more detailed information regarding coverages, benefits, limitations, and other provisions, as well as important information regarding how to submit benefit claims, appeal claim denials, and your rights under ERISA. Summary Plan Descriptions are available on the Employee Benefits page of the St. John's University website or by accessing Bswift through the University sign-on page, signon.stjohns.edu.

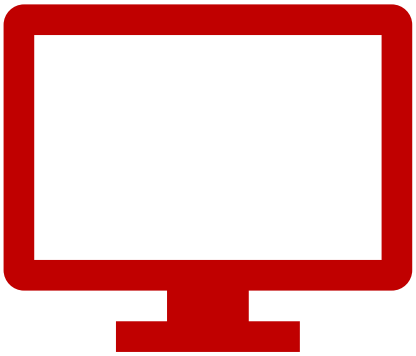
Benefit Basics

St. John's University offers a comprehensive suite of benefits to promote health and financial security for you and your family. This booklet provides you with a summary of your benefits. Please review it carefully so you can choose the coverage that's right for you.

As a St. John's University employee, you are eligible for benefits if you work at least 30 hours per week. Benefits are effective on the first day of the month coincident with or following your date of hire.

You may enroll your eligible dependents for coverage once you are eligible. Your eligible dependents include your legal spouse and your children up to age 26.

Once your benefit elections become effective, they remain in effect until the end of the year. Normally you may only change coverage within 31 days of a qualified life event.



Qualified Life Events

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

You must log onto Bswift and you will be asked to provide proof of the event.

Please contact a representative at 718-990-2363 or visit Bswift, through the University sign-on page, signon.stjohns.edu, to enroll and upload applicable documentation.

Medical Coverage

St. John's University offers a choice of medical plan options so you can choose the plan that best meets your needs – and those of your family.

All 3 medical plan offer the following:

- Comprehensive health care benefits
- In-network preventive care covered at 100%
- Prescription drug coverage
- Same network of providers: Aetna Choice POS II
- No referrals required for specialists visits
- Out-of-network benefits[1]
- Mandatory Generics[2]

IMPORTANT

The prescription drug program is managed through **OptumRx,** and you will be provided with a **separate Rx ID Card**.

Plan Provisions	Core Plan		Premier Plan		HDHP Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	Embedded $500/ $1,000	Embedded $1,000/ $2,000	None	Embedded $500/ $1,000	Aggregate $2,000 / $4,000	Aggregate $4,000 / $8,000
Out-of-Pocket Maximum (Includes Deductible)	Embedded $1,500/ $3,000	Embedded $3,000/ $6,000	Embedded $2,500/ $5,000	Embedded $3,000/ $6,000	Aggregate $4,000/ $8,000	Aggregate $6,000 / $12,000
University Account Funding (HRA / HSA)	HRA $200 single / $400 family		None		HSA $500 single / $1,000 family	
Preventive Care	100%	70%*	100%	80%*	100%	60%*
Primary Physician Office Visit	$30 copay	70%*	$30 copay	80%*	80%*	60%*
Specialist Office Visit	$40 copay	70%*	$40 copay	80%*	80%*	60%*
Inpatient Hospital Services	90%*	70%*	100%	80%*	80%*	60%*
Outpatient Hospital Services	90%*	70%*	100%	80%*	80%*	60%*
Urgent Care	$50 copay	70%*	$50 copay	80%*	80%*	60%*
Emergency Room Care	$100 copay waived if admitted		$100 copay waived if admitted		80%*	60%*
Retail Prescription Drugs (30-day supply) • Generic • Brand Preferred • Brand Non-preferred	$10 copay $25 copay $50 copay	Not covered	$10 copay $25 copay $50 copay	Not covered	80%* 80%* 80%*	Not covered
Mail Order Prescription Drugs (90-day supply) • Generic • Brand Preferred • Brand Non-preferred	$20 copay $50 copay $100 copay	Not covered	$20 copay $50 copay $100 copay	Not covered	80%* 80%* 80%*	Not covered

*After deductible is met.

For more information regarding the services provided by these plans, please refer to the Summary of Benefits Coverage (SBCs) found on Bswift.

Embedded

Each family member must meet their own individual deductible/out-of-pocket maximum (OOPM) until the total amount of deductible paid by all family members meets the overall family deductible/OOPM. Individuals will pay no more than the single deductible or single OOPM.

Aggregate

The family deductible or OOPM must be satisfied; one family member could meet the entire amount or it could be a combination.

[1]Out-of-network services are based on reasonable and customary (R&C) charges and you will be responsible for any expense above R&C charges.

[2]Mandatory Generics. If you select the non-generic medication when a generic option is available, you will pay the difference in cost between the brand name and the generic, plus your copay. The cost difference for the brand-name prescription would not apply to the out-of-pocket maximum.

Medical Resources – Aetna

If you enroll in the one of the University's medical plans you will have access to the following value-added services.

Aetna Member Website & Mobile App

Aetna member Website is Aetna's online tool to help you manage your health care online, anytime and from anywhere that you have computer access.

- Find in-network providers and services
- Review coverage
- Manage and track claims
- See cost estimates for procedures and prescription drugs
- Access a variety of health and wellness tools and resources
- Access a copy of your ID card electronically

The Aetna Mobile app works with iPhone® mobile digital devices and Android™ powered phones.

Aetna Concierge

Aetna concierge is available when you have questions about your health care plan

- Understand your benefits and claims
- Assist with questions regarding a diagnosis
- Talk through your bill or payment
- Show you how to use online tools
- Assist with scheduling appointments
- Take advantage of all your plan's health and well-being benefits

CVS Minute Clinic

If you are enrolled in any of the St. John's University Health plans, you can visit a CVS MinuteClinic for $0!

24-Hour Nurseline

Did you know you have access to a nurse 24 hours a day and seven days a week? Nurses are available to help you with your medical needs anytime, day or night. Just call the Aetna Nurseline at 800-556-1555.

Gym Reimbursement

Aetna will reimburse members up to $400 per year for employees and $200 per year for covered spouses. You can apply for the program as long as you have gone to the gym and/or exercise classes 50 times in 6-months.

Your reimbursement period is a preset 6-month period: **Jan 1st – June 30th** & **July 1st –Dec. 31st** .

To receive the reimbursement, you will need to meet the 50-visit requirement during the preset 6-month period.

Virtual Visits - Teladoc

Teladoc through Aetna provides 24/7 access to board certified, licensed physicians via virtual consult. Consult fees vary based on medical plan.

- General Medical: Physicians can treat and prescribe medication for non-urgent medical conditions, such as allergies, bronchitis, colds and flu, fever, headaches, pink eye, urinary tract infections, and more.
- Mental/behavioral health: Aetna members age 16+ can connect with a psychiatrist, psychologist, social worker or therapist by phone or video. Talk confidentially from the comfort of home, or anywhere.

Questions?

Contact Aetna at 833-359-0127

Pharmacy Resources - OptumRx

Prescription drug coverage is provided automatically with all three medical plans.

OptumRx

Members can take advantage of OptumRx benefits that include:

- Home delivery to receive up to a 3-month supply on maintenance medication for 2- copays
- Access to large national chain and local pharmacies
- Online account management

Digital Tools

Setup an online account with OptumRx to access the following; and/or mobile app to

- Setup home delivery
- Price medications
- Find an in-network pharmacy
- Access a copy of your member ID Card

Questions?

Contact OptumRx at 844-495-7077

Vision – Aetna

If you enroll in the Premier, Core or the HDHP medical plan, then you and your covered family members will automatically be enrolled in the Aetna vision plan.

Aetna's Vision care benefits include coverage for eye exams, standard lenses and frames, contact lenses, and discounts for laser surgery.

When you visit an eye doctor in the Aetna Vision Network, you will pay less out-of-pocket for these services. You can choose to receive care outside the network, but you will pay higher costs.

Plan Provisions	Aetna Vision Plan	
	In-Network	Out-of-Network
Routine Eye Exam *once every calendar year*	$0 copay	You pay any amount over $50
Frames *once every 2 calendar years*	$0 Copay; $150 Allowance[1], then 20% off balance	You pay any amount over $70
Standard Lenses[2] *once every calendar year*		You pay any amount over;
• Single Vision	$20 copay	$50
• Bifocal	$20 copay	$75
• Trifocal	$20 copay	$100
• Lenticular	$20 copay	$100
• Progressive[3]	$85 copay	$75
Contact Lenses *instead of glasses, once every calendar year*	$0 Copay; $150 Allowance[1], then 15% off balance	You pay any amount over $120

[1] Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.
[2] Some lens enhancements are covered under the plan. Please refer to the Aetna benefit summary for more details.
[3] The plan also covers non-standard progressive lenses with different cost-sharing amounts. Please refer to the Aetna benefit summary for more details,

Aetna & EyeMed

Providers participating in the Aetna Vision Network are contracted through EyeMed Vision Care, LLC (EyeMed).

Locating a Provider

With Aetna, you'll have a huge selection of neighborhood retail locations, as well as national retailers and online stores.

In-network providers include your private practitioner as well as selected chains, including Independent Provider Network, LensCrafters, Pearle Vision, Target, and Sears.

INDEPENDENT PROVIDER NETWORK LENSCRAFTERS PEARLE VISION OPTICAL

No ID Card Necessary

When it's time to receive services, use your Aetna medical ID Card or provide vision provider with your name and date of birth.

For More Information or Locate a Provider

visit www.aetnavision.com or call 833-359-0127

Health Reimbursement Account (HRA)

If you are enrolled in the **Core Plan**, then you will have a Health Reimbursement Account.

The employer paid HRA is administered by The P&A Group and is included with this plan to help participants offset the costs of copays, deductibles and co-insurance.

The University funds the HRA:

- $200 for single subscribers and
- $400 for family subscribers.

The funds are available via a debit card, provided by the P&A Group. Paper claim forms may also be used to submit for reimbursement.

The normal deadline to submit claims is March 31st of the following year.

Contact Information

Phone:	(800) 688-2611
Web:	www.padmin.com
Address:	6400 Main Street, Suite 210
	Williamsville, NY 14221

Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What's the Benefit?

A Health Savings Account (HSA) is a savings account that can be used to pay for qualified medical, dental and vision services.

How Does it Work?

When you enroll in an HSA, you elect an amount to be deducted from your paycheck and placed into a savings account. This account is designed to help offset medical, dental and vision expenses. You can use your HSA at the time of service, when you receive a bill or to reimburse yourself for a qualified expense which was paid with other funds.

Eligibility

You are **not** eligible to contribute to an HSA if:

- You are not a US Citizen, unless you are a resident Alien with a valid Social Security number
- You or your spouse are enrolled in a non-qualified high deductible health plan
- You are enrolled in a Healthcare Flexible Spending Account (FSA)
- You can be claimed as a dependent on another person's tax return
- You are enrolled in CHIP, Medicare or Medicaid benefits (special rules apply for VA benefits)

Important: If you do not automatically enroll in Medicare at age 65, Part A will be effective retroactively 6 months prior to your enrollment date (but no earlier than the month prior to your 65th birthday). You should determine in advance the intended date of enrollment for Medicare and, working backwards, contact the Office of Human Resources to ensure all contributions cease 6 months prior to that date.

Contact Information

Phone:	(800) 688-2611
Web:	www.padmin.com
Address:	6400 Main Street, Suite 210 Williamsville, NY 14221

Contributions

The maximum amount permitted to be contributed into an HSA for 2025 is $4,300 (single) and $8,550 family.

If you are age 55 or older, you may contribute an additional $1,000 "catch-up" contributions.

Considerations

- You must be enrolled in a qualified high deductible health plan to contribute to an HSA
    - Note, the University's HDHP Plan is a qualified plan
- Your contributions into the HSA and distributions made from the HSA are tax-exempt.
- Your HSA must be used for qualified expenses for yourself, your spouse or tax-dependent children (even if they are not covered by your plan) or the non-qualified purchase may be subject to income tax plus a 20% penalty. The list of qualified expenses is determined by the IRS and can be found at www.irs.gov.
- HSA funds rollover from year to year and may be invested after reaching a minimum balance of $1,000.

	Employee Only	Family
IRS Contribution Limits	$4,300	$8,550
SJU Contributions	$500	$1,000
Your Contribution Limit	$3,800	$7,550

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSAs) are designed to save you money on your taxes. They work in a similar way to a savings account. Each pay period, funds are deducted from your pay on a pretax basis and are deposited to your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses.

If you enroll in the HDHP Plan, the standard Health Care FSA is **not** available to you. However, you are eligible for a **Limited Purpose Health Care FSA**

Account Type	Eligible Expenses	Contribution Limits
Health Care FSA	• Medical, dental, vision and prescription drugs • Eye exams, glasses and contacts • Hearing aids • Laboratory fees; and • Mental health counseling	Maximum contribution is $3,200 per year
Limited Purpose FSA	• Dental and vision expenses • Eye exams, glasses and contacts	Maximum contribution is $3,200 per year
Dependent Care FSA	• Work-related child or elder care • Tuition for nursery school and licensed day care centers that provide care while you work • Day care expenses, including elder care, for the care of disabled dependents while you work • Before- and after-school programs while you work	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)

Save on Your Taxes with an FSA

Your FSA elections will be in effect from January 1 through December 31. Please plan your contributions carefully. Beginning in 2025, you can only carry over $640 into the next plan year.

Claims for reimbursement are normally due by March 31 of the following year.

The law requires that you forfeit amounts in excess of $640 after all eligible expenses have been reimbursed. This is known as the "use it or lose it" rule and it is governed by IRS regulations. Note that FSA elections do not automatically continue from year to year; you must actively enroll each year.

The chart below is an example of how much you can save when you use the FSAs to pay for your predictable health care and dependent care expenses.

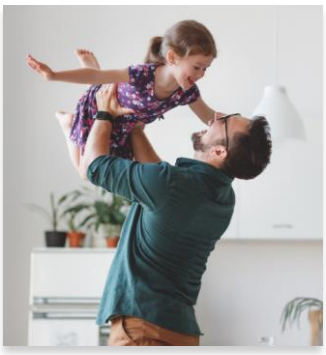
With an FSA, the money you contribute is never taxed—not when you put it in the account, not when you are reimbursed with the funds from the account, and not when you file your income tax return at the end of the year.

	With FSA	Without FSA
Your taxable income	$50,000	$50,000
Pretax contribution to Health Care and Dependent Care FSA	$2,000	$0
Federal and Social Security taxes*	$15,696	$16,350
After-tax dollars spent on eligible expenses	$0	$2,000
Spendable income after expenses	$32,304	$31,650
Tax savings with the Medical and Dependent Care FSA	**$654**	N/A

**This is an example only; not your actual experience. It assumes a 25% federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will save on any state and local taxes as well.*

Reimbursement Accounts (HRA vs. FSA vs HSA)

St. John's University offers several accounts that enable you to pay for eligible expenses tax-free.



- **Health Savings Account (HSAs) –** You can use this account for unreimbursed medical, dental and vision expenses.
- **Health Reimbursement Account (HRA) -** This is a reimbursement arrangement only if you are enrolled in the Core Plan.
- **Health Care FSAs** – You can use this account for unreimbursed medical, pharmacy, dental and vision expenses.
- **Limited Purpose FSAs** – You can use this account for unreimbursed dental and vision expenses.
- **Dependent Care FSA** – Use for eligible childcare expenses for dependents under age 13 or elder care.

Comparison of the Accounts

Account Type	HSA	HRA	Limited Purpose FSA	Health Care FSA	Dependent Care FSA
Eligibility Restrictions	Only if you are enrolled in the **HDHP Plan**	Only if you are enrolled in the **Core Plan**	Only if you are enrolled in the HDHP Plan with a HSA.	Cannot have an HSA	None
Eligible Expenses	Medical, pharmacy, dental and vision expenses	Medical and pharmacy expenses under the medical plan	Dental and vision expenses	Medical, pharmacy, dental and vision expenses	Dependent care expenses for children under age 13 or elder care
University Contribution	Employee: $500 Employee and Family: $1,000	Employee: $200 Employee and Family: $400	X	X	X
Can I contribute my own savings?	✓	X	✓	✓	✓
IRS annual contribution limit	$4,300 single / $8,550 family	X	$3,200	$3,200	$5,000
Will my savings roll over each year?	✓	X	! Up to $640	! Up to $640	X
Will I earn interest on my savings?	✓	X	X	X	X
Are the savings tax-free?	✓	✓	✓	✓	✓
Will I get a debit card?	✓	✓	✓	✓	X
Do I keep my money if I leave the University?	✓	! Option to continue only through COBRA	! Option to continue only through COBRA	! Option to continue only through COBRA	X

You can use HSA with a Limited Purpose FSA

If you have an HSA, you can also contribute to a Limited Purpose Flexible Spending Account (FSA), to give yourself even more pretax dollars to pay for out-of-pocket dental and vision expenses.

Dental Coverage

St. John's University offers two dental plan options to fit your family's needs:

- PPO Plan with Cigna
- DHMO Plan with Aetna (in-network only)

The dental benefit comparison chart on this page does not list a full description of coverage, but serves as a quick summary to assist you in making your decision.

Plan Provision	Cigna PPO Plan			Aetna DHMO
	In-Network		Out-of-Network	In-Network Only
	DPPO Advantage	DPPO		
Primary Dentist & Referrals	Not Required			**Required**
Annual deductible (Individual/Family)	$25 / $75		$25 /$75	None
Annual maximum (per person)	$2,000	$2,000	$2,000	None
Diagnostic and preventive care: Cleanings, fluoride treatments, sealants and x-rays	100% no deductible	80% no deductible	80% no deductible	covered at 100%
Basic Services: Fillings, periodontics, scaling and root planing, and oral surgery	80% after deductible	80% after deductible	80% after deductible	covered at 100%
Major Services: Crowns, bridges and full and partial dentures	50% after deductible	50% after deductible	50% after deductible	covered at 60%
Orthodontia	Children to age 19 $50 deducible, then covered at 60% with a Lifetime maximum of $1,500			Adult & Children $2,000 copay

Cigna PPO Plan

If you choose to enroll in the Cigna PPO Plan, you will have access to the *Total Cigna DPPO* network. The Plan also provides you with comprehensive coverage and maximum flexibility with in-network and out-of-network benefits.

- In-Network: the Cigna Total DPPO network plan offers two levels:
  - *DPPO Advantage*: the highest benefit level that may result in a lower cost.
  - *DPPO: lower benefit level than the DPPO Advantage.*
- Out-of-Network: If you choose a Nonparticipating Dentist, the percentages shown indicate the portion of Cigna's Nonparticipating Dentist Fee that will be paid for those services.
- The plan is based on coinsurance levels that determine the percentage of costs covered by the plan for different types of services.
- To find an in-network provider go to www.mycigna.com

Important: The Nonparticipating Dentist Fee may be less than what your dentist charges and you are responsible for that different.

Aetna DHMO Plan

If you choose to enroll in the Aetna DHMO plan, your dental care will only be covered if you use a DHMO participating dentist.

- In-Network only: You must receive dental care from an Aetna DHMO Dentist in order to receive Benefits.
- Out-of-Network: If you receive services from a Non-EPO Dentist, you will be responsible for paying for those services in full.
- To find a participating Aetna DHMO dentist, use the provider search tool on the Aetna site.
  - Go to: www.aetna.com
  - Select "Dental, Vision and Supplemental" under the "Shop for a plan" tab.
  - Click "Find a dentist" and type in your **home zip code** to see if a participating DMO dentist is in your area

Important: Only choose the Aetna plan if a DMO network dentist is available to you in your home state.

Life Insurance

Life Insurance is an important part of your financial security, especially if others depend on you for support.

The University provides Basic Life and Accidental Death and Dismemberment (AD&D) Insurance to all active full-time employees working at least 30 hours each week.

- **Administrators/Faculty**: One times your basic annual earnings up to a maximum $200,000 ($30,000 minimum benefit)
- **Staff**: One times your basic annual earnings up to a maximum of $75,000 ($10,000 minimum benefit)

The Basic Life Insurance is provided by the University at **no cost to you**. You may elect to purchase Optional life insurance through the convenience of payroll deduction.

Optional Life Insurance

Coverage	Benefits
Employee	• 1x to 4x your annual salary up to $600,000 • Minimum benefit of $10,000 • Guarantee Issue amount is the lesser of 3x your annual salary or $300,000
Spouse	• Available if you purchase Optional Life for yourself • Election amounts of $10,000, $25,000, or $50,000 • Cannot exceed 100% of your Life Insurance Benefits • Evidence of Good Health is required for amounts over $25,000 when first eligible
Dependent Child	• Available if you purchase Optional Life for yourself • 6 months to age 26 is $4,000 • Less than 6 months old is $500

Age Reduction Schedule
Benefit reduces to 65 percent at age 65
Benefit reduces to 50 percent at age 70

For additional information, please contact the Employee Benefits Department at 718-990-2363 or visit Bswift through the University sign-on page, signon.stjohns.edu.

High levels of life insurance require you to demonstrate your good health by completing an Evidence of Insurability form (EOI). The EOI is a medical questionnaire, though a medical exam may also be required.

If an EOI is required, you will be covered at your previous level (or the guaranteed issue amount) until the EOI has been approved. You will only be charged for the coverage you are receiving.

Approval is determined by Cigna/NY Life in accordance with their guidelines.

Important

- Basic life insurance never requires an EOI
- Employee Optional life insurance amounts of more than 3x your annual salary or more than $300,000 will require EOI
- Increasing Employee Optional life insurance coverage more than 1x your annual salary during Annual Enrollment will require EOI

Optional Life Insurance Cost Calculations

Your cost for supplemental life coverage is based on your age bracket and the amount of coverage elected. To calculate the cost of this coverage, use the following formulas.

For Employee & Spouse Coverage:

$_____ ÷ $1,000 = _____ x _____ = $_____

Benefit Amount | Rate based on Age (from chart) | Monthly Premium

Age	Employee and Spouse*
Under 30	$0.057
30-34	$0.076
35-39	$0.086
40-44	$0.095
45-49	$0.152
50-54	$0.285
55-59	$0.494
60-64	$0.656
65-69	$1.207
70+	$2.547

**Spouse rates based on spouse's age*

Dependent Child Life:
The cost to purchase coverage for your child(ren) is $0.60/per month. This amount covers all of your dependent children.

Disability Insurance Coverage

NY DBL

The goal of the St. John's University disability plan is to provide you with income replacement should you become disabled and unable to work due to a non-work-related illness or injury.

NY Paid Family Leave Program

Grants eligible employees time away from work with partial salary replacement to bond with a new child, care for a family member with a serious health condition, or qualifying military exigency.

Core Long Term Disability (LTD)

The University provides eligible employees with disability income benefits at not cost to you. You are eligible for the Core Long Term Disability coverage if you are full-time employee and have completed one year of employment with the University.

The Core LTD plan provides the following benefits;

- **Administrators/Faculty**: 60% of monthly pre-disability earnings to a maximum of $3,000
- **Staff**: 60% of monthly pre-disability earnings to a maximum of $2,000

Benefits begin after 180 days of disability or illness and continue to the earlier of recovery or the later of Social Security Normal Retirement Age or the maximum benefit period listed below.

Age on Date of Your Disability	LTD Maximum Benefit Period
59 or under	To Age 65
60-64	5 years
65-68	To Age 70
69 or older	1 year

For additional information, please contact the Employee Benefits Department at 718- 990-2363 or visit Bswift through the University sign-on page, signon.stjohns.edu.

Optional Long Term Disability (LTD)

You may also purchase optional (Buy-Up) coverage, however, because each person's financial situation during a disability can vary, you should evaluate your needs and decide if additional salary protection is right for you.

With the Optional LTD you have the option to increase your maximum monthly LTD benefit up to 66 2/3% of your monthly pre-disability to a maximum monthly benefit of $10,000 less deductible sources of income (i.e., Social Security, salary continuation, sick time, etc.) . You pay the full cost of this option.

Also with the Optional LTD Plan, the University makes a monthly contribution to a TIAA annuity during disability period; 15 % of monthly wages for administrators and faculty; 10% for staff.

Important

LTD Benefits are not payable for medical conditions for which you incurred expenses, took prescription drugs, received medical treatment, care or services during the three months just prior to the most recent effective date of insurance. Benefits are not payable for any disability resulting from a preexisting condition unless the disability occurs after you have been insured under this plan for at least 12 months after your most recent effective date of insurance.

Qualified Transportation Expense (QTE) Plan

Employees can use pre-tax dollars to pay for public transportation expenses while commuting to work.

You may contribute up to $315 per month for Qualified Transit Expense (QTE) for a commuter highway vehicle (e.g., bus, train, subway, vanpool).

How the Plan Works

- You will receive a QTE debit card from The P&A Group, which can be used to purchase applicable transit vouchers and tickets.
- Debit cards will be funded with the specific amount you elect to pay each pay period.
- Any excess balances in your QTE account will roll-over from month to month.
- When you leave the University, you will forfeit the balance in your account.

Zipcar Program

St. John's University Queens Campus is a designated Zipcar program location. Zipcar is a 24/7 on demand car-sharing service currently available to staff, administrators, and faculty members on the Queens campus that enables participants to reserve cars by the hour or the day.

For more information, including applications, rates, and rental procedures, please contact Zipcar directly.

Phone: 1-866-494-7227
Website: https://www.zipcar.com

Adoption Assistance Program

In support of the University's work-life initiatives and to assist all employees who are building families, St. John's University has a policy to provide eligible employees with adoption benefits, including financial reimbursement, adoption leave of absence, and resource and referral services.

Eligibility:

- Adopted child must be under the age of 18, or physically or mentally incapable of caring for him or herself, and may not be related to either parent
- Kinship adoptions and stepchild adoptions do not qualify under this program.
- The University's Adoption Assistance program does not cover surrogate parenting agreements.

To learn more, call the Employee Benefits Department at 718-990-2363.

The University will reimburse eligible employees;

- Up to a maximum of $5,000 per child for qualifying adoption expenses incurred by the eligible employee, or
- Up to $6,000 for qualifying adoption expenses incurred by the eligible employee for the adoption of a child with special needs (as defined by IRS Code Section 23(d)(3)).
- The maximum reimbursement per calendar year is $10,000, with no additional compensation for a child with special needs.

Tuition Remission

The University provides a tuition remission benefit to you, your spouse, and eligible children or one designee, as defined by policy and subject to IRS tax regulations.

Policies can be found in the HR Policy Manual located on at www.stjohns.edu/my-st-johns.

For information on the application process, which is web-based, please contact the Office of Student Financial Services at 718-990-2000.

Full-Time	Policy Information
Staff and Administrators, hired on or after June 1, 2010	Governed by tuition remission guidelines in policies #608-AA and #608-BB.
Staff and Administrators, hired prior to June 1, 2010, or Employees with adjusted service date prior	Governed by tuition remission guidelines in Policies #608-A and #608-B.
Contract and Law School Faculty	Governed by Faculty Tuition Remission Policy Not eligible for tuition remission benefits for themselves and are not subject to Policies #608-AA and #608-BB

Tuition Exchange Program

The Tuition Exchange Inc. (TE) is a partnership of over 650 colleges and universities offering competitive scholarships between member schools. Membership in this network of higher education institutions forms the basis for St. John's University's Tuition Exchange Program (TEP).

The TEP provides undergraduate scholarships to eligible employees, dependent children and legal dependents of eligible staff, administrators and faulty.

Eligibility:

- Staff and Administrators: must be full-time with at least two years of full-time service
- Faculty: must be full-time with at least three years of full-time service.

The University's TEP scholarships are determined based on the employee's years of service to the University and the available TEP scholarships available in each given year. These scholarships are competitive awards and as such are not guaranteed to any applicant. In exchange, dependent children of employees from other colleges and universities may apply for scholarships to attend St. John's University.

The number of scholarships varies each year, depending on the balance between TEP students enrolling in St. John's and TEP students that we transfer to other TEP member institutions.

For more information or questions, please contact the Employee Benefits Department at 718-990-2363 or the University's TEP Officer at 718-990-2020.

New York's 529 College Savings Program

The University offers the New York's 529 College Savings Program with Vanguard that makes saving for higher education expenses convenient . The Program is designed to help you save for higher-education expenses for your child, grandchild, friend - or even yourself.

What is a Qualified Expense?

Education expenses include tuition, fees, supplies, books, and equipment required for enrollment at eligible undergraduate, graduate or professional institutions (including vocational, business, and trade schools) in the United States and around the world.

Benefits of the Program:

- Contributions and earnings grow tax-deferred
- Qualified withdrawals are tax exempt from federal and New York State taxes
- Eligibility for a tax deduction ($10,000 married filing jointly; $5,000 filing single)
- As an account owner, you will have investment options that you can choice from.

To enroll, visit https://www.nysaves.org or call 1-877-697-2837 and follow the online enrollment instructions.

Group Legal Insurance

You may elect to participate in the ARAG Legal Plan, which provides you and your covered dependents with legal services such as these:

- Representation when you buy or sell a home
- Preparation of documents such as wills and estate planning
- Resolution of debt problems and bankruptcy
- Uncontested adoptions

ARAG Group Legal Insurance

ARAG Legal Plan provides a flexible platform of affordable legal solutions to meet your needs. Along with "everyday" legal needs, ARAG covers needs related to family, home, automobile, caregiving, identity theft, immigration issues, and financial needs. ARAG provides access to exceptional attorneys by partnering with many Fortune 500 companies and providing award- winning member care. In most instances, attorney fees for legal needs are 100% paid in full when you use a network attorney.

You may enroll at hire or through Open Enrollment. You cannot cancel the plan at any point during the year. The monthly $21.90 cost for the plan is deducted from your paycheck on a post-tax basis.

To learn more, please visit the ARAG site at http://www.araggroup.com, or call 1-800-247-4184. Also contact the Employee Benefits Department for additional information at 718-990-2363.

Voluntary Benefits & Discount Program

BenefitHub

BenefitHub is a benefits and rewards portal that offers the widest variety of discounted leisure, health and financial benefits, which are personalized to the individual. There are hundreds of benefits that may help with your everyday lives.

- One stop shopping – everything in one place
- Expanded range of benefits, including direct bill voluntary benefits
- Amazing deals on thousands of brands including restaurants, tickets, cars, apparel, travel and more
- Great local deals
- The best cash back offers in America
- Designed for mobile, you can shop anywhere

Questions?
If you have any questions about or need assistance with the BenefitHub website, you can contact Support at 1-866-664-4621.

Start Saving with BenefitHub today!

- **Log in at**: https://stjohnsu.benefithub.com/
- **Need to Register?**
  1.Enter Referral Code: **G82LC4**
  2.Complete Registration and
  3.Start Saving!

Questions?
Contact BenefitHub Support at 1-866-664-4621 or email customercare@benefithub.com.

It's more than just a place to get discounts on shopping and entertainment. It's your go-to for saving on **voluntary insurance plans**, too. BenefitHub works with carriers and voluntary insurance providers to offer you the best deal for the coverage you need.

- Auto Insurance
- Homeowner's Insurance
- Pet Insurance

Employee Assistance Program – "cca"

cca[tm] is a free, confidential benefit to help faculty, administrators, and staff – and their household or family members – handle life's challenges successfully, from routine concerns to major crises. St. John's employee's and their household or family members have immediate access to a wealth of resources and information. Additionally, professional counselors are available 24 hours a day, 365 days a year to offer support and resources covering an extensive list of topics relating to the following areas:

- Marital and family conflicts
- Job related difficulties
- Stress, anxiety, depression and overall emotional well-being
- Parent and child relationships
- Legal and financial counseling
- Financial planning
- Various other related issues

If you need help or guidance, you may reach out to the EAP through cca[tm] at 1-800-833-8707 or visit https://www.myccaonline.com and the company code is STJOHNS.

403(b) Defined Contribution Retirement Plan

The St. John's University 403(b) Defined Contribution Retirement Plan offers a convenient way for you to save for the future while tax-deferring part of your annual income.

Effective January 1, 2022

Upon completion of one year of service, you are eligible to receive a University contribution of 5% of your base salary, provided you contribute a minimum of 5% of your base salary to one of the plan options. After the 5 year anniversary of employment, the St. John's University contribution will increase to 8%, provided you contribute at least 5% of your base salary. There is no age requirement. You will be automatically enrolled when you become eligible for the employer contribution, unless you choose to opt-out of such enrollment or are already enrolled.

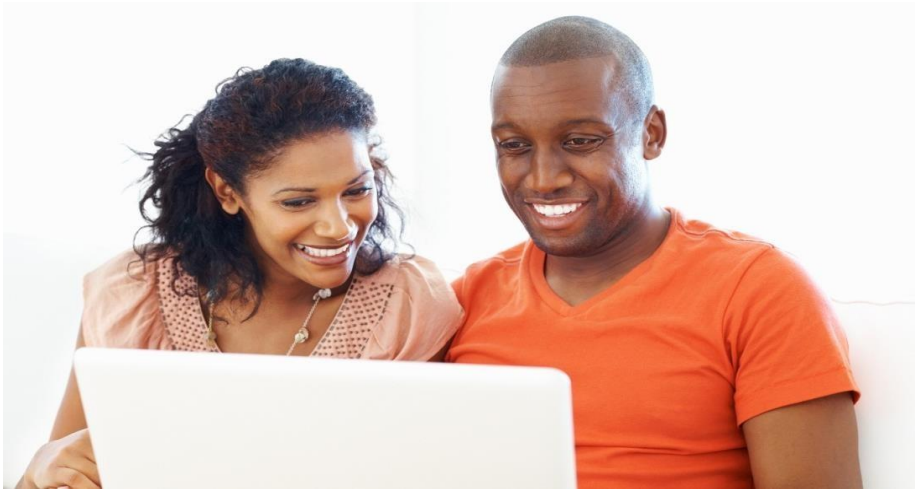
You may elect to contribute all or a portion of your salary deferrals as Roth contributions. The Roth contributions may be a good option for: younger employees who have a longer retirement horizon and more time to accumulate tax- free earnings, highly compensated individuals who are not eligible for Roth IRA, and/or employees who wish to leave tax-free money to their heirs.

For additional details about the 403(b) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, please contact the Employee Benefits Department at 718-990-2363.

Contacts

Plan	Contact	Phone Number	Website
Medical	Aetna	833-359-0127	www.aetna.com or Aetna Pre-Enrollment Website
Pharmacy	OptumRx	844-495-7077	www.optumrx.com
Vision	Aetna	833-359-0127	www.aetnavision.com
Dental – PPO Plan	Cigna	1-800-244-6224	www.mycigna.com
Dental – DMO	Aetna	877-238-6200	www.aetna.com
Flexible Spending Accounts (FSA) / Health Reimbursement Arrangement (HRA) / Health Savings Account (HSA)	P&A Group	1-800-688-2611	ww.padmin.com
Life & AD&D Insurance	NY Life	888-842-4462	www.newyorklife.com
Long-Term Disability Insurance	NY Life	888-842-4462	www.newyorklife.com
Commuter Benefits	P&A	800-688-2611	www.padmin.com
Legal Plan	ARAG Legal	1-800-247-4184	http://www.araggroup.com
Voluntary Benefits	BenefitsHub	1-866-664-4621	https://stjohnsu.benefithub.com customercare@benefithub.com
Employee Assistance Program (EAP)	cca[tm]	1-800-833-8707	https://www.myccaonline.com (company code: STJOHNS)
403(b) Retirement Savings Plan	Employee Benefits Department	718-990-2363	sjubenefit@stjohns.edu

About This Guide: This benefit summary provides selected highlights of the St. John's University employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the University. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. St. John's University reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.



Compliance Notices

Women's Health and Cancer Rights Act

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

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

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

Patient Protection Disclosure

Aetna generally allows the designation of a primary care provider for you and a pediatrician as the primary care provider for your children. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers contact Aetna.

You do not need prior authorization from Aetna 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 Aetna at www.aetna.com

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or

If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 31-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact: the Director of Benefits c/o the Benefits Department at 8000 Utopia Parkway, University Center Suite C, Queens, NY 11439; via phone: 718-990-2363 or via fax: 718-990-2311

Notice of Availability of Privacy Practices

This notice describes how you may obtain a copy of the Plan's notice of privacy practices, which describes the ways that the Plan uses and discloses your protected health information.

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

The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices, you should contact the Director of Benefits c/o the Benefits Department who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach this contact person at: 8000 Utopia Parkway, University Center Suite C, Queens, NY 11439; via phone: 718-990-2363 or via fax: 718-990-2311

Compliance Notices

Continuation Coverage Rights Under COBRA

Introduction

You are getting this notice because you may have coverage under St. John's University's group health, medical or dental. 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."

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child, any other events which are not listed directly above as the employer's responsibility to notify the Plan Administrator), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: the Director of Benefits c/o Benefits Department at 8000 Utopia Parkway, University Center Suite C, Queens, NY 11439; via phone: 718-990-2363 or via fax: 718-990-2311. If you experience a qualifying life event while on COBRA, you must provide this notice to P&A Group at 6400 Main St., Suite 210 Williamsville, NY 14221 ; via phone 1-800-688-2611.

Compliance 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. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Director of Benefits c/o the Benefits Department at 8000 Utopia Parkway, University Center Suite C, Queens, NY 11439; via phone: 718-990-2363 or via fax: 718-990-2311

Compliance Notices

Important Notice from St. John's University About Your 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 St. John's University 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 an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. St. John's University has determined that the prescription drug coverage offered by OptumRx are, 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 St. John's University coverage will not be affected. Your current OptumRx pharmacy coverage with St. John's University is as follows:

Premier Plan		
	Retail Up to 30-Day Supply	Mail Order Up to 90-Day Supply
Tier 1– Generic Drugs	$10	$20
Tier 2– Preferred Brand Drugs	$25	$50
Tier 3– Non-Preferred Brand Drugs	$50	$100

Core Plan		
	Retail Up to 30-Day Supply	Mail Order Up to 90-Day Supply
Tier 1– Generic Drugs	$10	$20
Tier 2– Preferred Brand Drugs	$25	$50
Tier 3– Non-Preferred Brand Drugs	$50	$100

If you do decide to join a Medicare drug plan and drop your current St. John's University coverage, be aware that you and your dependents will be able to get this coverage back subject to the plan's eligibility and enrollment provisions

Compliance 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 St. John's University and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through St. John's University 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).

Date:	October 15th, 2024
Name of Entity/Sender:	St. John's University
Contact--Position/Office:	Grace Zontini Director of Benefits
Address:	8000 Utopia Parkway Queens, NY 11439
Phone:	718-990-2941

Glossary

Deductible – The amount you have to pay for covered services before your health plan begins to pay. In the Core Plan, your HRA funds may be used to help pay for expenses that apply towards your deductible.

For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Calendar Year Maximum – The maximum benefit amount paid each year for each family member enrolled in the dental plan.

Coinsurance – The sharing of cost between you and the plan. For example, 80 percent coinsurance means the plan covers 80 percent of the cost of service after a deductible is met. You will be responsible for the remaining 20 percent of the cost.

For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount (80%).

Copayment (Copay) – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Out-of-pocket maximum – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.

Items that count towards the out of pocket maximum: Co-payments, Deductibles & Co-insurance payments

Items that DO NOT count towards the out of pocket maximum: Your premium, Balance-billed charges & Charges your health insurance plan does not cover

In-network – A designated list of health care providers (doctors, dentists, etc.) with whom the health insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.

Out-of-network – Health care providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Additional deductibles and higher coinsurance will apply.

Inpatient – Services provided to an individual during an overnight hospital stay.

Outpatient – Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Provider (PCP) – A doctor (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Specialist – A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).

Pre-Authorization / Prior Authorization – A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost

Reasonable & Customary Charges (R&C) – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.

Allowed Amount – Amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Balance Billing – When a provider bills you for the difference between the provider's charge and the allowed amount. A preferred provider may not balance bill you for covered services. Balance billed amounts do not apply toward meeting your deductible or out of pocket maximum.

> For example, if the provider's charge is $100 and the allowed amount is $70, the claim will be processed based on $70 and then the provider may bill you for any cost share you are responsible for based on your plan benefits PLUS the remaining $30.

Appeal – A request for your health insurer or plan to review a decision or a grievance again.

Medically Necessary – Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Glossary

Prescription Drugs

Formulary – The formulary is set by the prescription drug benefit manager based on their negotiations with the pharmaceutical companies. Generics are usually in the lowest cost tier – but not always.

Generic Drugs (Tier 1) – Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are regulated by the Federal Food and Drug Administration.

Brand-Name preferred drugs (Tier 2) – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.

Brand-Name Non-Preferred Drugs (Tier 2) – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.

Mail Order Pharmacy – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Specialty drugs – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Accounts

Flexible Spending Accounts (FSA) – FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.

Health Reimbursement Arrangement (HRA) – A fund you can use to help pay for eligible medical costs not covered by your medical plan. Funds are contributed to the HRA by the company

Health Savings Account (HSA) – A savings account that can be used to pay for qualified medical, dental and vision services.

Disability / Life Insurance

Elimination Period – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.

Evidence of Insurability – An application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.

Imputed Income – The addition of the value of non-cash compensation to your taxable wages in order to properly withhold income and employment taxes from wages. Imputed income is not a deduction from your wages or income; it is an amount that increases your taxable income.

Life Insurance: For purposes of employer-paid life insurance, imputed income is the value the IRS places on life insurance coverage that exceeds $50,000.

Domestic Partner Benefits: Because your domestic partner is not your legal spouse, an employer cannot provide tax-free benefits to him or her. This means the value of domestic partner benefits that are paid for by the company is considered as income to you for tax purposes. Although the company is paying their portion of the benefits just as they would for your spouse or dependent child — you are taxed on the portion of the premium that the company pays on behalf of your domestic partner. This can increase your IRS withholding significantly — depending on which benefit your domestic partner is enrolled in. In certain circumstances, your domestic partner may be considered by the IRS to be your tax dependent. If you believe this is the case, you should discuss this with your tax advisor so your income taxes are adjusted accordingly.

STD and LTD: For the purpose of disability insurance, imputed income is the value of the benefit that you will be taxed on. The value of the benefit is the amount of premium that Fujitsu pays for your coverage.

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