WENZHOU KEAN UNIVERSITY

温州肯恩大学

OFFICE OF HUMAN RESOURCES

Kean University - Summary of Benefits for Faculty on Assignment in Wenzhou, China

Contents

Benefits Question? Contact Us 3

PART I. CIGNA GLOBAL HEALTH PLAN 4

How do I enroll? 4

ID Cards 4

Premium Cost 4

1st Affiliated Hospital in Wenzhou 4

PART II. STATE HEALTH BENEFITS PROGRAM - ALTERNATE HEALTH CARE OPTION 5

Waivers 5

PART III. TRAVEL INSURANCE 6

TRANSLATION SERVICES 6

PART IV. ON-THE-JOB INJURY REPORTING PROCEDURES FOR WENZHOU, CHINA 6

PART V. TRAVEL HEALTH AND SAFETY 8

PART VI. ENVIRONMENTAL HEALTH AND SAFETY 8

PART VII. RETIREMENT PLANS 8

*Alternate Benefits Program (ABP) – State Administered Retirement Plan - Mandatory 8

How do I enroll in the ABP retirement plan? 9

Contribution 9

Vesting 9

ABP Life Insurance 10

ABP Long Term Disability Insurance 10

*Supplemental Retirement Savings Plans - Voluntary 10

Unreimbursed Medical Flexible Spending Account (FSA): 11

Dependent Care Flexible Spending Account (FSA): 12

APPENDIX A – CIGNA ENROLLMENT FORM 13

APPENDIX B – CIGNA WAIVER FORM 16

APPENDIX C – CIGNA CLAIM FORM 18

APPENDIX C – CIGNA INFORMATION 23

1. CIGNA WELCOME KIT 24

2. CIGNA SUMMARY OF BENEFITS & EXPLANATION OF BENEFITS 41

3. CIGNA EMPLOYEE SUPPORT SERVICES 62

4. CIGNA PHARMACY MANAGEMENT 66

5.NOTICE OF CIGNA'S PRIVACY PRACTICES 71

APPENDIX D – THE STATE HEALTH BENEFITS PROGRAM 76

APPENDIX E – RETIREMENT PLAN INFORMATION 89

APPENDIX F – RETIREMENT PLAN ENROLLMENT FORMS 113

Kean University - Office of Human Resources

Welcome to Kean University!

Congratulations on your new position at Kean University's extension program in Wenzhou, China. We would like to welcome you and give you some information regarding your benefits options and eligibility.

Kean University is committed to its employees and has many benefits to offer. This document is a summary of benefits for Faculty and staff on Assignment in Wenzhou, China. We hope that you find it useful in your transition to working in Wenzhou. If you have questions regarding your employee benefits, you may contact the Benefits unit at Kean University.

Benefits Question? Contact Us

Yrelys Tapanes
Managing Assistant Director, Benefits
ytapanes@kean.edu
908-737-3313
Skype: KUHR-YT

Lorice Thompson-Greer
Managing Administrative Assistant, Benefits
lgreer@kean.edu
908-737-3309

Tammina Guillaume
Professional Services Specialist, Benefits
guillaut@kean.edu
908-737-3314
Skype: tammina.guillaume.kean

Diane Baldwin
Program Assistant, Benefits
dbaldwin@kean.edu
908-737-3312

http://www.kean.edu/offices/human-resources/benefits

NOTICE OF DISCLAIMER: The content of this document is for informational purposes only, and is subject to change without notice. Employees should refer to their health plan's Summary Plan Description for details regarding health benefits coverage. State administered employee benefits are ***subject to employee eligibility determination through the State of New Jersey, Division of Pensions and Benefits.*** In the event of any conflict between the information contained herein, and the appropriate applicable law, employees will be afforded all rights required by law. This document is not intended to be, and should not be construed as, a promise or a contract, either express or implied.

PART I. CIGNA GLOBAL HEALTH PLAN

The Cigna Global Health Plan is the international health plan designed specifically for you, providing medical prescription drug and dental coverage. It offers worldwide health coverage to active employees working in Wenzhou, China and their dependents. Health coverage in China is 100% for in-network providers.

How do I enroll?

You must complete the Cigna Global Health Plan enrollment form **(See Appendix A)** and return it to Kean HR USA at benefits@kean.edu as soon as possible. If no enrollment form is received by HR USA, your coverage will start automatcally as of your date of hire, at the single coverage level.

ID Cards

You will receive an email with login information for the CignaEnvoy portal once you are enrolled in health coverage with your ID and Plan ID. You may login to CignaEnvoy.com to obtain a copy of your Cigna ID card. Hard copies of your cards will be sent to WKU HR within 30 days of your start date. You will be notified by WKU HR when the cards arrive.

Premium Cost: Shared between Employee and Employer. Employee pays a percentage of annual health premium deducted on biweekly basis. Employer assumes remaining expense. Please contact Kean HR USA at benefits@kean.edu, for estimated rates.

You will find additional information, regarding health coverage (medical, prescription and dental), offered by CIGNA in **Appendix C**.

1st Affiliated Hospital in Wenzhou

The 1st Affiliated Hospital in Wenzhou accepts Cigna insurance, and is considered an in-network Cigna provider. For non-emergency care, Cigna members may visit the VIP wing of the 1st Affiliated Hospital.

> *Address: VIP Department, Building No.5, Nan bai Xiang, Ouhai Distinct, Wenzhou.*
> *Phone: 0577-55579511 or 0577-55579843*
> *Working Hours: 8:00am to 12:00am, 1:30pm to 5:00pm Monday to Friday, Weekend is off.*

The Hospital has recommended that appointments be scheduled in advance whenever possible. (Annual routine checkups and maternity wellness visits should be confirmed via an appointment at least one day in advance). Due to limited English speaking capabilities of the hospital staff charged with making the appointments at this time, the hospital has suggested that it may be advisable for Cigna Members to engage the local WKU HR staff for help in scheduling appointments, particularly for initial visits.

Please note that VIP services available do not include dental, vision or any cosmetic treatments.

For emergency care, members will need to go to the 1st Affiliated Hospital General Emergency Department. The VIP wing does not offer emergency care. The local hospital card should be presented to facilitate payment of the emergency care visit.

PART II. STATE HEALTH BENEFITS PROGRAM - ALTERNATE HEALTH CARE OPTION

If you have US Citizenship and/or legal US Residency Status, with a current US Residence you may have the option of enrolling in the New Jersey State Health Benefits Plan (SHBP) as an alternative to the Cigna plan. The program has many plans for you to choose from in either the Horizon or Aetna network. However, only certain ***Horizon plans*** will offer you coverage abroad outside of emergency care through the "BlueCard Worldwide Services."

- BlueCard Worldwide services are exclusively pay-and-claim in Wenzhou, China, meaning all local services are considered out of network.
- BlueCard Worldwide services are available for all Horizon SHBP products – NJ DIRECT, NJ DIRECT HDHP and Horizon HMO. However, for HMO, only urgent/emergent care out-of-area is eligible for coverage.
- For NJ DIRECT, the BlueCard Worldwide network is available for all services including routine/preventive – subject to the benefit design of the plan (deductible, coinsurance, eligible services, authorizations, etc.).
- Services rendered by a BlueCard Worldwide in-network provider would be considered in-network, subject to the benefit design of the plan.
- Services rendered by a non-participating provider (not part of the BlueCard Worldwide network) would be considered out of network and subject to the out-of-network benefit of the plan. NOTE: There is no out-of-network benefit under HMO (except in the case of urgent/emergent services.)
- All international claims must be accompanied by itemized bills.

Dental is offered through the Aetna Dental Expense Plan if you select to enroll in one of the SHBP health plans. You may visit our website for further details on these plans. We encourage employees to review all available health plan options, and contact insurance carriers to confirm coverage levels outside of the US before making a selection.

You will find additional information, as well as enrollment forms, regarding health coverage (medical, prescription and dental), offered by the SHBP in **Appendix D**.

Waivers

You may choose to waive health coverage. To do so, you must complete the Cigna Global waiver form, as well as a SHBP waiver form, and provide sufficient proof of health insurance in China and in your country of origin, by email, no later than **15 days after your date of hire**. You will find a copy of the Cigna Global waiver form in **Appendix B**. If you do not submit this information to Kean HR USA at benefits@kean.edu, Cigna Global health deductions will be started and will continue until we receive an email with the required attachments.

Please note, if you are completely waiving coverage, you assume complete financial responsibility for paying your own medical expenses. You may enroll in the health plans offered by Kean University, in the future, only during the annual open enrollment period, which is usually during the month of October, or for

a qualifying event, such as loss of coverage. If you have a loss of coverage, you must immediately notify the Kean University Office of Human Resources in writing of the loss of other coverage, and provide proof of loss in order to enroll in the Cigna Global Health Plan.

PART III. TRAVEL INSURANCE

ACE Travel Assistance Services are provided to Kean University employees, members of the Board of Trustees and volunteers who travel to Wenzhou, China for official University business. Services available to you under these plans include, but are not limited to, Lost Document Assistance, Emergency Cash Advance, Concierge Services, as well as Emergency Medical Evacuation and Repatriation.

You will be emailed an ID card. Instructions on how to access the benefits, should you need them, are written on the ID card. We encourage you to print out and keep the card with you at all times during your visit. In the event of an emergency, it is critical that you activate the benefits by making a phone call to the phone number on the card. Please note that if the emergency is a medical one, you are encouraged to also present proof of medical insurance coverage, if available.

TRANSLATION SERVICES

Translators are available on the Wenzhou campus. Translators are available only on weekdays between the hours of 9:00am - 5:00pm. Translation services may be used to make an appointment for a routine health visit to a local health facility and/or to accompany employees on their hospital visits in cases of emergencies or non-emergencies. Contact information for the help line is below:

Appointment/ AccompanyingServices: 55870120

PART IV. ON-THE-JOB INJURY REPORTING PROCEDURES FOR WENZHOU, CHINA

All Kean University employees working or visiting Wenzhou, China shall comply with the following procedures in reporting work-related injuries:

1. General Notification Requirement - Upon the occurrence of a work-related injury, the injured employee shall immediately notify his/her immediate supervisor on location in Wenzhou, China.

2. HR Notification Requirement - Upon the occurrence of a work-related injury, the injured employee shall notify the Office of Human Resources, Benefits Section, no later than the end of the workday on which the injury occurred.

HR Contacts:

- Yrelys Tapanes at ytapanes@kean.edu, and/or
- Lorice Thompson-Greer at lgreer@kean.edu

1. Accident Report Form - For all cases, an accident report form (Form RM-2) must be completed by the employee, signed by the employee and the supervisor, and submitted to the Office of Human Resources (Benefits Section) by the employee within 48 hours from the time of the injury/illness, pursuant to New Jersey State regulations governing Worker's Compensation benefits. An original, signed Accident Report Form **is required.**

   Copies of the Accident Report form can be obtained by going to the HR webpage: http://www.kean.edu/offices/human-resources/benefits/workers-compensation

2. Supplemental Report of Accidental Injury – The employee is also required to complete a Supplemental Report of Accidental Injury Form and submit this to the Office of Human Resources along with the Accident Report Form, within 48 hours from the time of the injury/illness.

   Copies of Supplemental Report of Accidental Injury form can be obtained by going to the HR webpage: http://www.kean.edu/offices/human-resources/benefits/workers-compensation

3. Medical Care - The employee is advised to seek immediate medical care from a health care professional.

4. Post-Injury Notification – After the injured employee has been treated medically, the Office of Human Resources shall again be contacted by the employee and advised as to: 1) The nature of the injury; 2) The extent of such injury; 3) The general nature of the treatment received for the injury; and, 4) The estimated time that the employee will remain out of work, if recommended by a physician.

5. Medical Claims - Office of Human Resources will work closely with the employee to process any applicable claims for medical treatment, in the event that an employee sustains a work-related injury that is deemed valid and compensable by the workers' compensation insurance carrier. The employee will provide medical documentation to substantiate claims in a timely manner.

6. Failure to Comply with Reporting Procedures - Employees who do not comply with these procedures will be responsible for paying their medical bills and may prejudice the work-related injury claim.
7. Questions Regarding Notification Procedures - If there are any questions regarding the reporting of work-related injuries, please contact the Office of Human Resources, Benefits Section.

Revised: July2015

PART V. TRAVEL HEALTH AND SAFETY

The Centers for Disease Control and Prevention (CDC) publishes "The Yellow Book – Health Information for International Travel 2016." This information is available at the link below and may offer you additional resources for planning your trip overseas. http://wwwnc.cdc.gov/travel/yellowbook/2016/table-of-contents

PART VI. ENVIRONMENTAL HEALTH AND SAFETY

The Office of Environmental Health and Safety provides the campus community with services designed to ensure a safe and healthy workplace. For staff located at Wenzhou-Kean, services including, but not limited to, those listed below are available by contacting Suzanne Kupiec, 908-737-5109 or skupiec@kean.edu.

- Accident/Incident Investigation
- Blood borne Pathogens
- Campus Safety
- Emergency Management and Planning
- Hazardous Materials Management (purchase, storage, use, and disposal)
- Indoor Air Quality
- Laboratory Safety
- Personal Protective Equipment (type of eye protection or glove material needed)
- Physical Hazards (slips, trips, and falls, electrical hazards, noise, work near moving machinery)
- Risk Assessments (evaluate a process to determine hazards and recommend methods to reduce or eliminate the hazards presented)
- Standard Operating Procedures/Written Compliance Plans
- Technical Assistance and Research
- Training

IN AN EMERGENCY: If you urgently require assistance from the EHS office, day or night, please contact the Kean Department of Public Safety/Police Dispatch at 908-737-4800.

PART VII. RETIREMENT PLANS

Generally, US based retirement plans are available only for employees with legal US Residency Status, a current US Residence, and/or US Citizenship.

*Alternate Benefits Program (ABP) – State Administered Retirement Plan - Mandatory

The Alternate Benefit Program is a tax-deferred, defined contribution retirement program for higher education faculty (including adjuncts), and certain managers and administrators. This program provides retirement benefits, life insurance, long-term disability coverage and loans. Members contribute 5% of their base or contractual annual salary,

and are matched by an 8% employer contribution to a tax deferred investment account. There are seven investment carriers to choose from:

- AXA Equitable
- Mass Mutual (The Hartford)
- MetLife (CitiStreet/Travelers)
- Prudential
- TIAA
- VALIC
- VOYA (ING Financial Advisers, LLC)

If employment terminates during the initial year of participation, the employee contributions may be withdrawn, plus or minus any gains or losses on the selected investments. The employee is not entitled to the University's contributions if employment is terminated during the initial year of participation. If employment terminates after one year of service, contributions made by the University, as well as the employee, are fully vested.

How do I enroll in the ABP retirement plan?

Enrollment is Mandatory, as of start date in permanent position. *(Employees holding temporary positions are not eligible to enroll until position becomes permanent or one year has elapsed, whichever comes first.)*

If you are eligible, your action is required. You must do the following:

1. Review the ABP Enrollment Instructions **(See Appendix E)**
2. Select a Service Provider
3. Complete Required Forms **(See Appendix F)**
4. Submit enrollment forms to Kean HR USA at benefits@kean.edu as soon as possible

Contribution

The member and employer make regular tax-deferred contributions toward retirement savings. Members contribute 5% of base salary. Employers contribute 8% of base salary.

Vesting

After 1 full year of contributions (September to September). A member is vested in the ABP beginning the second year of ABP eligible employment; **or** is "immediately vested" if the member has an existing qualified retirement account from employment in higher education, **or** transfers an active or vested New Jersey State- administered retirement system to the ABP. Once vested, all of the contributions and accumulations in the member's account belong to the member, and provide benefits when the member is eligible to receive them. If a member leaves the institution of higher education prior to becoming vested, only the "employee" contributions, including any investment gain or loss can be refunded. The "employer" contributions revert back to the employer.

ABP Life Insurance

3 ½ times prior 12 months salary. Noncontributory (Free to Employee). Funded by NJ Division of Pensions and Benefits for members of ABP. Employer-paid group life insurance is provided for all eligible members. No medical examination is required unless the member has attained the age of 60 prior to enrollment. Coverage equals three and one half times the member's base salary.

ABP Long Term Disability Insurance

Automatic Enrollment. Noncontributory (Free to Employee). Funded by NJ Division of Pensions and Benefits for members of ABP. Members are eligible for employer-paid long-term disability after one year of participation in the ABP. Benefits begins after six months of continuous disability. The plan pays 60% of the monthly base salary (reduced by other pension benefits such as short-term disability income and Social Security), if totally and permanently disabled.

*Supplemental Retirement Savings Plans - Voluntary

Supplemental Retirement Annuity (SRA) Plan: The Supplemental Retirement Annuity (SRA) Plan allow for eligible employees to obtain supplemental tax- deferred annuities with a variety of carriers through a salary reduction agreement. Participants can direct voluntary contributions among the six authorized ABP investment carriers. Each carrier provides a selection of investment choices to meet the needs and goals of retirement planning. To be considered eligible for an SRA, you must be actively enrolled in the ABP retirement plan. Maximum annual contribution for 2016 is $18,000 if under 50 years old/ $24,000 if 50 years old or more.

Enrollment: Voluntary.

Eligibility: Only employees enrolled in the Alternate Benefits Program may participate.

Investment Carriers: AXA Financial (Equitable), MassMutual (formerly The Hartford), MetLife (formerly Travelers/CitiStreet), TIAA, VALIC, and VOYA.

Benefit may not be available to third-country nationals.

***NJ State Employees' Deferred Compensation Plan - 457 or Roth*:** The New Jersey State Employees Deferred Compensation Plan (NJSEDCP) provides you, as an eligible State employee, an opportunity to voluntarily shelter a portion of your wages from federal income taxes while saving for retirement to supplement your Social Security and pension benefits. Under the plan, federal income tax is not due on deferred amounts or accumulated earnings until you receive a distribution (payment) from your account. Presumably, distribution is at retirement when your tax rate is expected to be lower.

Roth Option

Roth contributions combine the savings and investment features of a traditional deferred compensation plan with the tax-free distribution features of the Roth IRA. Instead of having all of your contributions deducted from your paycheck before taxes, you can designate some or all of those contributions to be put aside as after-tax Roth contributions. And, if you satisfy certain plan and tax law requirements, the Roth money you withdraw at retirement—including earnings—won't be taxable. Maximum annual contribution for 2016 - $18,000 if under 50 years old/ $24,000 if 50 years old or more.

Enrollment: Voluntary.

Eligibility: All employees may participate, even those holding temporary positions. **Administered by**: Prudential

Benefit may not be available to third-country nationals.

PART IV. TAX$AVE – SECTION 125 PLANS

Generally, US based Tax$ave plans are available only for employees with legal US Residency Status, a current US Residence, and/or US Citizenship.

***Premium Option Plan*:** Health, Prescription Drug and Dental insurance premiums are deducted from your paycheck before taxes.

Enrollment: Automatic, unless waived within 15 days of hire.

Unreimbursed Medical Flexible Spending Account (FSA): Allows employees to set aside pre-USA tax dollars to pay for eligible medical, dental and vision expenses not paid by insurance. (i.e., co-payments for doctor visits and prescription drugs, eyeglasses, orthodontics) Maximum election is $2,500 per year per family. Any unused benefits at the end of the year will be forfeited if not claimed for reimbursement.

Eligibility: Employees with US Residency. As of start date for faculty new hires starting as of September 1. Managers and 10-month Faculty with any start date other than ***September 1 follow a 60-day waiting period.***

Enrollment: Voluntary. May enroll within 30 days of hire, or at open enrollment. Must re-enroll each calendar year to continue in program.

Administered by: Wage Works

Benefit may not be available to third-country nationals.

Dependent Care Flexible Spending Account (FSA): Allows employees to set aside pre-USA tax dollars to pay for eligible dependent care expenses. (i.e., child care, adult day care) Maximum election is $5,000 per year per family. Any unused benefits at the end of the year will be forfeited if not claimed for reimbursement.

Eligibility: As of start date for faculty new hires starting as of September 1. Managers and 10-month Faculty with any start date other than September 1 follow a 30-day waiting period.

Enrollment: Voluntary. May enroll within 30 days of hire, or at open enrollment. Must re-enroll each calendar year to continue in program.

Administered by: Wage Works

Benefit may not be available to third-country nationals.

APPENDIX A – CIGNA ENROLLMENT FORM

Cigna

Global Health Benefits

Global Health Advantage 10+ Enrollment/Change Form

Mailing Address: P.O. Box 15050
Wilmington, DE 19850

Section A. – About You

Account Number:	Coverage Effective Date:	Hire Date:	Birth Date:	Gender: ☐ M ☐ F	Marital Status:
Employer Name:		Last Name:	First Name:	Middle Name:	
Social Security No.	Medicare No.	Country of assignment:		Country of citizenship:	

Current International Assignment Information

Address	Street:	Home phone number:	Work phone number:
	City: / State:	E-mail address:	Facsimile number:
	ZIP code: / Country:	Do you agree to accept the Notice of Privacy Practices from Privacy Office electronically? ☐ Yes ☐ No	

If your lawful spouse resides separately from you and in the United States, please enter that United States address below.

Address	Street:		
	City:	State:	ZIP code:

Section B. – About Your Benefit Elections

☐ Medical	☐ Employee Basic Life	☐ Employee Additional Life $	Annual Base Salary $
☐ Dental	☐ Long Term Disability	☐ Dependent Life-Spouse $	☐ Accidental Death & Dismemberment Employee $
☐ Vision		☐ Dependent Life-Children $	☐ Additional AD&D $

Section C. – About Your Dependents

If your Employer's plan provides coverage for a Domestic Partner, please indicate under the Relationship box below.

Coverage Type	Name of Dependent	Relationship	Birth Date	Social Security No.	Medicare No.	Gender	Other Medical Coverage	Other Dental Coverage	Country of Residence
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Medical ☐ Dental ☐ Vision						☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	

*Dependents – Dependents are covered for medical, dental and vision (if applicable) to age 26. Proof of student status may be required for Dependent Life. If totally disabled prior to the dependent eligibility end date, attach proof of disability for eligibility review.

Section D. – Other Healthcare Coverage

If you or your dependents have other health insurance under a group plan, HMO or Medicare please provide the following:

Medical Carrier Name:	Insured Name:	Birth Date:	Effective Date:	Medicare:		Medicaid:
				☐ Part A	☐ Part B	
Dental Carrier Name:	**Insured Name:**	**Birth Date:**	**Effective Date:**	**Medicare:**		**Medicaid:**
				☐ Part A	☐ Part B	

Section E. – Changes

☐ Add Spouse Date of Marriage: ☐ Add Dependent Child Date of Birth / Adoption:

☐ Cancel Spouse Termination Date: ☐ Cancel Dependent(s) Termination Date: ☐ Cancel All Coverages Termination Date:

☐ Name Change Former Name: ☐ Your Address (SHOW NEW ADDRESS IN SECTION A) ☐ Your Work Location Effective Date:

ADD COVERAGE: ☐ Non-Medical Coverage ☐ Dental Coverage

OTHER:

Section F. – Beneficiary Information (for Life & AD&D Insurance)

Name(s) of Beneficiaries	Relationship	Address				% of Insurance
		(Street)	*(City)*	*(State)*	*(Zip Code)*	
						%
						%
						%

This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the Insured. Unless otherwise provided, where two or more beneficiaries are named under Life Insurance coverage, if any, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured. If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

Employee signature: _____ Date: _____

Provisions

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the insurance. This authorization applies only if employee contributions are required.

I agree, for myself and my dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage, or by the act or omission of another person to fully inform the insurer, I will execute such assignments, liens or other documents which may be necessary to enable the insurer to recover the value of the services provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided by the insurer, I will immediately reimburse the insurer to the extent of services provided, to the extent permitted by applicable law.

FRAUD NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Send Forms To: Once this form is completed in its entirety, please return to your employer's Human Resources Department

APPENDIX B– CIGNA WAIVER FORM

KEAN UNIVERSITY

CIGNA GLOBAL HEALTH PLAN
COVERAGE WAIVER FORM

Part 1: To be completed by the employee. Please print.

Name _____ SS# _____

Waiver of Coverage

I understand that it is a condition of my placement at Wenzhou Kean University that I maintain sufficient health insurance that will provide coverage in China as well as in my country of origin.

I agree to voluntarily waive medical, prescription drug and dental coverage offered to me under the Cigna Global Health Plan to which I am entitled because I have sufficient health coverage both in China and in my country of origin through another health plan.

I have provided proof of sufficient health insurance in China and in my country of origin through my health plan _____, Policy No. _____.

I understand that by waiving coverage under the Cigna Global Health Plan, I assume complete financial responsibility for paying my own medical expenses.

I understand that while coverage with Cigna Global Health Plan is waived, I will not be required to make payroll contributions for medical and/or prescription drug coverage.

I understand that I may enroll in the Cigna Global Health Plan coverage only during the annual open enrollment period or for a qualifying event, such as loss of coverage. If I have a loss of coverage, I am aware that I must immediately notify the Kean University Office of Human Resources in writing of the loss of the other coverage, and provide proof of loss in order to enroll in the Cigna Global Health Plan.

I understand that I must affirmatively waive coverage and provide proof of continued coverage on an annual basis during the open enrollment period.

I understand that if I fail to provide sufficient proof of alternate coverage, that I will be automatically enrolled in the Cigna Global Health Plan and payroll contributions for medical and/or prescription drug coverage will be automatically deducted in order to comply with the terms of my placement at Wenzhou Kean University.

Employee's Signature _____ **Date** _____

Proof of health coverage under an international health plan, including proof of coverage in China, is required to complete your request for waiver.

APPENDIX C – CIGNA CLAIM FORM

To: Healthcare Provider - **医**疗保健专业人員

From: Office of Human Resources **人力**资源办公室 – Kean University

Re: New Health Insurance Benefits Plan - **新的医**疗保险福利计划

Dear Healthcare Professional - **各位医**疗保健专业人員,

In order to help our staff receive financial reimbursement for the services you have rendered, we kindly ask for your support in helping them complete the attached claim form detailing the services you have performed and the total cost for each service rendered.

為了让我們的同仁因为您们提供的医疗服务得到適当的財务辅助，所以当您提供医疗服务時，
恳请您协助他們填写下列的申請表格**:**

On the attached form accompanying this letter we have highlighted the following information which we would kindly ask you to complete including:

在此随信附上的表格，**在強**调重卖的部分，恳请协助完成**:**

- DIAGNOSIS / REASON FOR TREATMENT / SYMPTOMS☐
- NAME
- ADDRESS
- PHONE NUMBER
- DATE OF SERVICE
- AMOUNT

- **診断/治**疗原因**/症狀**
- **姓名**
- **地址**
- 电話
- **診断日期**
- **金額**

If you could complete this information and provide a receipt/invoice, this will allow the insurance company to process the claim accordingly - **在您的**协助下完成表格的填写，以便保險公司能正確的完成作业.

Thank you - **多**谢您的合作,

Claim Form

Insured and/or Administered by:
Connecticut General Life Insurance Company
Cigna Health and Life Insurance Company

Mailing Address: P.O. Box 15050 | Wilmington, DE 19850, USA

Phone: 1.800.441.2668 (outside the USA)
001.302.797.3100 (outside the USA, collect calls accepted)

Fax: 1.800.243.6998 (outside the USA)
001.302.797.3150 (inside the USA)

Website: www.CignaEnvoy.com For faster service, submit your claims online via our secure website.

Please submit this completed claim form with itemized bills and receipts as soon as possible to the address, fax number, or website above. Tape small receipts on 8.5 x 11 inch or ISO A4 paper. Do not staple receipts to the claim form. Complete a separate Claim Form for each patient. In order for your claim to be considered for reimbursement, you must complete and sign this claim form.

Required information: Missing or incomplete information on this form will delay payment.

SECTION A. – Customer Information

CUSTOMER NAME (Last Name, First Name, Middle Initial)		
CUSTOMER DATE OF BIRTH (DD/MM/YY)	ID NUMBER -	
PRIMARY MAILING ADDRESS (Where check/Correspondence should be sent)		
CITY/STATE	COUNTRY/POSTAL CODE	EMAIL ADDRESS
HOME PHONE NUMBER	WORK PHONE NUMBER	FACSIMILE NUMBER
EMPLOYER		

SECTION B. – Patient Information

PATIENT NAME (If multiple, use separate claim forms for each)	
PATIENT DATE OF BIRTH (DD/MM/YY)	COUNTRY WHERE SERVICES WERE RENDERED
DIAGNOSIS / REASON FOR TREATMENT / SYMPTOMS 診断/治疗原因/症状	

NOTE: Please include a prescription from your general practitioner (GP) or medical specialist for prescribed drugs.

SECTION C. Health Care Professional Information

Complete this section if the bill does not include complete health care professional contact information

姓名 NAME	地址 ADDRESS	电話 PHONE NUMBER	診断日期 DATE OF SERVICE	金額 AMOUNT

SECTION D: Payment Information

Incomplete or incorrect information may result in a check payment made in US Dollars and mailed to your Primary Mailing Address

PAY CUSTOMER PAY HEALTH CARE PROFESSIONAL

Please be advised that if the health care professional is a provider in the US and holds a contract with Cigna®, payment will be made to the health care professional at the contracted rate even if this section indicates otherwise. If you have already paid for services, you should seek reimbursement directly from the health care professional.

If payment is being made to CUSTOMER – complete payment details below.

PAYMENT TYPE	CLAIM PAYMENT OPTIONS US DOLLAR OTHER CURRENCY (PLEASE SPECIFY) _____ Note: Some currencies may not be available for reimbursement. Cigna reserves the right to default the payment currency to US dollars in order to facilitate payment. CHECK	FOR OTHER AVAILABLE PAYMENT OPTIONS SEE PAGE 3 MORE INFORMATION IS ALSO AVAILABLE ON OUR SECURE WEBSITE www.CignaEnvoy.com
	ELECTRONIC PAYMENT	Payments issued in US Dollar or International currency via wire transfer to an international bank may be assessed fees by your bank for receipt of the wire transfer. FILL OUT THE BANK DETAILS SECTION

Cigna Global Health Benefits®

BANK DETAILS (THIS SECTION FOR ELECTRONIC PAYMENTS ONLY)	BANK ACCOUNT BENEFICIARY NAME	ACCOUNT NUMBER (INTERNATIONAL BANK ACCOUNT NUMBER – IBAN)
	BANK ACCOUNT TYPE	
	BANK NAME	BANK ADDRESS
	BANK ROUTING NUMBER	BANK CITY/STATE
	ABA / Routing / SWIFT / BIC / BSB / Sort codes	
	ACCOUNT CURRENCY	BANK COUNTRY/POSTAL CODE

Verify all account information, bank routing number requirements and currency requirements for your banking country to ensure the successful transmission of your payment. Incurred currency or US dollar check may be issued as a default payment. Cigna reserves the right to make electronic payments in the method and format deemed most cost effective and expedient way to reach the payee.

SECTION E: Injury / Occupational Claim Information

Complete this section only if you are filing the claim because of an accident or occupational (work-related) injury or illness.

INJURY OR ILLNESS OCCURRED WHILE ON THE JOB?	YES	NO
DESCRIPTION OF HOW INJURY OR ILLNESS OCCURRED		
DATE OF INJURY OR BEGINNING OF ILLNESS (DD/MM/YY)		
ARE YOU OR YOUR DEPENDENT(S) FILING A CLAIM OR LAWSUIT AGAINST A THIRD PARTY INCLUDING AN INSURANCE COMPANY IN ORDER TO RECOVER THE COST OF EXPENSES INCURRED AS A RESULT OF THIS INJURY OR ILLNESS? *	YES	NO
IF YES, PLEASE PROVIDE NAME OF THIRD PARTY *		

SECTION F: Other Coverage

Complete this section if other coverage is in effect

IS THE PATIENT COVERED UNDER ANOTHER HEALTH INSURANCE PLAN? *	YES	NO
IF YES, PROVIDE NAME OF HEALTH INSURANCE COMPANY:		
EFFECTIVE DATE OF COVERAGE (DD/MM/YY):	POLICY NUMBER:	
IS THE PATIENT COVERED UNDER MEDICARE? *	YES	NO
IF YOU ANSWERED YES TO EITHER QUESTION ABOVE AND THE OTHER INSURANCE COMPANY IS PRIMARY, PLEASE SEND US THIS FORM AND (1) A COPY OF THE EXPLANATION OF BENEFITS (EOB) AND (2) THE ITEMIZED BILL(S) FOR THIS CLAIM.		

SECTION G: Certification and Payment Authorization

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

CERTIFICATION: By signing this form, I certify that this claim form does not contain any false or misleading information. I understand that Cigna and/or its subsidiaries may investigate my claims by collecting additional relevant personal information from me and from third parties, if necessary.

PAYMENT AUTHORIZATION: I authorize payment as indicated in Section D of this claim form.

NOTE: The information provided on this form may be disclosed to other persons or entities, including my Plan Sponsor, for the purpose of processing this claim and performing health plan administration and for such purposes as stated on the privacy notices, available upon request or at http://www.cigna.com/privacyinformation/privacy-notices-and-forms/.

I authorize the release of any medical information necessary to process this claim and for the purposes stated in the privacy notices. I certify that the information supplied is true and correct. I authorize payment as indicated in Section D of this claim form.

PATIENT SIGNATURE / PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR _____ DATE (DD/MM/YY): _____

Cigna Global Health Benefits®

IMPORTANT CUSTOMER INFORMATION

Itemized bills must include:

Primary customer name	Type of Service	Health care professional name/credentials
Date of Service (DD/MM/YY)	Charge for the service	Health care professional address
Patient name	Diagnosis code/reason for service	

Payment Information:

Electronic Funds Transfer (EFT) – Referred to in the US as ACH (Automated Clearing House)

EFT is only available for electronic payments made in US Dollars to US Bank Accounts. An EFT authorization form must be completed prior to claim submission. The form can be found on our website at: www.CignaEnvoy.com, under My Account. Banking details will be updated within 10 business days after receiving the EFT authorization form. Within 24 hours of banking details being updated, Cigna can begin making electronic payments to the account. Claim payments made in the interim of receiving the authorization will be made by check in US Dollars.

ePayment Plus℠ (Int'l ACH)

International ACH payments are only available for electronic payments in the *United Kingdom, Canada, Hong Kong, Singapore, Australia, Denmark, Sweden or New Zealand* in the local currency of that country. Enrollment must be completed prior to claim submission. To enroll, please access the ePayment Plus online enrollment section found on our website at: www.CignaEnvoy.com, under My Account. Once enrolled, your claim reimbursements will be deposited electronically into the bank account you specify. To cancel electronic deposits to your account you must terminate your ePayment Plus account information through this website. Lifting fees and additional bank charges may apply, please contact your bank for details.

Wire Payments

Wire payments are only available for payments made to banks outside of the United States. For payment to banks located in the United States, you must use the EFT (ACH) option. Enrollment must be completed prior to claim submission. To enroll, please access the wire transfer online enrollment section found on our website at: www.CignaEnvoy.com, under My Account. To cancel electronic deposits to your account, you must terminate your banking information through our website at: www.CignaEnvoy.com. Your bank may charge a fee for incoming wire payments, please contact your bank for details.

Default Payment Process

- If an electronic payment is rejected due to incorrect bank account information, a local currency or US dollar check may be issued until you correct your electronic payment information through our website at: www.CignaEnvoy.com.
- If you're electronic bank information is incomplete or incorrect, your claims reimbursement will be issued as a check and mailed to the primary mailing address stated in the form. You will receive reimbursement through the method of choice, once the correct bank information is received.
- All currencies are not available for some countries. If a currency or payment method is not available, the default payment is a US dollar check.
- If payment currency is in Euros and being remitted to one of the following countries, it may be sent as a SEPA payment: *Aland Island, France, Italy, Norway, Austria, French Guiana, Latvia, Poland, Belgium, Germany, Liechtenstein, Portugal, Bulgaria, Gibraltar, Lithuania, Reunion, Cyprus, Guadeloupe, Luxembourg, Romania, Czech Republic, Greece, Malta, Slovakia, Denmark, Hungary, Martinique, Spain, Estonia, Iceland, Monaco, Switzerland, Finland, Ireland, Netherlands* or *United Kingdom*.
- Cigna reserves the right to make electronic payments in the method and format deemed must cost effective and expedient to reach the payee.

APPENDIX C – CIGNA INFORMATION

1. CIGNA WELCOME KIT

YOUR CIGNA JOURNEY

Expatriate Employees

Cigna Global Health Benefits®

Cigna®

112366-154078 11/15

WELCOME

To Cigna Global Health Benefits®

OUR MISSION:

TO HELP THE PEOPLE WE SERVE IMPROVE THEIR HEALTH, WELL-BEING AND SENSE OF SECURITY.

Table of Contents

Our personality: encouraging 1

Pre-departure: checklist and tips 2

We are here for you 4

Frequently asked questions: 5

Cigna Envoy: making it easy 6

When to file a claim and when you don't need to 8

Value-added services 9

Customer claims scenario: Direct pay 10

Customer claims scenario: Guarantee of payment 11

Together, all the way.℠

Cigna®

Our personality: encouraging

Cigna is the trusted expert in your life who understands, helps and encourages you.

You are about to begin work or may already be working outside of your home country . . .

. . . and whether it is your first or tenth time, you know it has the potential to be an amazing experience both professionally and personally. This opportunity also brings changes, questions and uncertainty. But one thing you can be sure of is you have valuable health coverage. When you are living in a different country, your health care questions are likely to be different than when you're at home, and the answers may be too!

Your satisfaction is important, and Cigna has developed specialized health benefit services for covered family members.

Before you go, spend some time reviewing your health care benefits and services, which are provided in this kit. You and your covered family members have all the advantages of Cigna services whenever you need them, wherever you are in the world.

Cigna is excited to share in this experience with you. You work hard and deserve a health plan that does too.

Pre-departure: checklist and tips

Before traveling to work outside of your home country, you'll need some assistance to make sure you're prepared. To help you out, we've designed an easy-to-follow checklist to make sure you have everything covered before you leave.

First, let's start with some basic questions. Information is power. So it's in your best interest to be sure all of your important information is updated and ready to travel with you.

1. Are your travel and ID documents up-to-date?
2. Are your health documents updated, renewed and reauthorized?
3. Have you visited **www.CignaEnvoy.com** to access our Pre-Assignment Tool?

Important Documents Checklist:

Medical

- ☐ Your Cigna ID card – If you have not received your card before you leave, you can reach the Customer Service Center:
  - Toll-free: **1.800.441.2668**.
  - Direct calling: **001.302.797.3100** (Collect calls accepted).

  — OR —

  - You can obtain a copy on **CignaEnvoy.com** or through the Envoy mobile app.
- ☐ Before you leave, get a 6-12 month supply of all prescriptions you take regularly (country limitations may apply).
- ☐ A record of past surgeries, diagnoses and medications (names/dosages).
- ☐ Copies of X-rays, MRIs, CT Scans, etc. (easily stored on a thumb drive or DVD).
- ☐ Blood type, blood group and Rh factor.
- ☐ List of all allergies – include medicine, foods, seasonal, etc.
- ☐ Vaccination history.
- ☐ International certificate of vaccinations for yellow fever (yellow card, if necessary).

Travel

- ☐ Passports.
- ☐ Birth certificates.
- ☐ Visas and work permits.
- ☐ Marriage certificate (if applicable).
- ☐ Home address.
- ☐ Emergency and contact information.
- ☐ A copy of Cigna customer service numbers:
  - Toll-free: **1.800.441.2668** and your Cigna ID number.
  - Direct calling: **001.302.797.3100** (collect calls accepted).
- ☐ Review your country guides specific to your assigned country available on Cigna Envoy.
- ☐ Pre-assignment screenings.
  - Research and create a list of physicians located in your assigned country on **CignaEnvoy.com.**
- ☐ Driver's license.

Things to ask your doctor before traveling outside of your home country.

Immunizations:

You will need to be sure you're up-to-date on your immunizations in your home country and the country you'll be working in. Some tips:

- Be sure to get your vaccines four to six weeks before you leave. They need time to become effective in your body.
- Ask your primary doctor if you need to schedule an appointment to get booster shots once you are working outside of your home country.
- If traveling to countries where exposure to malaria or other diseases may be common, ask how to best prevent it. Check out our Country Guides on **CignaEnvoy.com** for detailed information about the country where you will be assigned.

Did you know?

Different countries have different vaccination requirements. To find out what other vaccines you'll need, go to the **Centers for Disease Control** website at **www.cdc.gov.**

Did you know?

You can visit **CignaEnvoy.com** to learn the generic and local brand names of medicines.

Medications:

- Before you leave, get a 6-12 month supply of all prescriptions you take regularly.
- Check and see if the medications you take are available in the country where you will be working.

Now that you are working outside of your home country, what do you do in case of a medical emergency?

- If a situation arises, and you don't know what to do, contact us using the number on the back of your Cigna ID card. We can help you avoid paying **out of pocket expenses**[1] other than your patient responsibility (i.e., **deductibles**[2], **co-insurance**[3], etc.). If it is an emergency, contact Cigna from the hospital or doctor's office immediately after the situation is stabilized. We'll work with your doctor and help.
- If you're hospitalized, our global service center can also provide guidance from a health specialist with detailed knowledge of the country you're in.

Did you know?

Many employers choose to add **emergency evacuation services** to your list of benefits. Ask your employer if it's included in your plan.

1. **Out of Pocket Expenses:** Expenses not covered by your plan, such as co-pays, coinsurance, deductibles, and any other charges not covered under your plan.
2. **Deductibles:** This is the amount of covered expenses that you must pay before the plan pays any benefit. Once you meet this threshold, the plan will begin to pay benefits for covered expenses that you incur; this applies to both individual and family plans.
3. **Co-insurance:** A percentage of the cost of covered expenses you must pay after you have met your plan deductible.

We are here for you

Whether you're still at home planning your departure or already in your new country, rest assured knowing that Cigna is here to help.

Important contact information – Contact us anytime, anywhere

We can help you . . .

- ✓ Submit a claim
- ✓ Locate a health care professional
- ✓ Register for Cigna Envoy

. . . just to name a few.

Cigna representatives in our global service center can provide 24/7 multilingual information and professional support, and help connect you with doctors around the globe.

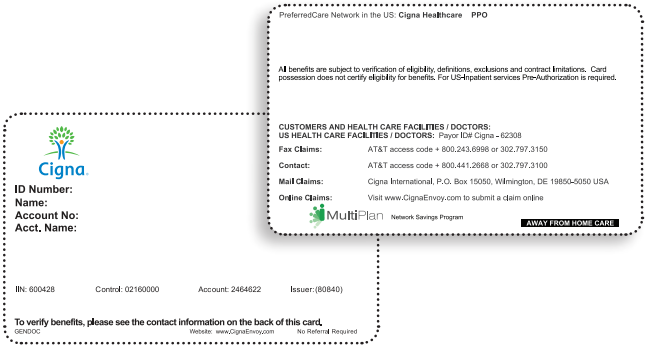
Website:	**www.CignaEnvoy.com**
Toll-free telephone number:	**1.800.441.2668**
Email:	Email is available for registered members; see page **6** for registration instructions
Toll-free TDD* telephone number for the hearing impaired:	**1.800.558.3604**
Direct telephone number:	**001.302.797.3100** (collect calls accepted)
Toll-free facsimile number:	**1.800.243.6998**
Direct facsimile number:	**001.302.797.3150**
Mail delivery:	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050, U.S.A.
Courier delivery:	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809, U.S.A.

* Telecommunications Device for the Deaf. | For other convenient ways to contact our Customer Service Center, please log on to **www.CignaEnvoy.com**.

Frequently asked questions:

Q: Do I need a Cigna ID card?

A: Yes. Your Cigna ID card is recognized by most health care professionals around the world. By using your Cigna ID card, we can directly reimburse the doctor or hospital where you received care.



When you receive your permanent ID card, please verify that your information is correct and call Cigna immediately if a change is required. Present your ID card whenever you receive services from a health care professional.

Q: Is my Cigna ID card a credit or payment guarantee card?

A: No. Your Cigna ID card is purely a means of identifying you. It has no payment capabilities. You should contact us for payment guarantees or questions.

Q: Do I need to select a Primary Care Physician (PCP)?

A: You are not required to select a PCP. However, it is recommended that you establish a relationship with a personal doctor, such as a family practitioner or an internist, in advance of requiring care. A personal doctor will care for you and your covered family members, including routine physical exams, sick visits and follow-up care. They can also provide information and guidance when selecting specialists. They will become a valuable resource and can be a personal health advocate for you and your covered family members.

Q: How can I locate a doctor?

A: With a network of more than one million health care professionals worldwide, it's easy to locate a doctor or hospital. To locate an international health care professional, go to **www.CignaEnvoy.com** and click on the **"Find health care"** tab or call us using the number on the back of your ID card for assistance.

Q: How do I get my prescriptions filled while I am away?

A: If you receive a prescription from a local doctor while working outside of your home country, you can have it filled locally. If you have any questions, please contact us using the number on the back of your Cigna ID card. Our customer service team will help you identify available options. Please be aware that medications can only be filled locally in the country where the prescription is written. For example, if you have a medication that was prescribed by a doctor in China, it cannot be filled in the United States. Likewise, a prescription written in the United States cannot be filled in a pharmacy outside of the United States.

Claim instructions are included on page 9 of this kit.

We also encourage you, when possible, to plan visits with your medical doctor in your home country for any new prescriptions, as well as having those prescriptions filled before you leave. If you have any questions or concerns about travel restrictions, you can call us at the phone number on the back of your Cigna ID card.

Q: What if my doctor is not in Cigna's international network?

A: You can see any licensed doctor in your assigned country. Cigna will be able to support with our Guarantee of Payment process and reach out to your doctor directly to initiate the payment.

Q: What is an Explanation of Benefits (EOB) and how can I check on my claim status?

A: Your EOB is a summary of how your claims were processed and what you may owe, not a bill. Your health care professional or the facility may bill you directly for the remainder of what you owe. To view your claims status, follow these steps:

1. Login to **www.cignaenvoy.com.**
2. Select **"Check my claims."**
3. Select **"View all claims."**
4. Under Explanation of Benefits, select **"View"** to see that specific EOB you are looking for.

Q: What if I have a medical emergency?

A: Should something serious happen, visit the nearest hospital and contact the global service center immediately. The professionals at our global service center will help you get the **emergency assistance** you need. From ground transportation and translators to finding a specialist and facilities, we're here to help.

Our contact information can be found on page 4.

Q: How do I obtain a claim form?

A: You can get a claim form and/or submit a claim online through **www.CignaEnvoy.com** or by contacting us by telephone, fax or e-mail.

Cigna Envoy: making it easy

Information at your fingertips.

Cigna Envoy® is your personalized online health resource. The tools and information are developed specifically for globally mobile individuals so you can easily find the information you need. Register for Cigna Envoy as soon as you receive your Cigna ID card. If you don't have an ID card, please call us toll-free at 1.800.441.2668 or direct at 001.302.797.3100 (collect calls accepted). With your ID card handy, enter the site (www.CignaEnvoy.com) and follow these simple steps to get started:

Step 1:	Go to www.CignaEnvoy.com and under "I am a Customer" select "I have not registered yet".
Step 2:	Fill in your registration details using the relevant information exactly as it appears on your Cigna ID card.
Step 3:	Answer the security questions and click Register.

You will be issued with a one-time PIN, which you can then change to a password of your choice for all future log-ins.

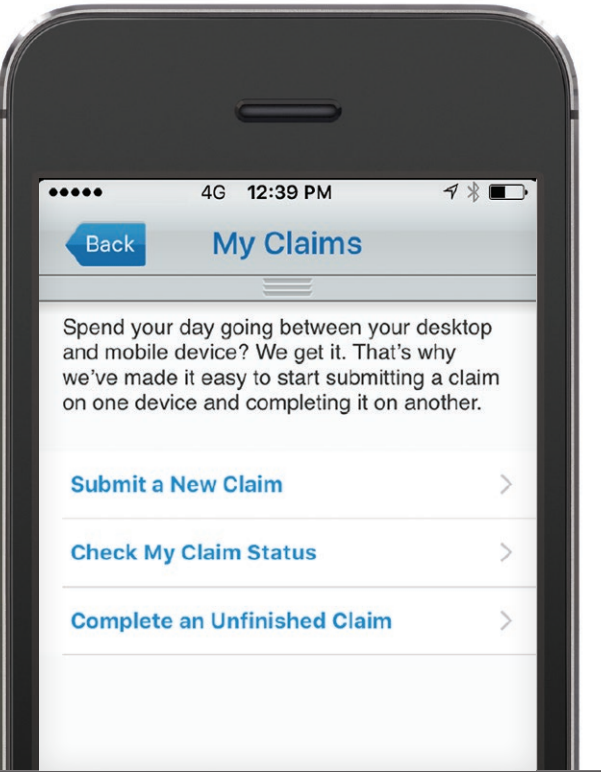
Why use the website?

There is a wide range of information available to you on our website, including:

- Your benefits and exclusions – what you and your family members are covered for.
- You and your covered family members' full claim history.
- Our health care professionals directory, allowing you to find a health care professional in your location.
- Health and well-being information on managing many conditions, plus healthy living information.
- Country guides which give you access to practical travel information, such as cultural, health & safety, travel tips, visitor and currency information for more than 190 countries.

On Cigna Envoy, you can also:

- Send questions to us through our messaging tool.
- Access pre-assignment tools.
- Print and view your ID card.
- Obtain a second opinion without having to visit a doctor.
- Look up translations for medical terms.
- Learn more about the country you are working in.
- Get tips to stay in better shape while you are working outside of your home country.
- Sign up for Electronic Funds Transfer (EFT) to make deposits and also claim reimbursements.
- Download claim forms, submit and track claims.



Still have questions or want to know more? Get in touch with our global service center by phone or e-mail.

Cigna Envoy on the go.

Instant, real-time access to your health information on the go. The Envoy Mobile App can be downloaded for free from the Apple App Store℠, Google Play™ or Amazon.com.

Download on the App Store | ANDROID APP ON Google play | Available at amazon

- Easy and simple navigation.
- Available whenever, wherever.
- Find health care all over the world through our app location services.
- Check and submit claims through our photo claim submission tool.
- View and print ID cards.

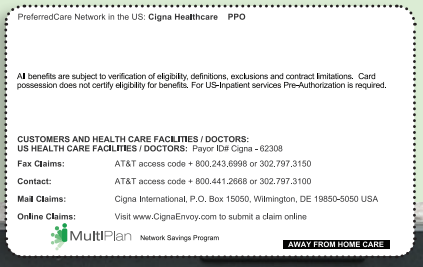
Finding and choosing a health care professional.

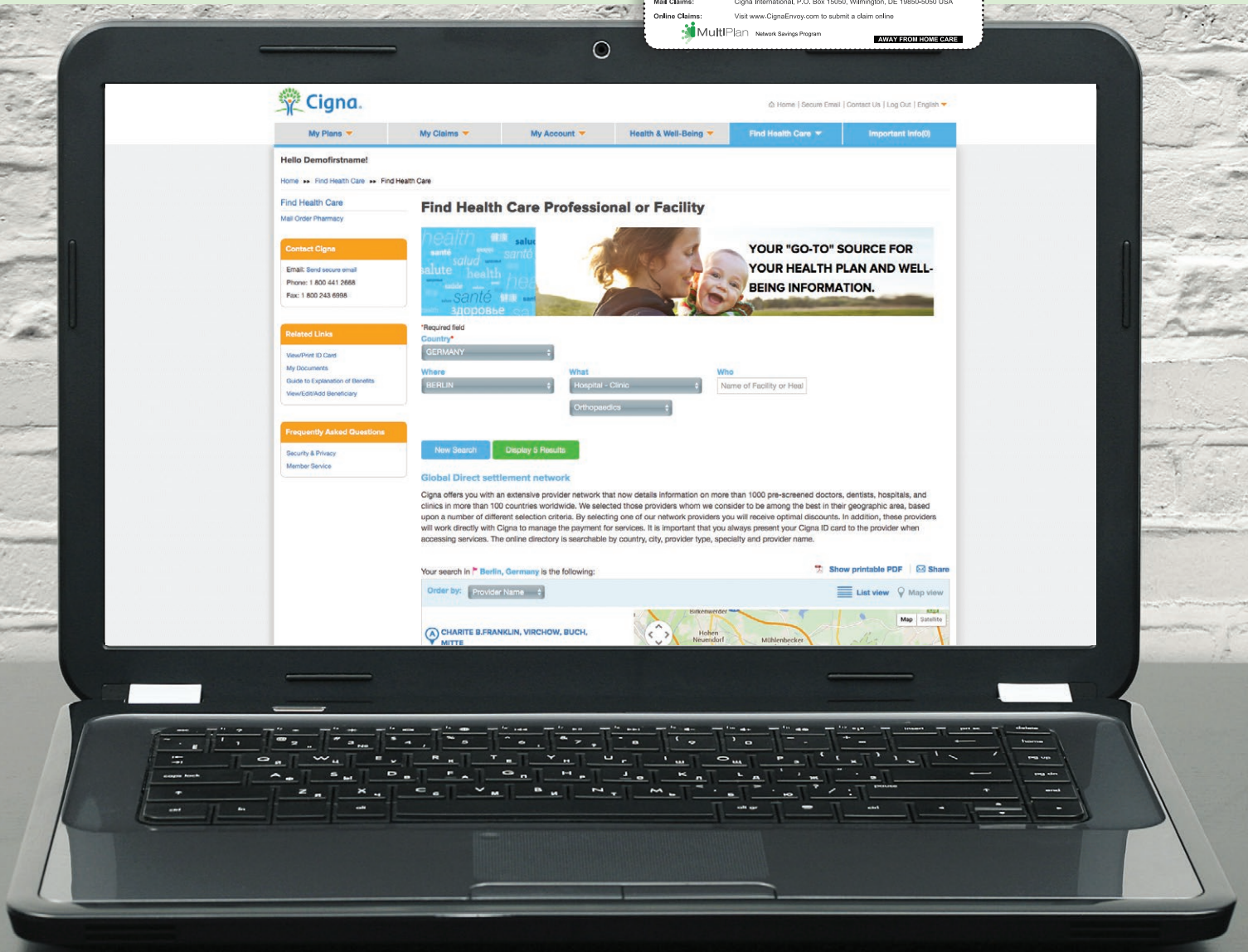
As a covered customer, you have access to the Cigna directory of more than 250,000 international doctors and hospitals and a U.S. network of more than 886,000 doctors and 138,000 dental access points. By choosing a health care professional in-network, your costs may be lower and paperwork is eliminated.

Two important ways to find a health care professional:

1. Access the online directory of thousands of doctors, hospitals, clinics and dentists through **www.CignaEnvoy.com.**
2. Call our global service center (24/7/365) by using the number on the back of your Cigna ID card.

www.CignaEnvoy.com





When to file a claim and when you don't need to

Outside the United States:

Outside the United States, you may need to file a claim unless you visit a health care professional that has a **direct pay arrangement**[1] or has obtained a **guarantee of payment**[2] from Cigna. To find out if a health care professional has a direct payment arrangement with Cigna, visit **www.CignaEnvoy.com** to find their contact information in the directory, and a note that says "direct settlement may be available." If so, all you need to do is present your Cigna ID card.

In the United States:

If you receive care from one of Cigna's **in-network**[3] health care professionals within the United States, you do not need to submit a claim for reimbursement because we have **direct pay arrangements**[1] with these doctors/hospitals. You would only be responsible for paying any **deductible**[4], **co-insurance**[5] or **co-pay**[6] amounts that are part of your plan. If you choose to seek care from an **out-of-network**[7] health care professional, you may need to file a claim.

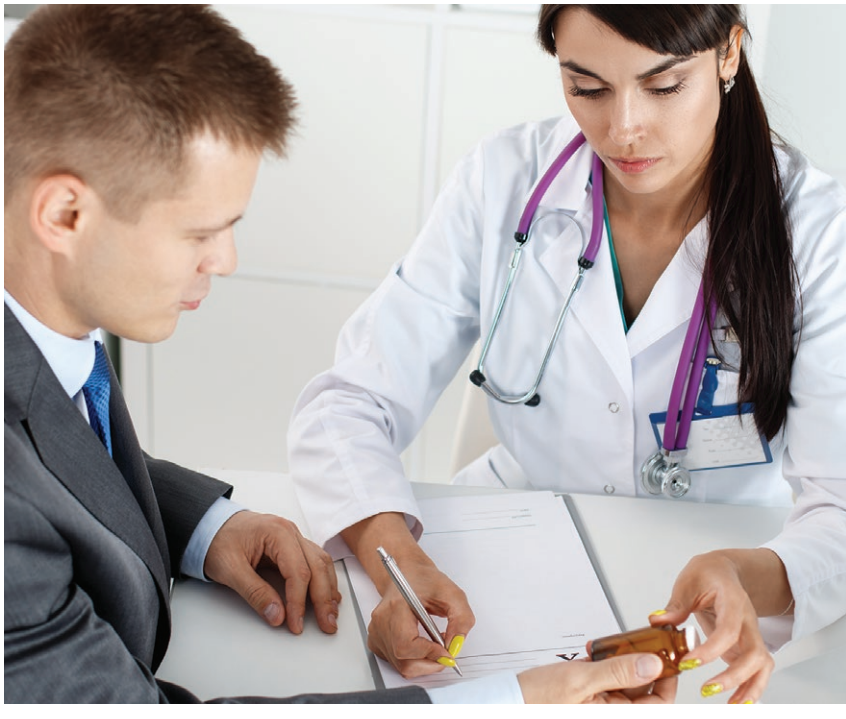
If you need to submit a claim for reimbursement, follow these tips to speed up the process:

- Submit your claim through **CignaEnvoy.com**. It's the fastest and easiest way to get your claims to Cigna.
- Make sure your form is complete. And don't forget to sign it!
- Fill out a separate form for each doctor or hospital visit.
- Be sure to add a diagnosis, type of treatment or explain your treatment.
- Provide a detailed list of fees for each service rendered along with the date it was performed.
- Make and keep handy copies of your bills, receipts, and claim forms.
- Clearly state how you would like to be reimbursed.
- If you can't submit your claim online, remember that even a fax is faster than regular mail.

Reimbursement Options:

- Direct Payment to a U.S. or Canadian bank.
- Electronic Funds Transfers (EFT).
- Checks to you in a variety of currencies (over 100 currencies).
- Wire transfers to bank accounts around the world.
- **ePayment *Plus*®** is an integrated and accurate process that includes automatic e-mail notification of payments directly into a bank account you maintain in a given country, regardless of where you are when working outside of your home country. You can quickly and easily self-enroll in ePayment *Plus* on Cigna Envoy. ePayment *Plus* complements the existing array of electronic payment options, such as wire transfers* and Electronic Funds Transfer (EFT), available in the U.S. After you enroll in ePayment *Plus*, charges often applied by your bank for wire transfers or other deposits, are removed or minimized. To sign up, go to **www.CignaEnvoy.com**.

* Your bank, or intermediary banks, may apply a fee for the receipt of wire transfers.



1. **Direct pay arrangements:** Cigna pays your health care professional directly, which helps reduce the amount you need to pay for covered services at the time of treatment.
2. **Guarantee of payment (GOP):** Assures payment directly to a doctor or hospital for covered services. This helps prevent you from having to pay for services that would normally be covered under your plan. Have your health care professional call Cigna using the number on the back of your ID card to arrange a GOP.
3. **In-network:** You'll receive care from doctors or other health care professionals who participate in the Cigna network, which eliminates your paperwork.
4. **Deductibles:** This is the amount of covered expenses that you must pay before the plan pays any benefit. Once you meet this threshold, the plan will begin to pay benefits for covered expenses that you incur; this applies to both individual and family plans.
5. **Co-insurance:** A percentage of the cost of covered expenses you must pay after you have met your plan deductible.
6. **Co-payment (co-pay):** A flat fee you pay a doctor for certain covered services, such as visits or prescriptions.
7. **Out-of-network:** Health care professionals or facilities that do not offer discount arrangements for services with Cigna and may require that you pay for services at the point of care. You may visit any health care facility you choose, but choosing a doctor who does not participate in the Cigna network may lead to higher out-of-pocket costs

Value-added services

You have special needs when working outside of your home country. Cigna offers to help you take care of issues that go far beyond health. For example, our concierge and travel assistance services provide:

- Advice on how to recover or replace lost documents like passports and credit cards.
- Coordination of emergency travel arrangements for family members who escort another family member to the hospital.
- Personal emergency telephone translation services.
- Help finding the right doctor or hospital closest to your location.
- Help finding or replacing prescription medication.
- Coordination of emergency travel arrangements for children under the age of 18 who are left unattended if a family member becomes sick.
- Help obtaining necessary documents for medical insurance claims.
- If covered, emergency medical evacuation can be arranged.

To inquire about these services, please call our 24/7 customer service number on the back of your Cigna ID card.

Get a second opinion online

e-Cleveland Online Second Opinion Program

One of the primary benefits of this program is that it enables you to get a second opinion without the burden of travel. Through our website, you can obtain a second opinion from e-Cleveland Clinic. Clinicians will determine if you or your covered family member is a good candidate for an online second opinion.

After you or your covered family member is approved for a medical second opinion, you'll need to formally register into the program just as if you were visiting the clinic in person. You'll be asked to complete some information, and a specialized physician will review the medical information before rendering an expert second opinion, usually within 10-14 days.

Once registered on CignaEnvoy.com, you can access the Online Second Opinion Program by following these steps:

1. Select the Health and Well-Being tab.
2. Under Getting Medical Care click on the Online Second Opinion link.

Customer claims scenario: Direct pay

Meet Johan,

Johan is a U.S. citizen, expatriate working in London.

While in London, Johan catches a stomach bug and needs medical attention. He visits Cigna Envoy to search for a health care professional.

Johan visits a health care professional that has a direct billing arrangement. Johan presents his Cigna ID card upon check-in.

Johan sees the doctor and is treated. He makes a follow-up appointment. The doctor bills Cigna directly for the services.

Johan goes to the pharmacist to fill the prescription given to him by the doctor.

Note: If the pharmacy doesn't participate in Cigna's network, they may require you to pay out-of-pocket.

Johan starts to feel better and goes to work the next day.

Customer claims scenario: Guarantee of payment

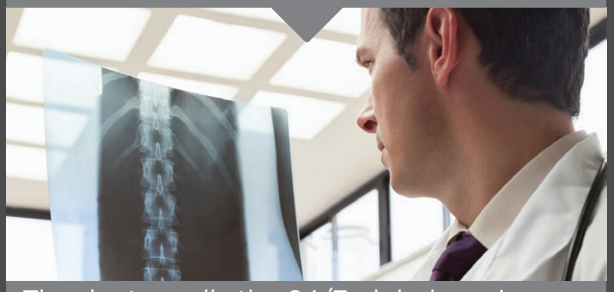
Meet Amelia,

Amelia is a German citizen working in France.

Amelia has a backache and needs to see a specialist, so she calls Cigna to find an orthopedic specialist.

Upon arriving at the doctor's office, Amelia presents her Cigna ID card. The doctor doesn't recognize Cigna and requires payment before treatment.

Amelia explains he needs to call the phone number located on the back of the ID card for a guarantee of payment (GOP). Now, Amelia doesn't have to pay out-of-pocket other than her patient responsibility (i.e., deductible or coinsurance) and can receive treatment.



The doctor calls the 24/7 global service center, receives a GOP and Amelia receives treatment, along with a physical therapy prescription.

Amelia goes back to Cigna Envoy to locate a physical therapist and calls to schedule her appointment.

Note: payment options and procedures may vary depending on the health care professional and your plan design.

We understand our customers' needs and work together to help them achieve healthier, more secure lives.

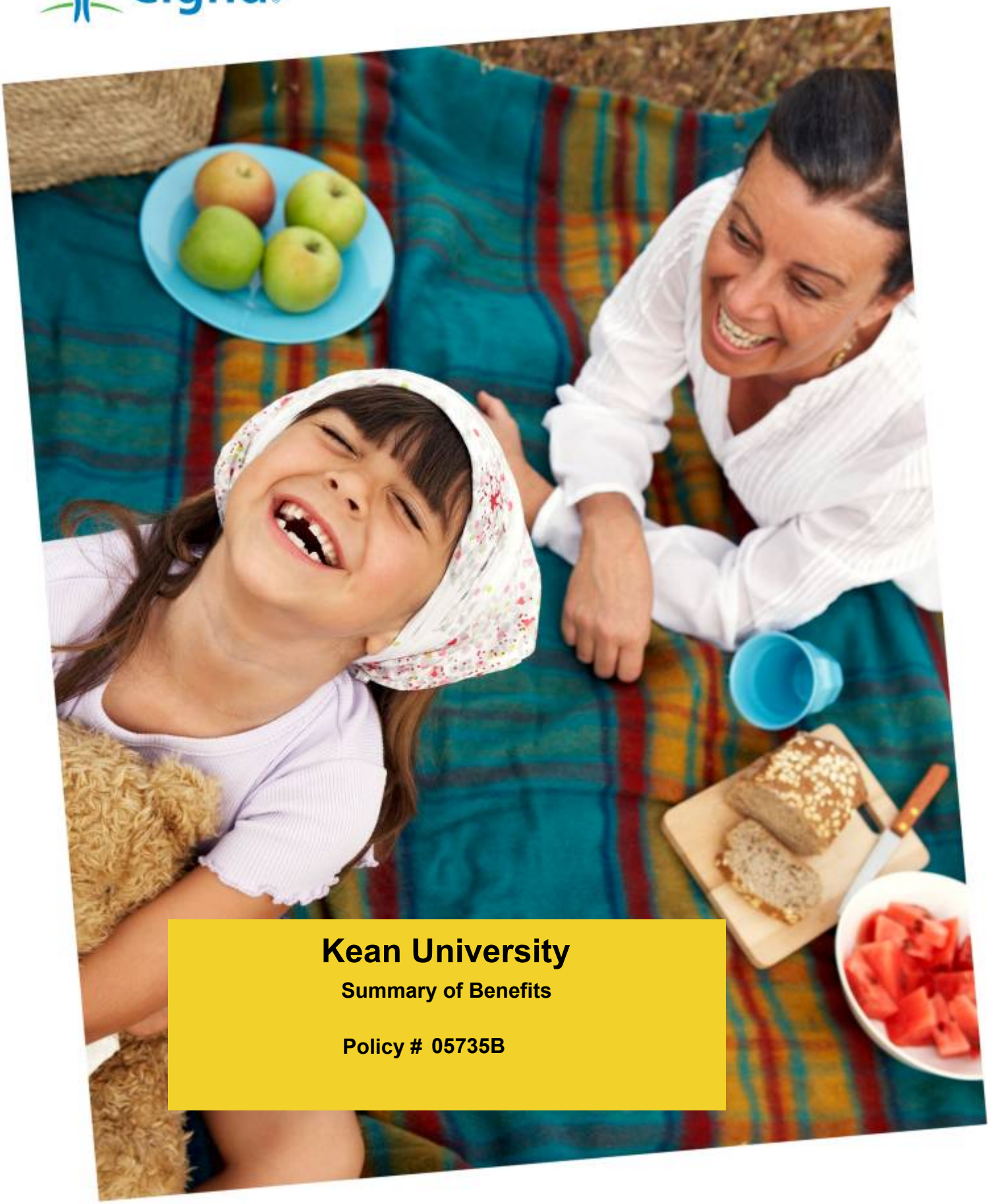
Together, all the way.℠

Together, all the way.℠

112366-154078 11/15

2. CIGNA SUMMARY OF BENEFITS & EXPLANATION OF BENEFITS

Cigna



Kean University

Summary of Benefits

Policy # 05735B

Global Health Benefits

KEAN UNIVERSITY
Summary of Benefits
Medical - Dental - IEAP -
Effective Date: 05/01/2015

Policy # 05735B

GENERAL PLAN PROVISIONS - (ALL AMOUNTS IN US DOLLARS)

Plan Type: OAP

Eligibility	All active, full-time Expatriate Employees of the Employer regularly working a minimum of 30 Hours Per Week. Eligible populations: US Expats ~ Non-US Expats/TCNs ~
Lifetime Maximum	Unlimited

Deductible:	**Outside of US**	**In-Network US**	**Out-Network US**
Individual	$0	$200	$500
Family	$0	$500	$1,500
Plan Coinsurance *What the plan pays*	100% of covered expenses	90% of covered expenses	70% of covered expenses
Out of Pocket Limit			
Individual	none	$400 (excl. deductible)	$5280 (excl. deductible)
Family	none	$1000 (excl. deductible)	$10560 (excl. deductible)

Note: Out of Pocket (OOP) Limits cross apply (Aggregate Family); OOP will exclude deductible payments; exclude copay payments; exclude pharmacy copays; include pharmacy coinsurance payments; exclude Pre-Admission Certification/Continued Stay Review penalties.

Physician Office Visit Services (General / Specialist)

	Outside of US	**In-Network US**	**Out-Network US**
Coinsurance	100%	100% **	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply

*** except for Wellness visits*

Outpatient Laboratory & X-Ray Services (including pre-admission testing)

	Outside of US	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

Inpatient Hospital Services Room & Board**

	Outside of US	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

***The most common semi-private room rate covered at Plan Coinsurance (private outside the US if there is no intermediate level between ward and private)*

Inpatient Hospital Services

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Deductible	Will Not Apply	Will Apply	Will Apply

Outpatient Hospital / Surgical Services

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

Hospital Emergency Room

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%**
Copay	$0	$75	$75
Deductible	Will Not Apply	Will Apply	Will Apply

*** Unless deemed true emergency, then benefit is covered at In-Network values*

Prescription Drugs

	Outside of US	In-Network US	Out-Network US
Generic Brand			
Coinsurance	100%	90%	70%
Retail Copay	$0	$5 Per 30 Day Supply	$0
Mail Order Rx	n/a	Same as Retail Copay	n/a
Brand Name			
Coinsurance	100%	90%	70%
Retail Copay	$0	$10 Per 30 Day Supply	$0
Mail Order Rx	n/a	Same as Retail Copay	n/a
Non-Preferred Brand			
Coinsurance	100%	90%	70%
Retail Copay	$0	$15 Per 30 Day Supply	$0
Mail Order Rx	n/a	Same as Retail Copay	n/a
Deductible (All Tiers)	Will Not Apply	Will Not Apply	Will Apply
Limit (All Tiers)	Unlimited	Unlimited	Unlimited
Over the Counter Drugs	Only covered outside of the US if accompanied by a prescription.		

Pharmacy copays do not contribute towards the out of pocket. Medications can be provided in up to a 12-month supply in accordance with the instructions specified by a U.S. physician. Limits cross apply

WELLNESS SERVICES

Well Child Care (Birth through Age 17 years)

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Maximum***	No Max Applies	No Max Applies	No Max Applies
Routine Immunizations	**Outside of US**	**In-Network US**	**Out-Network US**
Age Covered	Birth - 17years	Birth - 17years	Birth - 17years
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Preventive Care Max***	No Max Applies	No Max Applies	No Max Applies
Mandated Immunizations	**Outside of US**	**In-Network US**	**Out-Network US**
Age Covered	Birth - 17years	Birth - 17years	Birth - 17years
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Preventive Care Max***	No Max Applies	No Max Applies	No Max Applies
Lead Poisoning	**Outside of US**	**In-Network US**	**Out-Network US**
Age Covered	At/Around 12 mos./High Risk	At/Around 12 mos./High Risk	At/Around 12 mos./High Risk
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Preventive Care Max***	Will Not Apply	Will Not Apply	Will Not Apply

Adult Preventive Care (18 years and Older)

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Maximum***	No Max Applies	No Max Applies	No Max Applies
Routine Immunizations	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Travel Immunizations *	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Preventive Care Max***	No Max Applies	No Max Applies	No Max Applies

** Applies to Employee and Dependent immunizatons required for travel.*

**** Note: Maximums cross accumulate between Outside of US, In-Network US and Out-Network US*

Cancer Screening

Pap Smear	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Maximum***	*No Age Limit; Once Per Year; Does Not Contribute to Preventive*		

Mammogram	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Schedule	*Ages 35 – 39: One baseline exam.* *Ages 40 – 49: One exam every one or two years for asymptomatic women, but no sooner than two years after a woman's baseline.* *Age 50 & Over: One exam annually.* *Any Age: Whenever prescribed by a physician.*		

Colorectal Screening	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Maximum***	*50+ Years and High Risk; 1 Per Year; Does Not Contribute to Preventive*		

PSA	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	100%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Maximum***	*No Age Limit; No Frequency Limit; Does Not Contribute to Preventive*		

Hearing

Hearing Exam	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Exam Frequency	1 Exam every 24 months		
Exam Maximum***	Unlimited		

Hearing Aid	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Hearing Aid Maximum	$1,000 Every 36 Months		
Age Limit	Limited to Dependents Under 24 Years		

*** *Note: Maximums cross accumulate between Outside of US, In-Network US and Out-Network US*

OBESITY / BARIATRIC SURGERY

Lifetime Surgical Maximum	$10,000		
Physician Office	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Inpatient Facility	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply
Physician Services	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Deductible	Will Not Apply	Will Apply	Will Apply
Outpatient Facility	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

MATERNITY AND FAMILY PLANNING SERVICES

Family Planning

Physicians Office	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Vasectomy / Tubal Ligation	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%

Maternity

Physicians Office	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Inpatient	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply
Outpatient	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

Newborn Care

Hospital Nursery	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

Birthing Centers / Midwife Services

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

Infertility Treatments *Diagnosis of Infertility is covered under general Physician Office Visits.*

	Outside of US	In-Network US	Out-Network US
Gift, Zift, Invitro	Benefit Not Covered	Benefit Not Covered	Benefit Not Covered
Artificial Insemination	Benefit Not Covered	Benefit Not Covered	Benefit Not Covered
Coinsurance	Benefit Not Covered	Benefit Not Covered	Benefit Not Covered
Copay	Benefit Not Covered	Benefit Not Covered	Benefit Not Covered
Deductible	Benefit Not Covered	Benefit Not Covered	Benefit Not Covered
Lifetime Maximum	Benefit Not Covered		

Abortion**

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

***Coverage includes Elective or Spontaneous abortion procedures.*

FDA Approved Contraceptive Drugs and Devices

	Outside of US	In-Network US	Out-Network US
Generic Brand			
Coinsurance	100%	100%	100%
Retail Copay	$0	$0	$0
Mail Order Rx	n/a	n/a	n/a
Brand Name			
Coinsurance	100%	100%	100%
Retail Copay	$0	$0	$0
Mail Order Rx	n/a	n/a	n/a
Non-Preferred Brand			
Coinsurance	100%	100%	100%
Retail Copay	$0	$0	$0
Mail Order Rx	n/a	n/a	n/a

Covered as any other benefit based on place of service; coverage is for FDA approved prescription contraceptive drug/devices and for outpatient contraceptive services including consultations, exams, procedures and medical services related to the use of contraceptives.

Other Covered Medical Services

Mental Illness & Alcohol/Substance Abuse

Physicians Office	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Inpatient	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply
Outpatient			
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

Skilled Nursing Facility

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply
Maximum***	120 Days	120 Days	120 Days

Home Health Care

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Maximum***	120 Days	120 Days	120 Days

Hospice (Inpatient)

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

Hospice (Outpatient / Home)

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

**** Note: Maximums cross accumulate between Outside of US, In-Network US and Out-Network US*

Short Term Rehabilitative Therapy

Therapy Combined Max***	60 Days	60 Days	60 Days
Physical Therapy	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Physio Therapy	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Speech Therapy	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Occupational Therapy	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Cardiac Rehab	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply

Infusion Therapy

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply
Maximum***	Unlimited	Unlimited	Unlimited

Dialysis Treatment

Inpatient	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply
Outpatient	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply

**** Note: Maximums cross accumulate between Outside of US, In-Network US and Out-Network US*

Chiropractic Treatment

Office Visit	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Apply	Will Apply
Maximum***	Unlimited	Unlimited	20 Days
Inpatient			
Coinsurance	100%	90%	70%
Deductible	Will Not Apply	Will Apply	Will Apply

Allergy Testing/Treatment

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply

Diabetic Supplies and Equipment

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply

Coverage is for the following equipment and supplies, if recommended in writing or prescribed by a Physician: insulin pumps; blood glucose meters and strips; urine testing strips; syringes; lancets; alcohol swabs; and pharmacological agents for controlling blood sugar.

TMJ

Lifetime Maximum	$1,000		
Appliance Maximum	TMJ Appliances covered as a combined Maximum		
Office Visit	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply
Outpatient			
Coinsurance	100%	90%	70%
Deductible	Will Not Apply	Will Apply	Will Apply

Dental Care (Accident)

	Outside of US	In-Network US	Out-Network US
Coinsurance	100%	100%	70%
Copay	$0	$15	$0
Deductible	Will Not Apply	Will Not Apply	Will Apply

Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth.

**** Note: Maximums cross accumulate between Outside of US, In-Network US and Out-Network US*

Vision (Included With Medical)

Eligibility	All active, full-time Expatriate Employees of the Employer regularly working a minimum of 30 Hours Per Week. Eligible populations: US Expats ~ Non-US Expats/TCNs ~		
Eye Exams	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	90%	70%
Copay	$0	$0	$0
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Exam Frequency	*1 Exam every 24 months*		
Vision Hardware	**Outside of US**	**In-Network US**	**Out-Network US**
Coinsurance	100%	100%	100%
Deductible	Will Not Apply	Will Not Apply	Will Not Apply
Hardware Frequency	*1 HW every 24 months*		
Maximums			
Maximum Application	Separate Maximums for Hardware and Exams		
Hardware Maximum	$250		
Exam Maximum	n/a		

COST CONTAINMENT PROVISIONS

Pre-Admission Certification (PAC); Continued Stay Review (CSR); Surgical Pre-Certification	Precertification for inpatient and outpatient services received in the US is required. Network providers must call our toll-free number to precertify services. The customer is responsible for ensuring that out-of-network providers precertify services. Failure to obtain precertification may affect out-of-pocket costs. This is a summary only and further details can be found in the insurance certificate.
Case Management	A service provided through CareAllies, a Cigna company, which assists individuals with treatment needs that extend beyond the acute care setting. The goal is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in hospital or specialized facility. This service works with the treatment options which will best meet the patient's needs and keep costs manageable. Case managers will help coordinate the treatment program and arrange for necessary resources.
Cigna Pharmacy Management	A service provided through Cigna Pharmacy Management, a Cigna company, which offers a managed pharmacy benefit plan for prescription drugs purchased in the United States at participating retail pharmacies. Mail order drugs will also be available via Cigna Home Delivery Pharmacy, but can be shipped overseas to APO addresses only. Some limitations may apply.
Late Entrant Provision	Based on selections, Late Entrant/Pre-Existing Condition does not apply.
Pre-Existing Condition Limitation	Based on selections, Late Entrant/Pre-Existing Condition does not apply.

ADDITIONAL SERVICE RIDERS

International Employee Assistance Program (IEAP)

Level 2	Telephonic counseling: To resolve a behavioral issue, which includes consultation with a behavioral health professional for information and/or guidance. This benefit includes up to five face-to-face visits with a selected independent behavioral health professional (currently available in 160 countries). Counseling services are provided by Cigna Behavioral Health, the leading provider of EAP in the US, and by Workplace Options, the leading provider of EAP internationally.

Global Wellness

Cigna's mission is to help the people we serve improve their health, well-being, and sense of security. Cigna's goal is to improve the health and wellness of employees, thereby increasing productivity and lowering costs associated with medical care and absenteeism.

Cigna Global Health Benefits offers online health and wellness tools through CignaEnvoy.com to help keep customers healthy. A series of podcasts, which cover a variety of wellness topics, are also available online.

Included in this proposal is the following global wellness program:

Global Wellness Benefit	
Health and Well-Being Assessment (HA)	The HA is a short online assessment that is core to our wellness solutions and the first step to identifying personal health risks. Those who complete the HA immediately receive a personalized health risk profile report. The HA is medically validated by the World Health Organization.

GROUP DENTAL INSURANCE

Eligibility	All active, full-time Expatriate Employees of the Employer regularly working a minimum of 30 Hours Per Week. Eligible populations: US Expats ~ Non-US Expats/TCNs ~
Combined Maximum	A $1500 per person Calendar Year Maximum will be applied as a combined maximum as specified below.
Calendar Year Deductible	The Calendar Year Deductible will be waived for Class I and will accumlate as a Calendar Year. **Individual CY Deductible -** $25 **Family CY Deductible -** $75
Class I - Preventive Care	100% not subject to deductible for Diagnostic and Preventive services included those described below. **Oral Exam** 2 Per Person Per Year **Cleanings** 2 Per Person Per Year **Bitewing X-Rays** 2 Per Person Per Year **Flouride Applications** 1 Per Person Per Year (Up to Age 19) **Sealants** 1 Per Person Per 3 Years **Full Mouth X-Rays** Unlimited **Panaromic X-Rays** 1 Per Person Per 3 Years This class does not have a Class Specific Maximum.
Class II - Basic Restorative	80% subject to deductible for Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery including Fillings, Root Canal, Periodontal Scaling and Root Planing and repair to Bridgework and Dentures. This class does not have a Class Specific Maximum.
Class III - Major Restorative	50% subject to deductible for Major Restorations, Dentures and Bridgework including Crowns. This class does not have a Class Specific Maximum.
Class IV - Orthodontia	50% not subject to standard deductible; additionally, there will be an Ortho specific deductible of $50. An Ortho specific Lifetime Maximum of $1500 will apply. Children Under 19 Yrs are eligible for this benefit.
Class V - Implants	Benefit Not Covered

Additional Plan Information

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the 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, visit www.CignaEnvoy.com or contact customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

How we make a difference – Customer Service

Cigna is committed to providing superior service to our clients and customers. It doesn't matter where you are working or what time zone you are in. Our clients and customers can reach us 24 hours a day, 7 days a week by calling our global Service Center or online through Cigna Envoy®.

Phone	
Toll-Free Phone (U.S. & Canada)	**1.800.441.2668**
Toll-free TDD telephone number for the hearing impaired	**1.800.558.3604**
Direct Phone (Collect Calls Accepted)	**001.302.797.3100**
Fax	
Toll-Free Facsimile	**1.800.243.6998**
Direct Fax (inside the U.S.)	**001.302.797.3150**
Website	
Cigna Envoy	**www.CignaEnvoy.com**

Global Health Benefits

Cigna Global Health Benefits®

UNDERSTANDING YOUR Explanation of Benefits

Making it easy for you to get quality health care is only part of our mission.

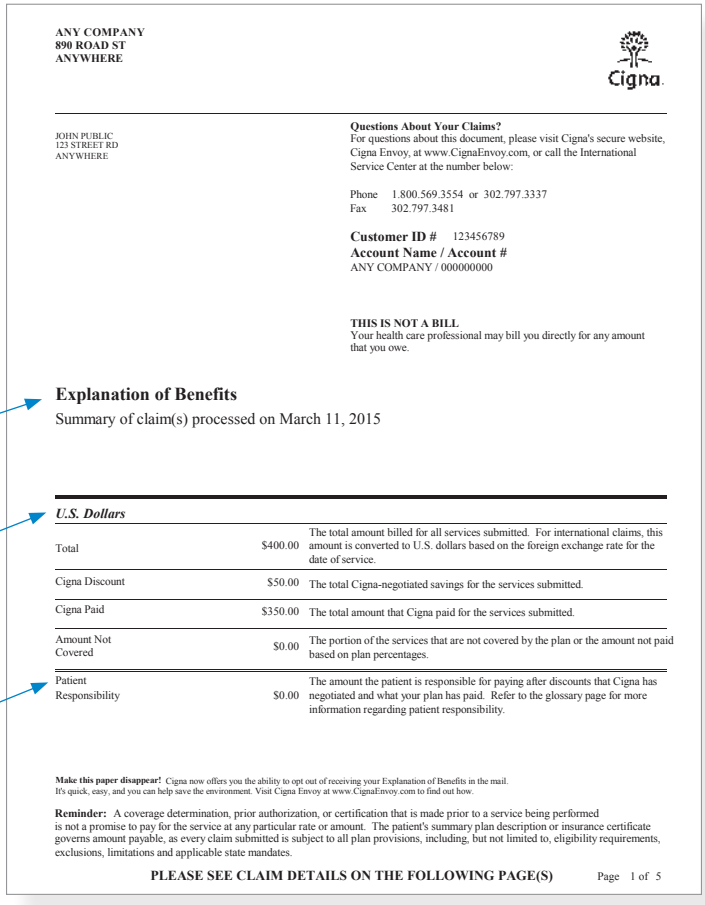
We also make it easy for you to understand the costs. Our Explanation of Benefits uses simple language and only includes the information you need to know. Take a look at the sample below.

The Summary page gives an overview of how your benefits are working for you – quickly see how much was submitted, how much has been paid, and what may be your responsibility.

Your Explanation of Benefits is a summary of how your claims were processed and what you may owe, not a bill. Your health care professional or the facility may bill you directly for the remainder of what you owe.

If your claim was billed in local currency, total local currency amount will be listed here.

The amount that you may owe is stated in the Patient Responsibility field.



ANY COMPANY
890 ROAD ST
ANYWHERE

Cigna

JOHN PUBLIC
123 STREET RD
ANYWHERE

Questions About Your Claims?
For questions about this document, please visit Cigna's secure website, Cigna Envoy, at www.CignaEnvoy.com, or call the International Service Center at the number below:

Phone 1.800.569.3554 or 302.797.3337
Fax 302.797.3481

Customer ID # 123456789
Account Name / Account #
ANY COMPANY / 000000000

THIS IS NOT A BILL
Your health care professional may bill you directly for any amount that you owe.

Explanation of Benefits
Summary of claim(s) processed on March 11, 2015

U.S. Dollars		
Total	$400.00	The total amount billed for all services submitted. For international claims, this amount is converted to U.S. dollars based on the foreign exchange rate for the date of service.
Cigna Discount	$50.00	The total Cigna-negotiated savings for the services submitted.
Cigna Paid	$350.00	The total amount that Cigna paid for the services submitted.
Amount Not Covered	$0.00	The portion of the services that are not covered by the plan or the amount not paid based on plan percentages.
Patient Responsibility	$0.00	The amount the patient is responsible for paying after discounts that Cigna has negotiated and what your plan has paid. Refer to the glossary page for more information regarding patient responsibility.

Make this paper disappear! Cigna now offers you the ability to opt out of receiving your Explanation of Benefits in the mail. It's quick, easy, and you can help save the environment. Visit Cigna Envoy at www.CignaEnvoy.com to find out how.

Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description or insurance certificate governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations and applicable state mandates.

PLEASE SEE CLAIM DETAILS ON THE FOLLOWING PAGE(S) Page 1 of 5

Together, all the way.℠

Cigna®

Offered by: Cigna Health and Life Insurance Company or its affiliates.

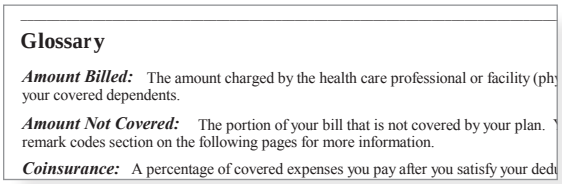
111973 a 03/15

Cigna Global Health Benefits®

Page 2

If you're unsure of the meaning of a word or phrase, you can look it up in the glossary.

Claim submission tips are included at the bottom of page two, clarifying what you need to include for the quickest processing time.

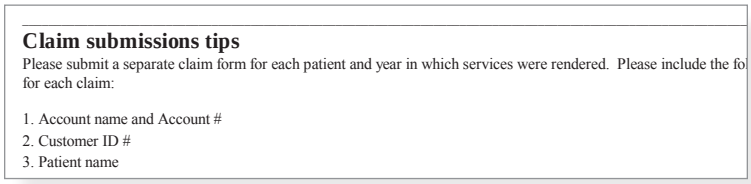


Glossary

Amount Billed: The amount charged by the health care professional or facility (phy
your covered dependents.

Amount Not Covered: The portion of your bill that is not covered by your plan. Y
remark codes section on the following pages for more information.

Coinsurance: A percentage of covered expenses you pay after you satisfy your ded



Claim submissions tips

Please submit a separate claim form for each patient and year in which services were rendered. Please include the fo
for each claim:

1. Account name and Account #
2. Customer ID #
3. Patient name

Page 3

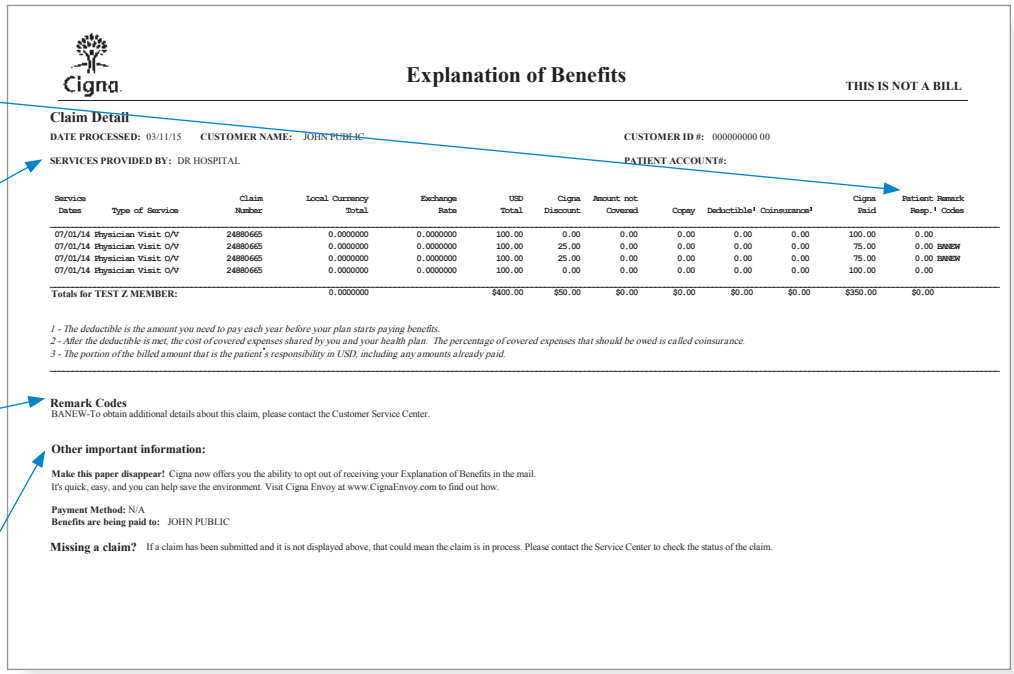
The Claims Detail page follows the Glossary page. Here, you'll find:

The total amount you may owe is listed in the Patient Responsibility column.

You may owe this amount to the health care professional or facility that provided your services, which is listed above the details of your visit.

Remark Codes are notes that explain processing methods. Cigna has clarified and simplified remark codes to help make your Explanation of Benefits easier to understand.

Payment amount and method are stated in the Other Important Information section.



Cigna

Explanation of Benefits

THIS IS NOT A BILL

Claim Detail

DATE PROCESSED: 03/11/15 **CUSTOMER NAME:** JOHN PUBLIC **CUSTOMER ID #:** 000000000 00

SERVICES PROVIDED BY: DR HOSPITAL **PATIENT ACCOUNT#:**

Service Dates	Type of Service	Claim Number	Local Currency Total	Exchange Rate	USD Total	Cigna Discount	Amount not Covered	Copay	Deductible[1]	Coinsurance[2]	Cigna Paid	Patient Resp.[3]	Remark Codes
07/01/14	Physician Visit O/V	24880665	0.0000000	0.0000000	100.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	
07/01/14	Physician Visit O/V	24880665	0.0000000	0.0000000	100.00	25.00	0.00	0.00	0.00	0.00	75.00	0.00	BANEW
07/01/14	Physician Visit O/V	24880665	0.0000000	0.0000000	100.00	25.00	0.00	0.00	0.00	0.00	75.00	0.00	BANEW
07/01/14	Physician Visit O/V	24880665	0.0000000	0.0000000	100.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	
Totals for TEST Z MEMBER:			0.0000000		$400.00	$50.00	$0.00	$0.00	$0.00	$0.00	$350.00	$0.00	

1 - The deductible is the amount you need to pay each year before your plan starts paying benefits.
2 - After the deductible is met, the cost of covered expenses shared by you and your health plan. The percentage of covered expenses that should be owed is called coinsurance.
3 - The portion of the billed amount that is the patient's responsibility in USD, including any amounts already paid.

Remark Codes
BANEW-To obtain additional details about this claim, please contact the Customer Service Center.

Other important information:

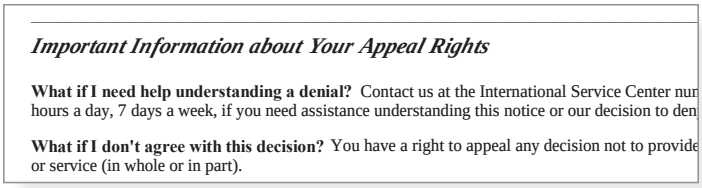
Make this paper disappear! Cigna now offers you the ability to opt out of receiving your Explanation of Benefits in the mail.
It's quick, easy, and you can help save the environment. Visit Cigna Envoy at www.CignaEnvoy.com to find out how.

Payment Method: N/A
Benefits are being paid to: JOHN PUBLIC

Missing a claim? If a claim has been submitted and it is not displayed above, that could mean the claim is in process. Please contact the Service Center to check the status of the claim.

Page 4

The Important Information about Your Appeal Rights page details how you can file an appeal for a denied claim, how to receive additional information, and other resources that may be able to help you, if applicable.



Important Information about Your Appeal Rights

What if I need help understanding a denial? Contact us at the International Service Center nur
hours a day, 7 days a week, if you need assistance understanding this notice or our decision to den

What if I don't agree with this decision? You have a right to appeal any decision not to provide
or service (in whole or in part).

Cigna®

IMPORTANT INFORMATION

For Customers Traveling to Countries Sanctioned By the U.S. Government

As a global health service company, Cigna is committed to complying with all applicable laws and regulations.

Recently, the U.S. government's Office of Foreign Assets Control (OFAC) informed us that insurance coverage can be provided to non-US persons who engage in personal or business travel to the sanctioned countries of Cuba, Crimea region of Ukraine, Iran, N. Korea, Sudan and Syria because the coverage is a service "ordinarily incident" to travel to such countries i.e. medical treatment is sought on an emergent basis.

However, OFAC also informed us that elective medical treatment is not considered "ordinarily incident" to travel. This means that Cigna cannot provide coverage for elective medical treatment for anyone who is a national of a sanctioned country if they travel back to their home country to receive the elective treatment. Essentially we can cover unplanned urgent or emergent care received in the sanctioned country, but not previously scheduled treatment.

Furthermore, we also cannot cover anyone who is ordinarily resident in a sanctioned country. If you or your family members return to the sanctioned country for an extended stay other than for a holiday or business trip you will be considered ordinarily resident in the sanctioned country and no longer eligible for coverage under the plan.

As a result of these requirements, beginning February 19, 2016, if we receive a claim incurred in a sanctioned country by a national from that country we will contact and request additional information before the claim can be processed. Specifically, we will ask about the length of the stay in the sanctioned country. If the length of stay indicates that the person is ordinarily resident in the sanctioned country or the claim involves elective medical treatment, Cigna must – unfortunately – deny the claim. Elective medical treatment is any treatment that is schedulable in advance, such as preventive care. All treatment that is not urgent or emergent is considered elective medical treatment. Elective medical

treatment covered under your plan will be covered if received in your work location country.

It’s important to remember that if emergency or urgent care is needed during a personal or business visit of a short duration, coverage will be provided.

If you have any questions about these requirements, please contact Cigna customer service at 1-800-441-2668. We are committed to minimizing any 1 disruption this change may cause and will work with you to find alternative locations for elective medical treatment outside of the sanctioned country. We appreciate your cooperation in ensuring compliance with OFAC requirements and apologize for any inconvenience.

Together, all the way.®

3. CIGNA EMPLOYEE SUPPORT SERVICES

EMPLOYEE SUPPORT

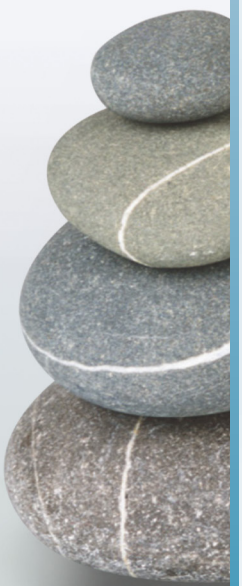
Balanced living relies on total well-being. It is important to recognise when situations create an unhealthy amount of stress, distraction, or worry. Before any work or life issue becomes a larger problem, or for support when you're facing difficulties, contact the service for free, confidential counselling and information to help you regain focus.

Live assistance is always available.

As an employee, you and your family have access to free, confidential assistance with any work, personal, or family issue. Any time, any day, you can contact the service for live assistance including: short-term professional counselling, in-the-moment telephonic support.

You're supported worldwide.

- Available 24 hours a day, 7 days a week, 365 days a year
- Access available worldwide by phone, email, or web
- Access to 5 face-to-face sessions with a counsellor
- Provides information and counselling on any work, personal, or family issue that matters to you
- No cost to you to use the service
- Support available in your language



The service is confidential.

Employee support is provided by Cigna, an organisation staffed by professionals who are completely independent of your employer. Cigna is bound by professional standards regarding confidentiality, and does not disclose details of individuals who have contacted the service. Any information you share is at your discretion and will not be shared with your employer.

We are here to support you.

Professionals are ready to assist you with any issue that matters to you and your family. Topics include, but are not limited to:

- Improving family communication
- Harmony between work and home life
- Managing life changes
- Handling stress
- Surviving the loss of a loved one
- Managing anxiety and depression
- Substance use
- Bullying and harassment
- Managing workplace pressure
- Couples' support
- Parenting
- Caring for an elder

Access is easy.

No matter when, no matter where, you have free, confidential support by phone, email, or web. Call or log on to get started.

REVERSE CHARGE CALLING:
+44 208 987 6550
Contact your international operator and request that the charges be reversed or dial us direct and we will call you back.

WEBSITE:
Available via www.Cignaenvoy.com

E-MAIL:
support@worldwideassist.co.uk

SMS TEXTING:
+44 790 934 1229
Standard text messaging rates may apply. Please include your name, country location, and phone number where you can be reached.

Calls placed from mobile phones or Internet-based lines (VOIP) are carrier dependent and not guaranteed. Please log into the website for additional information.

Cigna **International** Assistance Programme

Global Toll-Free Phone List

If you are calling from:	Dial this toll-free number:
ARGENTINA	00 800 8000 3030
AUSTRALIA	0011 800 8000 3030
AUSTRIA	00 800 8000 3030
BAHAMAS	1 800 389 0475
BAHRAIN	800-19-909
BELGIUM	00 800 8000 3030
BERMUDA	1 877 353 0635
BRAZIL	0021 800 8000 3030
CANADA	877 847 4525
CHINA	00 800 8000 3030
COLOMBIA	009 800 8000 3030
COSTA RICA	0800 044 0122
CZECH REPUBLIC	00 800 8000 3030
DENMARK	00 800 8000 3030
ESTONIA	00 800 8000 3030
FINLAND	999 800 8000 3030
	990 800 8000 3030
FRANCE	00 800 8000 3030
GERMANY	00 800 8000 3030
GREECE	00 800 8000 3030
GUAM	1 877 857 2952
HONG KONG	001 800 8000 3030
HUNGARY	00 800 8000 3030
INDIA	000800 100 7898
IRELAND	1800 490 390
ISRAEL	0014 800 8000 3030
ITALY	00 800 8000 3030
JAPAN	001-010 800 8000 3030 (KDDi)
	0033-010 800 8000 3030 (NTT)
	0041-010 800 8000 3030 (TEL)
	0061-010 800 8000 3030 (Softbnk)
KOREA, REPUBLIC OF	001 800 8000 3030 (Korea-Tele)
	002 800 8000 3030 (Dacom)

If you are calling from a location not listed above, or if you are experiencing difficulty with a toll-free number, you may place a reverse-charge call. Access your local operator and request to place a reverse-charge call to + 44 208 987 6550.

Cigna **International** Assistance Programme

Global Toll-Free Phone List

If you are calling from:	Dial this toll-free number:
LITHUANIA	00 800 8000 3030
LUXEMBOURG	00 800 8000 3030
MALAYSIA	00 800 8000 3030
MEXICO	01 800 681 9539
NETHERLANDS	00 800 8000 3030
NEW ZEALAND	00 800 8000 3030
NORWAY	00 800 8000 3030
PANAMA	00 800 8000 3030
PERU	00 800 8000 3030
PHILIPPINES	00 800 8000 3030
POLAND	00 800 8000 3030
PORTUGAL	00 800 8000 3030
PUERTO RICO	1 877 857 2952
ROMANIA	0 800 895 946
RUSSIAN FEDERATION	00 800 8000 3030
SAUDI ARABIA	800 844 3261
SINGAPORE	001 800 8000 3030
SLOVAKIA (Slovak Republic)	00 800 8000 3030
SOUTH AFRICA	00 800 8000 3030
SPAIN	00 800 8000 3030
SWEDEN	00 800 8000 3030
SWITZERLAND	00 800 8000 3030
TAIWAN	00 800 8000 3030
THAILAND	001 800 8000 3030
UNITED ARAB EMIRATES	800 044 0597
UNITED KINGDOM	0800 243 458
UNITED STATES	1 888 851 7032
	1 877 857 2952 (Minor Outlying Islands)
URUGUAY	00 800 8000 3030
VIRGIN ISLANDS (U.S.)	1-877-857-2952

If you are calling from a location not listed above, or if you are experiencing difficulty with a toll-free number, you may place a reverse-charge call. Access your local operator and request to place a reverse-charge call to + 44 208 987 6550.

TELEMEDICINE

What you need to know.

Telemedicine is a form of telehealth, which is the delivery of clinical health services by means of real-time two-way audio, visual or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery.

What's covered by Cigna Global Health Benefits®?

- Telemedicine services are covered at the same coverage level and cost share as the same service if rendered through in-person consultation or contact – subject to the same medical necessity criteria.
  - Must be provided by an appropriately licensed and credentialed health care professional.
  - Coverage is provided per the terms and conditions of the policy and the health care professional's or vendor's contracting status: In- or out-of-network.
- Health care professionals, such as mental health professionals, primary care physicians, etc., may provide consultations via telemedicine.
- Telemedicine vendors, such as MDLIVE, Relay for Health, AmWell, etc., provide services for minor, non-urgent conditions.

Who can use telemedicine and how can they access services?

- **U.S. inpatriates** (non-U.S. employees on an expatriate assignment in the U.S.)
  - Access services from any health care professional inside or outside the U.S. – home country or locally – via web, email, phone, etc.
    - Be aware of potential treatment limitations (including prescriptions) when seeking services from a remote health care professional.
  - Access services from a U.S. telemedicine vendor for minor, non-urgent care.

Applies to:

- Fully insured medical policies issued from North America by the following underwriting entities: Cigna Health and Life Insurance Company, Cigna Life Insurance Company of Canada, and Cigna Global Insurance Company. (Includes self-funded plans not subject to ERISA.)
- Clients with self-funded plans subject to ERISA have the option to opt in for telemedicine coverage.
- Medical policies issued outside of North America do not yet include coverage for telemedicine services.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, or its affiliates.

886474 02/16

- **Third Country Nationals** (non-U.S. employees on assignment in a country other than the U.S.)
  - Access services from any health care professional inside or outside the U.S. – home country or locally – via web, email, phone, etc.
    - Be aware of potential treatment limitations (including prescriptions) when seeking services from a remote health care professional.
  - Access services from a local telemedicine vendor (such as Apollo Hospitals in India) for minor, non-urgent care.
    - For employees not located in the U.S., we do not recommend seeking services from a U.S. telemedicine vendor due to licensing regulations and treatment limitations.
- **U.S. expatriates** (U.S. employees on assignment outside the U.S.)
  - Access services from any health care professional inside or outside the U.S. – home country or locally – via web, email, phone, etc.
    - Be aware of potential treatment limitations (including prescriptions) when seeking services from a remote health care professional.
  - Access services from a local telemedicine vendor for minor, non-urgent care.
  - For employees not located in the U.S., we do not recommend seeking services from a U.S. telemedicine vendor due to licensing regulations and treatment limitations.

General considerations

- Cigna Global Health Benefits is not currently contracted with any telemedicine vendors. Customers seeking services from a vendor may be required to pay and submit a claim. Claims will be processed as out-of-network.
- Customers seeking telemedicine services should be aware of the following limitations.
  - Recommended treatments and prescriptions may not be available in the customer's location. (Many countries have strict prescription regulations.)
  - Health care professionals may not be able to prescribe medication in the customer's location, due to local regulations.
- Telemedicine works best for treating minor illnesses and conditions such as allergies, headache, or cold and flu.
  - Additionally, customers looking to establish and continue a relationship with a behavioral health care professional can also benefit from telemedicine.

4. CIGNA PHARMACY MANAGEMENT

CIGNA PHARMACY MANAGEMENT

Whether you are going on assignment, already in your new location, coming home to visit or have family members back home, you can take advantage of Cigna pharmacy options. We make it easy and convenient to fill your prescriptions before you leave and while you are on assignment. Below are some commonly asked questions regarding your prescription medications. If you have additional questions, feel free to call our service center at the phone number on the back of your Cigna ID card. Our service team is available to help you 24 hours a day, seven days a week.

Frequently asked questions

Receiving prescription medication outside the United States

Why do I need to think about my prescription medication before I leave on assignment?

You may find that certain countries have specific laws around you bringing medications into the country. These laws may include limits, exclusions of some medications, and even restrictions on forms of medications such as powders or liquids, which may not be allowed to enter the country. In your country of assignment, you may also find that certain medications are not available locally, dosages may differ, or counterfeit medications may be an acceptable practice. Simply put, you may not be able to receive the medication you need. If you have any questions or concerns about travel restrictions or the availability of a prescription medication, you can call us at the phone number on the back of your Cigna ID card.

Are there steps I can take to receive assistance before I leave for assignment?

Yes. There are different steps to take depending on whether or not you have received a Cigna ID card.

Cigna Global Health Benefits®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

112096 a 03/15

Have you received your Cigna ID card?

If you have not received a Cigna ID card please follow these instructions:

1. Visit **CignaEnvoy.com**.
2. Select "**Pre-departure**" from the drop-down menu, and click "**Go**."
3. The next screen will ask you to enter your client ID and password.
4. Your employer can provide you with the login credentials.
5. Once you have logged in, you will be able to complete the pre-assignment assistance questionnaire and access country guides to learn more about your destination.

If you have received a Cigna ID card please follow these instructions:

1. Visit **CignaEnvoy.com**.
2. Select "**Members**" from the drop-down menu, and click "**Go**."
3. If you have not registered for Cigna Envoy®, you will need to do so now using your ID number.
4. If you have registered, use your ID number and password to log in.
5. Logging in will bring you to the Cigna Envoy homepage.
6. Click on the "Health and Wellness" tab located at the top of the page.
7. On the next page, click the "**Condition Management Questionnaire**" link that can be found in the Programs and Services box.

After you complete the appropriate assessment, a member of our medical team may reach out to further assist you. You can also call our service team at the phone number on the back of your Cigna ID card.

Is it possible to receive 12 months of prescriptions before I leave?

When possible, you may be able to take advantage of 12-month prescriptions prior to leaving the United States through Cigna Home Delivery Pharmacy℠. Please be aware that due to state and federal laws, some controlled medications can not be filled for more than one month at a time or may have other distribution limits. To learn if your prescriptions can be filled for 12 months and if there are any associated travel restrictions, please call our service center at the phone number on the back of your Cigna ID card.

What do I do if I need a prescription filled when I am abroad?

If you receive a prescription from a local doctor while on assignment, you may be able to fill it locally. If you have any questions, please contact our service center at the phone number on the back of your Cigna ID card. Our customer service team will help you identify available options. Please be aware that medications prescribed in foreign countries can only be filled locally in the country where the prescription is written. For example, if you have a medication that was prescribed by a doctor in China, it can not legally be filled in the United States. Likewise, a prescription written in the United States can not be filled in a pharmacy outside of the United States. We also encourage you, when possible, to plan visits with your health care professional in the United States for any new prescriptions. Please fill prescriptions during your time in the United States, but if you have any questions or concerns about travel restrictions, you can call us at the phone number on the back of your Cigna ID card.

Receiving medication when in the United States

Filling your prescription with Cigna Home Delivery Pharmacy

How can I receive my medication when I am in the United States?

Cigna Home Delivery Pharmacy is a convenient and easy way for you to receive your medication when in the United States. This service offers a number of advantages including a three-month supply of medication at one time, as well as having it delivered directly to your home at no additional cost.

What are the benefits of Cigna Home Delivery Pharmacy?

Cigna Home Delivery Pharmacy is a convenient alternative to filling your prescriptions at the pharmacy. Not only does it save you time by skipping the lines in the store, but it may also save you money.

Can I use Cigna Home Delivery Pharmacy if I already have a prescription with another pharmacy?

Yes. If you already have a prescription with another pharmacy in the United States, you can transfer it to Cigna Home Delivery Pharmacy.

How long will it take to fill a new prescription?

For new orders, please allow five to seven business days after Cigna Home Delivery Pharmacy receives your request. Refills ship within two business days of receiving your request. You can have your prescriptions shipped to any address in the United States, Puerto Rico, and U.S. Virgin Islands – home, work or any other alternative, including a PO box. Standard shipping of prescription medications is free of charge.

How can I place an order with Cigna Home Delivery Pharmacy?

Placing an order with Cigna Home Delivery Pharmacy is easy and convenient. If you have a mailing address in the United States or an APO address, you can request that Cigna Home Delivery Pharmacy contact the United States-based physician for a copy of the prescription.

To place an order yourself, please send your prescription requests to the address below:

Cigna Home Delivery Pharmacy

PO Box 5101
Horsham, PA 19044, USA
or call 800.622.5579

Filling your prescription with a traditional pharmacy

Can I fill my prescriptions at any pharmacy in the United States?

Yes. However, when in the United States and obtaining medication from a prescription written by a U.S. physician, you have access to a network of more than 62,000 in-network pharmacies, including those in the U.S. Virgin Islands and Puerto Rico.

What are the benefits of visiting an in-network pharmacy?

Customers enjoy substantial discounts of both brand and generic prescriptions by using their ID card at in-network pharmacies.

Will I need to pay for my prescription medication when I visit an in-network pharmacy?

When you visit one of these pharmacies, we will also pay the pharmacy directly for our portion of a covered purchase, which eliminates the need to file a claim. You are only responsible for paying the remaining balance (copay coinsurance, etc.) based on your specific plan benefits.

Should I transfer my prescriptions to an in-network pharmacy if my current pharmacy is not part of the Cigna pharmacy network?

Yes. You are encouraged to transfer your prescriptions to an in–network pharmacy. This allows us to pay the pharmacy directly for covered purchases.

To transfer your prescriptions to an in-network pharmacy, please contact the pharmacy directly.

Cigna pharmacy options are available 24 hours a day, seven days a week.

Easy access to quality health care around the world.

Cigna®

5. NOTICE OF CIGNA'S PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

Cigna Global Health Benefits®

This notice describes how medical information about you, may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our privacy commitment

Thank you for giving us the opportunity to serve you. In the normal course of doing business – providing medical care to you – Cigna Global Health Benefits ("CGHB") creates records about you and the treatment and services we provide to you. The information we collect is called Protected Health Information ("PHI"). We take our obligation to keep your PHI secure and confidential very seriously.

We are required by federal and state law to protect the privacy of your PHI and to provide you with this Notice about how we safeguard and use it and to notify you following a breach of your unsecured PHI.

When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice. This Notice applies to all electronic or paper records we create, obtain, and/or maintain that contain your PHI.

How we protect your privacy

We understand the importance of protecting your PHI. We restrict access to your PHI to authorized workforce members who need that information for your treatment, for payment purposes and/or for health care operations. We maintain technical, physical and administrative safeguards to ensure the privacy of your PHI.

To protect your privacy, only authorized and trained workforce members are given access to our paper and electronic records and to non-public areas where this information is stored.

Para recibir este Aviso de prácticas de privacidad en español, llame al Centro de servicio internacional al 302.797.3100 o al 800.441.2668.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures including how paper and electronic records are labeled, stored, filed and accessed.
- Technical, physical and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow the policies and procedures, and educates our organization on this important topic.

How we use and disclose your PHI

Uses of PHI without your authorization

We may disclose your PHI without your written authorization if necessary while providing your health benefits. We may disclose your PHI for the following purposes:

- **Treatment:**
  - To share with hospital staff, nurses, doctors, pharmacists, optometrists, health educators and other health care professionals and personnel at health care facilities so they can determine your plan of care.
  - To help you obtain services and treatment you may need – for example, to order lab tests and using the results.

Together, all the way.℠

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

855489 d 09/13

- To coordinate your health care and related services with a different health care facility or professional.

- **Payment:**
  - To obtain payment of premiums for your coverage.
  - To make coverage determinations – for example, to speak to a health care professional about payment for services provided to you.
  - To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
  - To obtain payment from a third party that may be responsible for payment, such as a family member.
  - To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.
- **Health care operations:**
  - To provide customer service.
  - To support and/or improve the programs or services we offer you.
  - To assist you in managing your health – for example, to provide you with information about treatment alternatives to which you may be entitled.
  - To support another health plan, insurer, or health care professional who has a relationship with you for activities such as case management, care coordination and quality improvement activities. For example, we may share your claims information with your doctor if you have a medical need that requires attention.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**
  - If you are present or otherwise available to direct us to do so, we may disclose your PHI to others – for example, a family member, a close friend, or your caregiver.
  - If you are in an emergency situation, are not present, or are incapacitated, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interests. If we do disclose your PHI in a situation where you are unavailable, we would disclose only information that is directly relevant to the person's involvement with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location or your general medical condition.
  - We may disclose your child's PHI to your child's other parent.
- **Disclosures to your employer as sponsor of your health plan**. We may disclose your PHI to your employer or to a company acting on your employer's behalf, so that entity can monitor, audit and otherwise administer the employee health plan in which you participate. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. The Health Plan may also provide Summary Health Information to the plan sponsor as allowed by law so that the plan sponsor may solicit premium bids from other health plans or modify, amend or terminate the plan. See your employer's health plan documents for information on whether your employer receives PHI and, if so, the identity of the employees who are authorized to receive your PHI.
- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
  - Companies that perform certain services we've requested. For example, we may engage vendors to help us to provide information and guidance to users with chronic conditions like diabetes and asthma.
  - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

  Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.
- **Communications.** We may disclose your PHI to:
  - Encourage you to purchase or use a product or service that is not part of the health care services and benefits we provide when we meet with you in person, as permitted by law.
  - Provide you with a promotional gift of nominal value.

  Except as permitted by law, we will not use your PHI for marketing purposes without your prior written authorization.
- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of another individual or the general public
- **Public health activities.** We may disclose your PHI to:
  - Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations;
  - Report child abuse or neglect, or adult abuse, including domestic violence, to a

government authority authorized by law to receive such reports;

- Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety or effectiveness of the product or activity;
- Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give this Notice.

- **Health oversight activities.** We may disclose your PHI to:
  - A government agency that is legally responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid.
  - Other regulatory programs that need health information to determine compliance.
- **Research.** We may disclose your PHI for research purposes, but only according to and as allowed by law.
- **Compliance with the law.** We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government such as the U.S. military or the U.S. Department of State as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws and similar programs.

Uses of PHI that require your authorization

Other than for the purposes described above or as permitted by applicable law, we must obtain your written authorization to use or disclose your PHI. For example, we would need your authorization:

- To use your PHI to a prospective employer.
- Use your PHI for marketing communications and when we receive direct or indirect payment from a third party for making such communications.
- For any sale involving your PHI, as required by law.
- To use genetic information for underwriting purposes.

Uses and disclosures of certain PHI deemed "Highly Confidential." For certain kinds of PHI, federal and state law may require enhanced privacy protection. These would include PHI that is:

- Maintained in psychotherapy notes;
- About alcohol and drug abuse prevention, treatment and referral;
- About HIV/AIDS testing, diagnosis or treatment;
- About venereal and/or communicable disease(s);
- About genetic testing.

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law. Any other uses and disclosures not described in this Notice will only be made with your prior written authorization.

Cancellation. You may cancel ("revoke") a written authorization you gave us before. The cancellation, submitted to us in writing, will apply to future uses and disclosures of your PHI. It will not impact disclosures made previously, while your authorization was in effect.

Your individual rights

You have the following rights regarding the PHI that CGHB creates, obtains, and/or maintains about you.

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment and health care operations, as explained in this Notice. We are not required to agree to the restrictions, but we will consider them carefully. If we do agree to the restrictions, we will abide by them.
- **Right to receive confidential communications.** You may ask to receive CGHB communications containing PHI by alternative means or at alternative locations – for example, you may ask that we contact you by phone at home, rather than at work. We will accommodate reasonable requests whenever feasible.
- **Right to inspect and copy your PHI.** You may ask in advance to review or receive a copy of your PHI that is included in certain paper or electronic records we maintain such as prescription and billing records. Under limited circumstances, we may deny you access to a portion of your records.

  You may request that we disclose or send a copy of your PHI to a Health Information Exchange (HIE).
- **Right to amend your records.** You have the right to ask us to correct your PHI contained in our electronic or paper records if you believe it is inaccurate. If we determine that the PHI is inaccurate, we will correct it if permitted by law. If a health care facility

or professional created the information that you want to change, you should ask them to amend the information.

- **Right to receive an accounting of disclosures.** Upon your request, we will provide a list of the disclosures we have made of your PHI for a specified time period. However, the list will exclude:
  - Disclosures you have authorized.
  - Disclosures made earlier than six years before the date of your request (in the case of disclosures made from an electronic health record, this period may be limited to three years before the date of your request).
  - Disclosures made for treatment, payment, and health care operations purposes except when required by law.
  - Certain other disclosures that are excepted by law.

  If you request an accounting more than once during any 12-month period, we will charge you a reasonable fee for each accounting report after the first one.
- **Right to name a personal representative.** You may name another person to act as your Personal Representative. Your representative will be allowed access to your PHI, to communicate with the health care professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make health care decisions for you.
- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have already received one, as described in the Notice Availability and Duration section later in this Notice.

Actions you may take

Contact GHB If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us at the following address or telephone number:

Privacy Office
Cigna Global Health Benefits
300 Bellevue Parkway
Wilmington, DE 19809
International Service Centers:
302.797.3100 or 800.441.2668

For certain types of requests, you must complete and mail to us an applicable form, which is available by calling the International Service Centers or going to our website **(www.Cignaenvoy.com)**.

Contact a government agency. If you believe we may have violated your privacy rights, you may also file a written complaint with the Secretary (the "Secretary") of the U.S. Department of Health and Human Services ("HHS").

Your complaint can be sent by email, fax, or mail to the HHS' Office for Civil Rights ("OCR"). For more information, go to the OCR website **http://www.hhs.gov/ocr/privacy/hipaa/complaints.** We will provide you with the contact information for the OCR Regional Manager in your area if you request it from our Privacy Office.

We will not take any action against you if you exercise your right to file a complaint, either with us or with the Secretary.

Notice availability and duration

Notice availability. A copy of this Notice is available by calling the International Service Centers or on our website (go to **www.Cignaenvoy.com** and click Notice of Privacy Practices).

Right to change terms of this Notice. We may change the terms of this Notice at any time, and we may, at our discretion, make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will update the Notice on our website and, if you are enrolled in a CGHB plan at that time, we will send you the new Notice, as required. In addition, you can obtain a copy of the new Notice upon request when you call the International Service Centers or from our website

Effective date. This Notice is effective as of April 14, 2003, and updated as of September 23, 2013.

APPENDIX D – THE STATE HEALTH BENEFITS PROGRAM

BlueCross BlueShield Global | Core

Healthcare coverage when you are traveling or living abroad

As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global Core program, you have access to doctors and hospitals around the world.

To take advantage of the program:

- Always carry your current member ID card.
- Before you travel, contact your Blue Cross and Blue Shield (BCBS) company for coverage details. Coverage outside the United States may be different.
- If you need to locate a doctor or hospital, call the Service Center for Blue Cross Blue Shield Global Core (see number below). An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.
- If you need inpatient care, call the Service Center (see number below) to arrange direct billing. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.
- In addition to contacting the Service Center, call your BCBS company for precertification or preauthorization. Refer to the phone number on the back of your member ID card. *Note: This number is different from the phone number listed below.*
- For outpatient and doctor care or inpatient care not arranged through the Service Center, you may need to pay upfront. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (the address is on the form). You can also submit your claim online or through the Blue Cross Blue Shield Global Core mobile app. The claim form is available from your BCBS company or online at www.bcbsglobalcore.com.

In an emergency, go directly to the nearest hospital.

To learn more about Blue Cross Blue Shield Global Core:

TheBlueCard®
Now, Home Is Where The Card Is®

- Visit www.bcbsglobalcore.com.
- Use the Blue Cross Blue Shield Global Core app for Android*, iPhone, and iPod touch.** (Rates from your wireless provider may apply).
- Call your BCBS company.
- Call the Service Center at 1.800.810.2583 or collect at 1.804.673.1177, 24 hours a day, seven days a week.

The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

16-581-N35

International Claim Form

Please see the instructions on the reverse side of this form before completing.

BlueCross BlueShield Global | Core

Blue Cross and Blue Shield Companies are independent licensees of the Blue Cross and Blue Shield Association.

Send completed form and documentation to:
or online at www.bcbsglobalcore.com

Service Center
P.O. Box 2048
Southeastern, PA 19399

or claims@bcbsglobalcore.com

1. Patient Information — 1A. Alpha prefix Identification number

Copy this from your Blue Cross Blue Shield identification card.

1B. Patient's name (First, middle initial, last)	1C. Patient's date of birth MM/DD/YYYY	1D. Patient's sex ☐ Male ☐ Female
1E. Name of subscriber (First, middle initial, last)	1F. Subscriber's date of birth MM/DD/YYYY	1G. Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child
1H. Subscriber's current mailing address (Street, city, state, and country or ZIP code)		1I. Patient's e-mail address

2. Other Health Insurance — Is the patient covered under other health insurance, including Medicare A or B? ☐ Yes ☐ No

If yes, complete 2A through 2K below.

2A. Name and address of other insuring company

2B. Type of policy ☐ Family ☐ Individual	2C. Effective date MM/DD/YYYY	2D. Termination date MM/DD/YYYY	2E. Policy or identification number of other coverage
2F. Type of coverage Medical: ☐ Yes ☐ No Hospital: ☐ Yes ☐ No Mental illness: ☐ Yes ☐ No		2G. Name of subscriber	2H. Date of birth MM/DD/YYYY
2I. Employer of subscriber		2J. Employment status ☐ Active employee ☐ Retired employee	

2K. If patient is covered under Medicare, complete the following: Medicare Part A: ☐ Yes ☐ No Effective date _____ Medicare Part B: ☐ Yes ☐ No Effective date _____

3. Diagnosis — 3A. Describe illness, injury, or symptoms requiring treatment and onset date of symptoms or injury.

3B. Was patient's treatment due to a work-related accident or condition? ☐ Yes ☐ No

3C. Complete for care related to accidental injuries

Date of accident _____ Location: ☐ At home ☐ Auto ☐ Other _____

Time of accident _____ *If the accident was caused by someone else, attach a statement describing the accident.*

4. Charges — Use a separate line to list each type of service or provider and attach itemized bills for all services.

4A. Name and address of provider making charge	4B. Type of provider	4C. Description of service	4D. Dates of service or purchase	4E. Charges

5. Payee — Select one of the following payment options:

Option A. ☐ Make payment to subscriber; provider has been paid.

Select your payment preference: ☐ **Check** – US Dollar ☐ **Electronic Funds Transfer** – US Dollar ☐ **Electronic Funds Transfer** – Currency on itemized bill(s)

If you want to receive an electronic funds transfer provide the following:

Subscriber name as it appears on bank account: _____ Bank name: _____

Bank's Physical Address: _____

Account # /IBAN: _____ Routing # / ABA / BIC / SWIFT: _____

Option B. ☐ Make payment to provider (hospital, doctor), if appropriate. Please complete and sign to authorize direct payment to provider.

I, the undersigned, authorize and request payment for benefits due herein to be made to the following provider of services, if such direct payment is deemed appropriate by the subscriber's Blue Cross and Blue Shield company:

Name of provider _____ Signature of subscriber or spouse _____ Date _____

6. Signature —

I certify the above is complete and correct and that I am claiming benefits only for charges incurred by the patient named above. Authorization is hereby given to any provider of service, that participated in any way in the patient's care, to release to the subscriber's Blue Cross and Blue Shield company and its business associates in any country any medical or other personal information that they deem necessary to provide service or adjudicate this claim, recognizing that applicable law concerning personal information may differ among countries. Authorization is also given to the subscriber's Blue Cross and Blue Shield company and its business associates in any country to collect, use or release any medical or other personal information that they deem necessary to provide service, adjudicate a claim or as otherwise described in such Blue Cross and Blue Shield company's Notice of Privacy Practices.

Signature of subscriber or patient _____ Date _____

General Information

- The Blue Cross Blue Shield Global Core International Claim Form is to be used to submit institutional and professional claims for benefits for covered services received outside the United States, Puerto Rico and the U.S. Virgin Islands.
- **For other claim types (e.g., dental, prescription drugs), contact your Blue Cross and Blue Shield Company for filing instructions.**
- Please complete all fields. If the information requested does not apply to the patient, indicate N/A (Not Applicable).
- Please attach receipts and medical records (test results, x-rays, etc.), if available.
- Please keep photocopies of all documentation for your personal records.

Itemized Bill Information

Each provider's original itemized bill must be attached and must contain:

– The letterhead indicating the name and address of the person or organization providing the service

– The full name of the patient receiving the service

– The date of each service

– A description of each service

– The charge for each service in local currency

SPECIAL CARE SHOULD BE TAKEN WHEN COMPLETING THE FOLLOWING FIELDS:

1. Patient Information

1E. Name of subscriber – For check payments, provide your full name (initials are not acceptable).
1H. Subscriber's current mailing address – If check payment is requested, this address will be used. Please provide your physical address (payments cannot be sent to a P.O. Box).

2. Other Health Insurance

If the patient holds other insurance coverage, please complete items A through K as completely as possible. It is especially important to indicate the name and address of the other insurance company and the policy or identification number of that coverage, as well as the name and birth date of the person who holds that policy.

In addition, if the patient is someone other than the subscriber and has received benefits from any other health insurance plan held by reason of law or employment, the Explanation of Benefits Form furnished by the other carrier pertaining to these charges must be included with the claim. A clear photocopy of the other carrier's Explanation of Benefits Form is acceptable in place of the original document.

4. Charges

Please list the attached bills. Although itemized bills from the provider showing a separate charge for each service must be submitted, your listing will enable us to process the claim more quickly. If additional space is needed, please use a separate sheet of paper to list the following information:

4A. Name and Address of provider — as indicated on the bill. Multiple bills from the same provider may be included on the same line, as long as they are for the same type of service.
4B. Type of provider — for example: hospital, nurse, physician, clinic, physical therapist, etc.
4C. Description of service — for example: hospital admission, office visit, x-ray, laboratory test, surgery, etc.
4D. Date of service or purchase — inclusive dates may be indicated for bills containing multiple dates of service.
4E. Charge —as indicated on the bill. If the bill has already been paid, please indicate the date it was paid.

5. Payee

Option A. Make payment to subscriber, designation of currency and payment method — Please note that not all forms of currency may be available for payment. In the event that you select payment in a currency that is not available, you will be paid in U.S. dollars. Banks may charge a fee to receive a wire. You may want to research fees charged by your bank prior to requesting a wire since you will be responsible for any such fees.

For an electronic funds transfer, provide the bank's physical address where the account was opened (not a P.O. Box). Please provide a copy of a voided check or deposit slip so that the bank information can be validated.

Option B. Authorization for payment to provider — complete option B if you prefer that benefits be paid directly to the provider of service. Direct payment to the provider is at the discretion of your Blue Cross and Blue Shield Company, except where required by law.

6. Signature

The International Claim Form must be signed and dated by the subscriber, spouse, or the patient.

Disclosure Statement

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

HEALTH BENEFITS PROGRAM APPLICATION — SHBP STATE ACTIVE EMPLOYEE GROUP

Division of Pensions and Benefits, PO Box 299, Trenton NJ 08625-0299 HA-0891-0816

EMPLOYMENT STATUS: ☐ FULL TIME ☐ PART-TIME ☐ INTERMITTENT ☐ NATIONAL GUARD ☐ ACA (monthly only)

1 EMPLOYEE INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number

Last Name | Title (Jr., Sr., etc.)

First Name | MI

Street Address (Include Apartment #)

City | State

ZIP Code + 4 | Date of Birth (mm/dd/yy) | Gender (M/F)

Status: ☐-Single ☐-Married ☐-Civil Union ☐-Domestic Partnership ☐-Divorced ☐-Widowed

(Area Code) Home Telephone Number

Are you transferring your health benefits from another SHBP/SEHBP participating employer?

☐ No ☐ Yes If yes, list name of employer: _____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION (Choose only one plan)

HORIZON	AETNA
☐ OMNIA Health Plan	☐ Aetna Liberty Plan
☐ NJ DIRECT15	☐ Aetna Freedom15
☐ NJ DIRECT1525	☐ Aetna Freedom1525
☐ NJ DIRECT2030	☐ Aetna Freedom2030
☐ NJ DIRECT2035	☐ Aetna Freedom2035
☐ Horizon HMO	☐ Aetna HMO

For HMO Plans, enter Primary Care Physician's ID# _____

☐ I elect to waive medical coverage in any medical plan (see instructions).*

To sign up for a High Deductible Health Plan (HDHP), you must complete a *High Deductible Health Plan Application*. For more information, see your benefits administrator, or go to www.nj.gov/treasury/pensions

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

3. PRESCRIPTION DRUG COVERAGE

3a. EMPLOYEE SELECTION

☐ I wish to be covered by the Employee Prescription Drug Plan.

☐ I elect to waive Employee Prescription Drug Plan coverage.*

3b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

*Both Medical **and** Prescription Drug coverage must be waived to avoid paying a contribution.

DIVISION USE ONLY

Effective Dates: Event Reason:

H _____ _____ _____

P _____ _____ _____

EMPLOYER CERTIFICATION

See instructions on reverse

Employer Name: _____

Payroll # (State Biweekly) | Union Code (Rx) Only

Location # (State Monthly)

10/12-month employee (Enter "10" or "12")

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began _____/_____/_____ (mm/dd/yy)

☐ Return from Leave of Absence _____/_____/_____ (mm/dd/yy)

_____ Signature of Certifying Officer

_____ Telephone # Date Mailed

4. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of dependency documents (see instructions).

	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) (See Instructions)
Spouse/Civil Union/Domestic Partner								
Children								

5. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

☐ Marriage - Date of Event (mm/dd/yy) _____

(Copy of Marriage Certificate required)

Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____

(Copy of Certificate of Civil Union or Domestic Partnership required)

☐ Birth of Child ☐ Adoption/Guardianship - proof required

Date of Event (mm/dd/yy) _____

5b. DELETION OF SPOUSE OR PARTNER

☐ Divorce ☐ Dissolution of Civil Union ☐ Death

☐ Termination of Domestic Partnership

Date of Event (mm/dd/yy) _____

5c. DELETION OF CHILD

☐ Deletion of Child - Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN# _____

Give Reason _____

5d. OTHER CHANGES

☐ Change in last name only (Attach copy of supporting documentation)

(List former name) _____

☐ Change in SSN# (Attach copy of Social Security card)

(List former SSN#) _____

☐ Change in Birth Date (Attach copy of birth certificate)

(List name and correct date) _____

_____

☐ Other - give reason (i.e., address change, dependent returns from military service) _____

6. EMPLOYEE CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

_____ _____

Employee Signature Date Completed

INSTRUCTIONS FOR THE HEALTH BENEFITS APPLICATION
STATE ACTIVE EMPLOYEE GROUPS

- **To change your primary care physician** (PCP) with your HMO, contact your health plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR PRIMARY CARE PHYSICIAN.**
- **To enroll** for the first time, complete all sections of the application with the exception of section 5.
- **To change health plans only** complete sections: 1, 2a and 2b (if enrolling in an HMO be sure to list your primary care physician's identification number), 4 (list all eligible dependents), and 6.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a, and 2b, 3a and 3b (if Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5 (list why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 3a and 3b (if Employee Prescription Drug Plan coverage is provided by your employer), 4 (list all eligible dependents), 5a, and 6. You must also attach the required proof of dependency documents.
- **To terminate/decline coverage** complete sections: 1, 2a and/or 3a (as applicable), and 6 (If you are eligible to waive coverage under the provisions of N.J.S.A. 52:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer. Both Medical **and**, if applicable, Prescription Drug coverage must be waived to avoid paying the 1.5% contribution). If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP or SEHBP medical plan, provided that you request enrollment within 60 days after other group health coverage ends.

EMPLOYMENT STATUS: Indicate Employment Status (check one box only)

SECTION 1 - EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 - MEDICAL COVERAGE

2a. Check the box and indicate the medical plan you wish to be enrolled in. If you do not want medical coverage or wish to cancel coverage, check the box to waive coverage. Both Medical **and** Prescription Drug must be waived to avoid paying any contribution.

2b. If you are electing coverage, check the level of coverage desired.

SECTION 3 - PRESCRIPTION DRUG COVERAGE

The Employee Prescription Drug Plan is available to State employees:

3a. To enroll, check the box to indicate that you wish to be covered. If you do not want prescription drug coverage or wish to cancel coverage, check the box to waive coverage. Both Medical **and** Prescription Drug must be waived to avoid paying the 1.5% contribution.

3b. If you are electing coverage, check the level of coverage desired (if enrolling a domestic partner, see eligibility information in “Domestic Partner” below).

NOTE: Once you decline or cancel Medical or Prescription Drug coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 - DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b and 3b. List the name, date of birth, gender, and Social Security number of the family members you wish to cover under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, or your child under age 26 (as defined on page 3). If enrolling in an HMO, include each dependent’s HMO Primary Care Physician identification number — all dependents must have this information listed. Refer to the HMO plan’s provider directory or Web site for this information, or call the HMO plan directly. Plan Web sites and phone numbers can be found on the *Plan Comparison Summary*.

NOTE: If you are deleting dependents, do not list them in section 4. Refer to section 5b and 5c.

SECTION 5 - TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and indicate the event date.

5b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 6 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, date the application, and attach any required proof for dependents.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application to the Health Benefits Bureau. By signing this application the employer certifies that:

1) The employee is eligible;
2) The application is legible and completed in its entirety;
3) The employee's selected plans and coverage levels are appropriate;
4) The Employer Certification section is completed in its entirety; and
5) The information presented is true to the best of their knowledge.

HIGH DEDUCTIBLE HEALTH PLAN APPLICATION — SHBP STATE ACTIVE EMPLOYEE GROUP

Division of Pensions and Benefits, PO Box 299, Trenton NJ 08625-0299 HA-0910-0816

EMPLOYMENT STAUS: ☐ FULL TIME ☐ PART TIME ☐ INTERMITTENT ☐ NATIONAL GUARD ☐ ACA (monthly only)

1 EMPLOYEE INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ___ - ___ - ____

Last Name | Title (Jr., Sr., etc.)

First Name | MI

Street Address (Include Apartment #)

City | State

ZIP Code + 4 | Date of Birth (mm/dd/yy) | Gender (M/F)

Status:

☐ -Single ☐ -Married ☐ -Civil Union ☐ -Domestic Partnership ☐ -Divorced ☐ -Widowed

(Area Code) Home Telephone Number

Are you transferring your health benefits from another SHBP/SEHBP participating employer?

☐ No ☐ Yes If yes, list name of employer: _____

2. HIGH DEDUCTIBLE HEALTH PLAN (HDHP) MEDICAL COVERAGE

2a. EMPLOYEE SELECTION (Choose only one HDHP)

HORIZON	AETNA
☐ NJ DIRECT HD4000	☐ Aetna Value HD4000
☐ NJ DIRECT HD1500*	☐ Aetna Value HD1500*

☐ I elect to waive medical coverage in any medical plan.

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

Employees who choose a HDHP plan cannot enroll in another prescription drug plan. Prescription drug benefits will be provided in conjunction with the medical plan.

*Part-time employees cannot enroll in the NJ DIRECT HD1500 plan and the Aetna Value HD1500 plan.

3. HEALTH SAVINGS ACCOUNT (HSA)

☐ I wish to establish a HSA at this time and understand that I will be contacted to establish banking.

By applying for and funding your HSA you represent that you:

1) are covered under a High Deductible Health Plan;
2) are not covered by any other non-HDHP product;
3) are not enrolled in Medicare; and
4) cannot be claimed as a dependent on another person's tax return.

To enroll in the Health Savings Account (HSA), complete the attached HSA contribution form to authorize payroll deductions.

☐ I am not enrolling in a HSA at this time and understand that if I choose to at a later date, I must contact my carrier.

DIVISION USE ONLY

Effective Dates: Event Reason:

H _____ _____ _____

P _____ _____ _____

EMPLOYER CERTIFICATION

See instructions on reverse

Employer Name: _____

Location # ____ - ____

10/12-month employee (Enter "10" or "12")

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began _____/_____/_____ (mm/dd/yy)

☐ Return from Leave of Absence _____/_____/_____ (mm/dd/yy)

_____ Signature of Certifying Officer

_____ Telephone # Date Mailed

4. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of dependency documents (see instructions).

	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Dependent's HMO Primary Care Physician ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) (See Instructions)
Spouse/Civil Union/Domestic Partner								
Children								

5. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

☐ Marriage - Date of Event (mm/dd/yy) _____

(Copy of Marriage Certificate required)

Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____

(Copy of Certificate of Civil Union or Domestic Partnership required)

☐ Birth of Child ☐ Adoption/Guardianship - proof required

Date of Event (mm/dd/yy) _____

5b. DELETION OF SPOUSE OR PARTNER

☐ Divorce ☐ Dissolution of Civil Union ☐ Death

☐ Termination of Domestic Partnership

Date of Event (mm/dd/yy) _____

5c. DELETION OF CHILD

☐ Deletion of Child - Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN# _____

Give Reason _____

5d. OTHER CHANGES

☐ Change in last name only (Attach copy of supporting documentation)

(List former name) _____

☐ Change in SSN# (Attach copy of Social Security card)

(List former SSN#) _____

☐ Change in Birth Date (Attach copy of birth certificate)

(List name and correct date) _____

_____

☐ Other - give reason (i.e., address change, dependent returns from military service) _____

6. EMPLOYEE CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

_____ _____

Employee Signature Date Completed

INSTRUCTIONS FOR THE HDHP HEALTH BENEFITS APPLICATION

- **To enroll** for the first time, complete all sections of the application with the exception of section 5.
- **To change health plans only** complete sections: 1, 2a and 2b, 4 (list all eligible dependents), and 6.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 4 (list all eligible dependents), 5 (list why you are changing coverage level), and 6.
- **To add a dependent** complete sections: 1, 2a and 2b, 4 (list all eligible dependents), 5a, and 6. You must also attach the required proof of dependency documents.
- **To terminate/decline coverage** complete sections: 1, 2a, and 6 (If you are eligible to waive coverage under the provisions of N.J.S.A. 52:14-17.31(a), you must also complete and attach the *Waiver/Reinstatement Declaration* form available from your employer. Both Medical **and**, if applicable, Prescription Drug coverage must be waived to avoid paying the 1.5% contribution). If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP or SEHBP medical plan, provided that you request enrollment within 60 days after other group health coverage ends.

EMPLOYMENT STATUS: Indicate Employment Status (check one box only)

SECTION 1 - EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 - MEDICAL COVERAGE

2a. Check the box and indicate the HD medical plan you wish to be enrolled in. If you do not want medical coverage or wish to cancel coverage, check the box to waive coverage. Both Medical **and** Prescription Drug must be waived to avoid paying any contribution.

2b. If you are electing coverage, check the level of coverage desired.

SECTION 3 - HEALTH SAVINGS ACCOUNT (HSA)

Health Savings Accounts (HSA) are only available to members who have opted to take a HD medical plan.

Indicate whether or not you are signing up for the HSA plan. **To enroll you must complete a separate *Health Savings Account* form.** For more information about a Health Savings Account or the HSA form, please see your benefits administrator.

NOTE: Once you decline or cancel Medical coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 - DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in section 2b. List the name, date of birth, gender, and Social Security number of the family members you wish to cover under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, or your child under age 26 (as defined on page 3). Plan Web sites and phone numbers can be found on the *Plan Comparison Summary*.

NOTE: If you are deleting dependents, do not list them in section 4. Refer to section 5b and 5c.

SECTION 5 - TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and indicate the event date.

5b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 6 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, date the application, and attach any required proof for dependents.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application to the Health Benefits Bureau. By signing this application the employer certifies that:

1) The employee is eligible;
2) The application is legible and completed in its entirety;
3) The employee's selected plans and coverage levels are appropriate;
4) The Employer Certification section is completed in its entirety; and
5) The information presented is true to the best of their knowledge.

HB-0840-0816

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A photocopy of the *Marriage Certificate* **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/ retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, *regardless* of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, (2) the child continues to be disabled, (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), **and** if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

* ***NOTE:*** *For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org***
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.nj.gov/health/vital/index.shtml***

HD-0719-0914

NEW JERSEY EMPLOYEE DENTAL PLANS APPLICATION

Division of Pension and Benefits, P.O. Box 299,Trenton, NJ 08625-0299

DIVISION USE ONLY

Effective Dates: D _____ _____ _____ Event Reason: ☐

EMPLOYER CERTIFICATION
See instructions on reverse

Employer Name:_____

Payroll # (State Biweekly) ☐☐☐☐

Union Code (Rx) Only ☐☐

Location # (State Monthly or Local/Educational) ☐☐☐☐ - ☐☐

10/12 month employee (Enter "10" or "12") ☐☐

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began _____/_____/_____ (mm/dd/yy)

☐ Return from Leave of Absence _____/_____/_____

_____
Signature of Certifying Officer

_____
Telephone # Date Mailed

1. EMPLOYEE INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

Last Name Title (Jr., Sr., etc.)

First Name MI

Street Address (Include Apartment #)

City State

ZIP Code + 4 Date of Birth (mm/dd/yy) Gender (M/F)

Status:

☐ -Single ☐ -Married ☐ -Civil Union ☐ -Domestic Partnership ☐ -Divorced ☐ -Widowed

Are you transferring from another SHBP/SEHBP participating employer? ☐ Yes ☐ No

(Area Code) Home Telephone Number

If yes, name of employer: _____

2. DENTAL COVERAGE

2a. EMPLOYEE SELECTION (You must remain enrolled in the Dental Plan for a minimum of 12 months)

☐ I wish to be covered under the Dental Expense Plan. (Aetna DEP) ; or

I wish to be covered under a Dental Plan Organization (DPO).

☐ Aetna DPO ☐ Healthplex

☐ Cigna ☐ Horizon BCBSNJ

☐ MetLife

Name of Dentist or ID# _____

☐ I am changing dental plans only:

From _____

To _____

☐ I elect to waive dental coverage in any dental plan (see instructions).

2b. LEVEL OF COVERAGE

☐ Single ☐ Member and Spouse/Civil Union Partner

☐ Member and Domestic Partner (see instructions)

☐ Family ☐ Parent and Child(ren)

3. DEPENDENT INFORMATION - List only eligible dependents and attach required proof of dependency documents (see instructions on reverse).

	Last Name	First Name	MI	Date of Birth (mm/dd/yy)	Gender (M/F)	Social Security Number	Name of Dependent's Dentist or ID#	Natural (C) Adopted (A) Foster (F) Step (S) Legal Ward (L) See Instructions
Spouse/Civil Union/Domestic Partner								
Children								

4. TYPE OF ACTIVITY
(complete only if requesting changes to existing coverage)

4a. ADDITION OF DEPENDENT
(attach required proof of dependency documentation)

☐ Marriage
Date of Event (mm/dd/yy) _____
(attach Marriage Certificate and supporting documents)

Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (mm/dd/yy) _____
(attach Certificate of Civil Union or Domestic Partnership and supporting documents)

☐ Birth of Child (attach supporting documents)

☐ Adoption/Guardianship - proof required
Date of Event (mm/dd/yy) _____

4b. DELETION OF SPOUSE OR PARTNER

☐ Divorce ☐ Dissolution of Civil Union

☐ Termination of Domestic Partnership ☐ Death

Date of Event (mm/dd/yy) _____

4c. DELETION OF CHILD

☐ Deletion of Child -

Date of Event (mm/dd/yy) _____

Child's Name _____

Child's SSN _____

Give Reason _____

4d. OTHER CHANGES

☐ Change in last name only
(Attach copy of supporting documentation)

(List former name) _____

☐ Change in Soc. Sec. #
(Attach copy of Social Security card)

(List former Soc. Sec. #) _____

☐ Change in Birth Date
(Attach copy of birth certificate) (List name and correct date)

_____

☐ Other - give reason (i.e., address change, dependent returns from military service)_____

_____

5. EMPLOYEE CERTIFICATION - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist, or dental care provider to furnish my dental plan or its assignee with such dental information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Employee Signature _____

Date Completed _____

HD-0719-0914

INSTRUCTIONS FOR THE EMPLOYEE DENTAL PLANS APPLICATION

- **To change your dentist** with your DPO, contact your dental plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR DENTIST.**
- **To enroll** for the first time complete all sections of the application with the exception of "Division Use Only" box.
- **To change dental plans only** complete sections: 1, 2a and 2b (if enrolling in a DPO be sure to list the name of your dentist or his/her identification number), 3 (listing all eligible dependents), and 5.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4 (listing why you are changing coverage level), and 5.
- **To add a dependent** complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4a, and 5. You must also attach the required proof of dependency documents.
- **To terminate/decline coverage** complete sections: 1, 2a, and 5. If you are declining enrollment for yourself or any or all of your eligible dependents because of other group dental insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a dental plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 - EMPLOYEE INFORMATION

This section is completed in its entirety each time an application is submitted. The employee enrolling/enrolled in the plan completes this section.

SECTION 2 - DENTAL COVERAGE

2a. Check only one box indicating the dental plan you wish to be enrolled in. If you do not want dental coverage or wish to cancel coverage, check the box to waive coverage.

NOTE: Once you decline or cancel Dental coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

2b. If electing coverage, check the level of coverage desired. (No employee or dependent can be covered under more than one Dental Plan.)

NOTE: Once enrolled, you and your eligible dependents must remain in the plan you elect for a minimum of 12 months before you can switch plans or drop coverage.

SECTION 3 - DEPENDENT INFORMATION — Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may list an eligible spouse, civil union partner, or same-sex domestic partner, and your children under age 26.

SPOUSE: This is a person to whom you are legally married. A photocopy of the *Marriage Certificate* **and** a photocopy of the employee's most recent Federal tax return* that includes the spouse are required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of civil union partner coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP or SEHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the employee's most recent NJ tax return* that includes the partner are required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

***Note:** On tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.

CHILDREN: This is your child under age 26. A photocopy of a child's birth certificate showing the name of the employee as a parent is required for enrollment. In addition, if you have listed a child who is an adopted child, foster child, stepchild, legal ward, has a different last name than the employee, or if the member has a Parent/Child contract, additional supporting documentation is required. If you have more than four eligible dependent children, attach a separate application and complete Sections 1, 3, and 5. For all dependents, include the dentist's name or identification number. All dependents must have this information listed. Refer to the DPO directory for this information or call the dental plan directly.

NOTE: If you are deleting dependents, do not list them in this section. Refer to section 4b and 4c.

SECTION 4 - TYPE OF ACTIVITY

4a. If you are adding a dependent, check the appropriate box, indicate the event date, and attach required proof of dependency documentation.

4b. If you are deleting a dependent spouse, civil union partner, or domestic partner, check reason and indicate the event date.

4c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

4d. For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

SECTION 5 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer before submitting the application. By signing this application the employer certifies that:

1) The employee is eligible;
2) The application is legible and completed in its entirety;
3) The employee's selected plans and coverage levels are appropriate;
4) The Employer Certification section is completed in its entirety; and
5) The information presented is true to the best of their knowledge.

HB-0840-0913

REQUIRED DOCUMENTATION FOR SHBP/SEHBP DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, eligible children, and eligible dependents are receiving health care coverage under the programs. As a result, the Division of Pensions and Benefits must guarantee consistent application of eligibility requirements within the plans. Employees or Retirees who enroll children or dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or over age children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person of the opposite sex or same sex to whom you are legally married.	A photocopy of the *Marriage Certificate* **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the spouse.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A photocopy of the *New Jersey Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions **and** a photocopy of the front page of the employee/retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A photocopy of the *New Jersey Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another State of foreign jurisdiction that recognizes same-sex domestic partners **and** a photocopy of the front page of the employee/ retiree's most recently filed New Jersey tax return* that includes the partner **or** a photocopy of a recent (within 90 days of application) bank statement or bill that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, *regardless* of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A photocopy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent **and** a photocopy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Guardian, Grandchild, or Foster Child** – Photocopies of Final Court Orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the covered employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, and (2) the child continues to be disabled, and (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the employee/retiree's most recently filed federal tax return* (*Form 1040*) that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. **Please note** that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVER AGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of Chapter 375, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate "Child" type (as noted above) **and** a photocopy of the front page of the child's most recently filed federal tax return* (*Form 1040*), **and** if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

***Note:** For tax forms you may black out all financial information and all but the last 4 digits of any Social Security numbers.*

To obtain copies of the documents listed above, contact the office of the Town Clerk in the city of the birth, marriage, etc., or visit these Web sites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org***
Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration Web site: ***www.state.nj.us/health/vital/index.shtml***

STATE OF NEW JERSEY
DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 299
TRENTON, NJ 08625-0299

STATE EMPLOYEE COVERAGE WAIVER/REINSTATEMENT
STATE HEALTH BENEFITS PROGRAM

Part 1: To be completed by the employee. Please print.

1. Name _____ SS# _____

Check one box below.

☐ **Waiver of Coverage**

I agree to voluntarily waive State Health Benefits Program (SHBP) coverage to which I am entitled because I am covered under other health coverage. I understand that while coverage is waived, I will not be required to make payroll contributions required for medical and/or prescription drug coverage.

I understand that I may resume State Health Benefits Program coverage if I lose coverage under the other health coverage, provided that I notify the SHBP within 60 days of the loss of the other coverage and provide proof of loss of that coverage.

☐ **Reinstatement of Coverage**

I previously waived State Health Benefits Program coverage because I had other health coverage.

As of _____, I am no longer covered by the other health plan, request reinstatement of the State
(date)
Health Benefits Program coverage, and have provided proof of loss of the other coverage. I further understand that coverage is permitted as an employee, retiree, or dependent, however, multiple coverage under the State Health Benefits Program is prohibited.

Employee's Signature _____ **Date** _____

Part 2: To be completed by the employer. Check one box below.

☐ We understand that this employee is requesting to voluntarily waive State Health Benefits Program coverage.

☐ We request reinstatement of this employee's State Health Benefits Program coverage.

A completed *State Health Benefits Program Application* must be attached to either a waiver or a reinstatement. The reinstatement application must be filed within 60 days of the loss of other health coverage. If this timetable is followed, the coverage will be retroactive to the date of loss. If the 60 day time limit has passed, the employee must wait until the next open enrollment period to reenroll.

Employer Name _____ SHBP Location # _____

Signature of Certifying Officer _____ Date _____

APPENDIX E – RETIREMENT PLAN INFORMATION

Alternate Benefit Program Enrollment Instructions

Step A. Select a Designated Service Provider and set up an account

Select one of the seven approved ABP designated service providers, and set up your account with the provider. Contact information for each of the ABP designated service providers can be found on the following page. You may select from the following ABP Designated Service Providers:

- AXA/Equitable
- Mass Mutual (Formerly The Hartford)
- Met Life
- Prudential
- TIAA
- VALIC
- Voya Financial (Formerly ING)

Step B. Complete Required Forms

- ABP Enrollment Application
- Salary Reduction Allocation Agreement Form
- Inquiry of Pension Membership Form

Step C. Submit to HR

Please submit the following forms to the Office of Human Resources:

- ABP Enrollment Application
- Salary Reduction Allocation Agreement Form
- Inquiry of Pension Membership Form

Notice of Force Enrollment

Enrollment in the ABP retirement plan is mandatory. If you do not select an investment carrier or notify us of your retirement from another state-administered retirement plan, you will be automatically enrolled into this year's default ABP investment carrier.

CONTACTS FOR ABP DESIGNATED SERVICE PROVIDERS

AXA/EQUITABLE

Ryan Mickendraw	(732) 452-7278 ryan.mickendrow@axa-advisors.com

MASS MUTUAL (Formerly - The Hartford)

Theodore Kowalchyn	(848) 248-4360 tkowalchyn@gawmllc.com
Yolanda Gonzalez	(848) 248-4875 ygonzalez@gittermanwealth.com
Participant Services	(800) 528-9009

MET LIFE

David Sharpe	(973) 575-3254 dsharpe@financialguide.com

PRUDENTIAL

Lily Lau	(732) 236-6782 lily.lau@prudential.com

TIAA

Jonathan Collazo	(201) 498-8339 Jonathan.Collazo@tiaa.org

VALIC

Mary Ann Bradford	(732) 616-7817 maryann.bradford@valic.com
Customer Service:	(800) 448-2542 (Group Number: 25602)

VOYA FINANCIAL (Formerly - ING)

Frank Booth	(732) 326-5628 frank.booth@voyafa.com
David Ryan	(732) 887-2710 davidjryan@voyafa.com

Updated 11/07/2016

RETIREMENT PLANNING

ALTERNATE BENEFITS PROGRAM (ABP) - MANDATORY

The Alternate Benefit Program is a tax-deferred, defined contribution retirement program for higher education faculty (including adjuncts), and certain managers and administrators. This program provides retirement benefits, life insurance, long-term disability coverage and loans. Members contribute 5% of their base or contractual annual salary, and are matched by an 8% employer contribution to a tax-deferred investment account. There are seven designated service providers to choose from:

- AXA Equitable
- Mass Mutual (The Hartford)
- MetLife (CitiStreet/Travelers)
- Prudential
- TIAA
- VALIC
- VOYA Financial (ING)

If employment terminates during the initial year of participation, the employee contributions may be withdrawn, plus or minus any gains or losses on the selected investments. The employee is not entitled to the University's contributions if employment is terminated during the initial year of participation. If employment terminates after one year of service, contributions made by the University, as well as the employee, are fully vested.

SUPPLEMENTAL RETIREMENT SAVINGS - VOLUNTARY

Supplemental Retirement Annuity (SRA) Plan - 403b Plan

The Supplemental Retirement Annuity (SRA) Plan allow for eligible employees to obtain supplemental tax-deferred annuities with a variety of service providers through a salary reduction agreement. Participants can direct voluntary contributions among the six authorized ABP service providers. Each provider provides a selection of investment choices to meet the needs and goals of retirement planning. To be considered eligible for a 403(b) plan, you must be actively enrolled in the ABP retirement plan.

New Jersey State Employees Deferred Compensation Plan (NJSEDCP)

- **Traditional Option**

The New Jersey State Employees Deferred Compensation Plan (NJSEDCP) provides you, as an eligible state employee, an opportunity to voluntarily shelter a portion of your wages from federal income taxes while saving for retirement to supplement your Social Security and pension benefits. Under the plan, federal income tax is not due on deferred amounts or accumulated earnings until you receive a distribution (payment) from your account. Presumably, distribution is at retirement when your tax rate is expected to be lower.

- **Roth Option**

Roth contributions combine the savings and investment features of a traditional deferred compensation plan with the tax-free distribution features of the Roth IRA. Instead of having all of your contributions deducted from your paycheck before taxes, you can designate some or all of those contributions to be put aside as after-tax Roth contributions. And, if you satisfy certain plan and tax law requirements, the Roth money you withdraw at retirement—including earnings—won't be taxable.

Alternate Benefit Program

The Alternate Benefit Program (ABP) is a tax-sheltered, defined contribution retirement program for higher education faculty and certain administrators. The ABP provides retirement benefits, life insurance, and disability coverage, which — when combined with Social Security and other tax-deferred plans — can provide security in retirement.

ELIGIBILITY

Full-time and adjunct faculty, part-time instructors, officers, visiting professors, and certain professional administrative staff required to possess a college degree or its equivalent participate in the ABP. "Full-time" is defined by statute to include anyone receiving 50% or more of base salary and may include anyone on sabbatical or paid leave of absence for a period not to exceed one year.

Individuals not eligible for membership include: temporary employees (with the exception of visiting professors appointed for a school year, a semester, or a lesser period of time); faculty members temporarily in the U.S. under an F or J visa; employees in a career service title as defined by the New Jersey Civil Service Commission; employees in clerical and other nonprofessional positions; and any employee receiving a retirement benefit from any New Jersey State-administered retirement system including the ABP.

The following State agencies and institutions of higher education are covered by the ABP:

ATLANTIC CAPE Community College
BERGEN Community College
BROOKDALE Community College
CAMDEN COUNTY College
COUNTY COLLEGE of MORRIS
CUMBERLAND COUNTY College
DEPARTMENT of EDUCATION
(limited positions — refer to ABP Section)
ESSEX County College
HIGHER EDUCATION STUDENT ASSISTANCE AUTHORITY
HUDSON COUNTY Community College
KEAN University of NJ
MERCER COUNTY Community College
MIDDLESEX COUNTY College
MONTCLAIR State University
NEW JERSEY CITY State University
NJ INSTITUTE OF TECHNOLOGY
OCEAN COUNTY College
PASSAIC COUNTY Community College
RAMAPO College of NJ
RARITAN Valley Community College
ROWAN University of NJ
ROWAN College at Burlington County
ROWAN College at Gloucester County
RUTGERS BIOMEDICAL
RUTGERS, The State University
SALEM Community College
STOCKTON University
SUSSEX COUNTY Community College
THE COLLEGE of NEW JERSEY
THOMAS EDISON State University
UNION COUNTY College
UNIVERSITY HOSPITAL
WARREN COUNTY Community College
WILLIAM PATERSON University of NJ

TAX-SHELTERED INCOME

Members annually contribute 5% of base or contractual salary matched by an 8% employer contribution* to a tax-deferred investment account. This account may be established with any of the current authorized providers: AXA Financial (Equitable), MassMutual Retirement Services (formerly The Hartford), MetLife (formerly Travelers/CitiStreet), Prudential Retirement Services, TIAA, VALIC, and Voya.

Additional voluntary federal tax-deferred contributions under Internal Revenue Code, Section 403(b), may also be made based on the actual base salary paid less the mandatory 5% member contribution. Before having any additional contributions deducted, members should contact the authorized carrier of their ABP account for a calculation on the exact amount available to them for a Section 403(b) contribution. These contributions cannot exceed the actual dollar limits eligible for tax-shelter in a given tax year.

For most ABP members, mandatory "employee" and "employer" contributions are held in a **"delayed vesting"** status during the first year of ABP eligible employment. The member is vested in the ABP beginning in the second year of ABP eligible employment.

Some ABP members can be **"immediately vested"** if the member has an existing retirement account containing employee and employer contributions from employment in higher education **or** is an active or vested member of a federal or state retirement system **and** transfers that retirement system membership to the ABP.

When vested, all contributions and accumulations in the ABP account belong to the member and provide benefits when the member is eligible to receive them. Vested members of the ABP are also eligible to apply through their provider for loans made from the member's account balance. Contact the authorized provider for borrowing and repayment procedures.

Note: While in delayed vesting status, loans or the transfer of funds between carriers are not permitted. If a member leaves ABP eligible employment before becoming vested, only the "employee" contributions, including any investment gain or loss, can be refunded. The "employer" contributions revert back to the employer. The refund of contributions to a "non-vested" member is considered a withdrawal from the ABP.

RETIREMENT

Six months before retirement, a member should contact the employer and the authorized carrier for information regarding benefits and options. The carriers regularly provide informational seminars on retirement.

A member may elect to receive all or a portion of his/her account in a lump-sum distribution, or as a fixed term or life annuity. Lump-sum cash distributions to members under the age of 55 are limited to the member's contributions and earnings. The remaining employer contributions and earnings are only available after age 55. The types of payout plans vary from carrier to carrier and should be considered when selecting a carrier. All returns of contributions and earnings are considered taxable in the year they are received.

There is no minimum retirement age under the ABP. A member may begin collecting an annuity, or take a cash distribution, at any time after termination of employment; however, **if you return to public employment in New Jersey, you cannot participate in any State-administered retirement system. The member will automatically be considered retired, regardless of age, if there is any distribution of *mandatory* contributions.**

**N.J.S.A. 18A:66-174 established that as of July 1, 2010, the employer contribution may not exceed 8% of the maximum salary for State department officers as established by law. Currently, N.J.S.A. 52:14-15.107 sets the maximum annual salary of department officers at $141,000 per calendar year.*

POST-RETIREMENT EMPLOYMENT RESTRICTIONS

If you are considering working after retirement you should be aware of the restrictions imposed by laws and regulations governing post-retirement employment. It is your responsibility to inform your prospective employer that you are receiving retirement benefits from a New Jersey public retirement system. As a retiree of the ABP you are prohibited from enrolling in any New Jersey State-administered retirement system once you have collected a distribution from your tax-deferred investment account. If you want to supplement your retirement income after you retire, employment with a private company, the federal government, or another state will not affect your right to receive your retirement benefits.

Retirees are required to completely separate from service before returning to public employment in New Jersey (in a position covered by a different retirement system). Internal Revenue Code (IRC) sections 401(a) and 414(d) establish the ABP as a qualified governmental defined contribution retirement program. New Jersey State-administered retirement systems generally do not permit the payment of retirement benefits without a complete severance from your employer. In order to preserve the qualified status of the plan and to protect retirees from a 10% early distribution tax penalty on their monthly pensions, the Division of Pensions and Benefits is required to adopt and to enforce regulations to ensure compliance with the IRC requirements.

Should you return to work with your former employer, you must first determine if you have met the requirements of a "bona fide severance of employment" as defined under N.J.A.C. 17:1-17.14(a)2. "Bona fide severance from employment" means there was a complete termination of the employer/employee relationship for a period of at least 180 days from the date of your retirement. Re-employment by a different unit of the same public employer within the 180 days of retirement, whether in a position covered by the same retirement system or a different retirement system, is considered to be employment by the same employer. (See the exception below for the Transition to Retirement Programs.)

TRANSITION TO RETIREMENT PROGRAMS

For ABP members, a Transition to Retirement Program (TTRP) allows members to collect retirement benefits in conjunction with continued active employment without penalty. Members are eligible to participate in a TTRP if they:

- sign a contract with the employer to participate in a TTRP;
- are full-time tenured faculty with a minimum age of 55;
- served a minimum of 10 years at a college or university; and
- submitted a request to retire under the terms of the TTRP to their employer no later than April 1 of the calendar year preceding the academic year in which they wish to participate in the program.

If eligible to participate in a TTRP, members must adhere to the following program requirements:

- participating faculty must officially retire from the college or university, then seek re-employment under the terms of the program requirements;
- as retirees, participating faculty have no claims of tenure or other rights and/or obligations of a tenured faculty member;
- in no event shall the total assignment exceed 50% of a full-time faculty load; and
- participating faculty shall receive compensation proportional to the assignment approved by the college or university, which shall not exceed 50% of their final year's salary.

IS THERE ANY LIFE INSURANCE COVERAGE?

All ABP members are covered by employer-paid life insurance, payable to their designated beneficiaries, in the amount of three and one-half times the employee's annual base salary. This coverage is available without a medical examination to members under age 60. Newly enrolled members 60 years of age or older must undergo a medical examination to qualify. The Internal Revenue Service classifies all life insurance coverage over $50,000 as a fringe benefit subject to taxation. The amount of the life insurance coverage is not taxable, but *the premium* required to pay for the life insurance coverage is taxable. Members can elect to waive insurance coverage over $50,000 at any time; for further information on this topic, you may contact the Division of Pensions and Benefits (see bottom of this fact sheet) and request Fact Sheet #22, *Waiver of Non-Contributory Group Life Insurance over $50,000*.

ABP members on leave of absence without pay continue to be insured for

- up to two years while on approved leave of absence for illness;
- up to one year while on approved leave of absence to fulfill a residency requirement for an advanced degree; or
- up to 93 days while on leave for other reasons, including child care.

Upon retirement, life insurance reduces to one-half of the annual base salary. This life insurance coverage is available in retirement only to members age 60 or older and only if the member has completed 10 years of participation in the ABP at an eligible New Jersey institution of higher education. The member also had to be an active employee in the twelve months immediately preceding the initial receipt of a retirement annuity payment.

Insurance coverage ceases 31 days after termination of employment. During the 31-day period following termination of employment, the member may convert existing group life insurance coverage (less any amount of coverage carried over into retirement) into an individual whole life policy, without medical examination. For more information, request Fact Sheet #13, *Conversion of Group Life Insurance.*

WHAT HAPPENS IF I BECOME DISABLED?

A member is eligible for employer-paid long-term disability insurance coverage after one year of participation in the ABP. If a member is totally disabled due to an occupational or nonoccupational condition, the member is eligible to receive a regular monthly income benefit up to 60% of the base salary earned during the 12 months preceding the onset of the disability. This monthly income benefit is offset by any other periodic benefit the member may be receiving, such as Workers' Compensation, short-term disability, or Social Security. In addition, the member's and the employer's mandatory contributions are automatically credited to the member's retirement account while the member is considered disabled. The member becomes eligible for the disability benefit after six consecutive months of total disability. These benefits will be paid as long as the member remains disabled or until the member attains age 70. Should the member begin receiving payments under the retirement annuity, these benefits terminate.

To be considered totally disabled due to sickness or accidental bodily injury, the member must be unable to perform any and every duty pertaining to his/her occupation. The member need not be confined to home, but must be under a doctor's regular care. Eighteen months after the onset of Long-term Disability eligibility, the member must be unable to engage in any gainful occupation for which he/she is reasonably suited by education, training, or experience. Total disability is not considered to exist if the member is gainfully employed, incarcerated, or if the disability resulted from an act of war, or was intentionally self-inflicted.

The following providers are currently approved by the Division of Pensions and Benefits to offer annuity investment accounts for ABP members:

AXA Financial (Equitable)
333 Thornall Street, 8th Floor
Edison, NJ 08837
1-866-752-0072

VOYA Financial Services
581 Main Street, 4th Floor
Woodbridge, NJ 07095
1-877-873-0321

MassMutual (formerly The Hartford)
70 Wood Avenue South, 3rd Floor
Iselin, New Jersey 08830
1-848-248-4405

MetLife (formerly Travelers/CitiStreet)
MetLife Insurance Company of Connecticut
581 Main Street, 6th Floor
Woodbridge, NJ 07095
1-800-545-0108 or
732) 602-0500

Prudential Retirement Services
30 Scranton Office Park
Scranton, PA 18507
1-866-657-3327

Teachers Insurance and Annuity Association/College Retirement Equities Fund (TIAA/CREF)
155Village Blvd, Suite A
Princeton, NJ 08540
1-800-842-8412

VALIC
135 Route 202/206, Suite 13
Bedminster, NJ 07921
(908) 470-4110

This fact sheet has been produced and distributed by:
New Jersey Division of Pensions and Benefits • PO Box 295 • Trenton, New Jersey 08625-0295
(609) 292-7524 • TDD for the hearing impaired (609) 292-7718
URL: http://www.state.nj.us/treasury/pensions • E-mail: pensions.nj@treas.state.nj.us

Making the Most of Your Retirement Plan Opportunities in New Jersey

DESIGNATED SERVICE PROVIDERS COMPARISON GUIDE

State of New Jersey
DIVISION OF PENSIONS AND BENEFITS

JANUARY 2016

Alternate Benefit Program (ABP)
and
Additional Contributions
Tax-Sheltered Program (ACTS)
(PERS and TPAF Employees)

You should consider the investment objectives, risks, and charges and expenses of the variable product and its underlying fund options carefully before investing. The prospectuses/prospectus summaries containing this and other information can be obtained by contacting your local representative. Please read the information carefully before investing.

Variable annuities are intended as long-term investments designed for retirement purposes. Withdrawals from an annuity may be subject to an early withdrawal fee and, if taken prior to age 59½, an IRS 10% premature distribution penalty tax will apply, unless an IRS exception applies. Money taken from the annuity will be taxed as ordinary income in the year the money is distributed. Account values fluctuate with market conditions, and when surrendered the principal may be worth more or less than its original amount invested. An annuity does not provide any additional tax deferral benefit, as tax deferral is provided by the plan. Annuities may be subject to additional fees and expenses to which other tax-qualified funding vehicles may not be subject. However, an annuity does provide other features and benefits, such as lifetime income payments and death benefits, which may be valuable to you.

For 403(b) (1) fixed or variable annuities, employee deferrals (including earnings) may generally be distributed only upon your: attainment of age 59½, severance from employment, death, disability, or hardship. **Note:** Hardship withdrawals are limited to employee deferrals made after 12/31/88. Exceptions to the distribution rules: No Internal Revenue Code withdrawal restrictions apply to '88 cash value (employee deferrals (including earnings) as of 12/31/88) and employer contributions (including earnings). However, employer contributions made to an annuity contract issued after December 31, 2008 may not be paid or made available before a distributable event occurs. Such amounts may be distributed to a participant or if applicable, the beneficiary: upon the participant's severance from employment or upon the occurrence of an event, such as after a fixed number of years, the attainment of a stated age, or disability.

The New Jersey Alternate Benefit Program (ABP) and the Additional Contributions Tax-Sheltered Program (ACTS) are retirement plans that allow you to take an active role in establishing financial goals, evaluating investment options, and monitoring your retirement portfolio. Whether a new participant or one enrolled in the ABP and ACTS for many years, you have a continuing opportunity to manage your financial affairs in the manner you deem best suited for your needs, time horizons, and risk tolerance.

The ABP and ACTS are defined contribution plans that offer opportunities for long term tax-deferred investment. The State of New Jersey has authorized seven Designated Service Providers (DSP) to provide investment options and services in the ABP. Six of the seven DSPs are also authorized to provide investment options and services for the ACTS. By accessing the array of investment options offered in each plan, you have the flexibility to create a retirement investment strategy that accommodates your personal circumstances and goals.

This guide provides an overview of the plans and a brief introduction to the DSPs. You may direct ACTS and ABP contributions to one or more of the DSPs authorized under the appropriate plan. You may also transfer some or all of your existing ACTS account from one ACTS DSP to another authorized DSP under that plan. You may transfer some or all of your existing ABP account among DSPs under that plan only if you are vested in employer contributions (generally after you have received credit in the Retirement Plan for 12 months of service). Other features of the two plans include loans and—at retirement or separation from service—cash distributions and annuity options. The specific provisions, requirements, and restrictions of the ABP and ACTS are detailed on the websites listed below. You should, of course, carefully review this material prior to making any investment decision.

Alternate Benefit Program (ABP):
http://www.state.nj.us/treasury/pensions/abp1.shtml

Additional Contributions Tax-Sheltered Program (ACTS):
http://www.state.nj.us/treasury/pensions/acts.shtml

Eligibility for NJ ABP

The New Jersey Alternate Benefit Program (ABP) is a tax-sheltered, defined contribution retirement program under Section 401a of the Internal Revenue Code. Eligibility is limited to state or county college and state university full-time officers; full-time, part-time, or adjunct faculty; administrative personnel who are required to possess a bachelor's degree or its equivalent as a condition of employment, and certain other state agencies involved with higher education. This includes visiting professors and faculty paid by federal grant. Eligible employees must elect to participate in the ABP in lieu of the Public Employees' Retirement System (PERS). Note: A retiree from any other New Jersey State-administered retirement system is ineligible to participate in the ABP.

The employer contributes 8% of the members' contractual base salary, and members contribute a mandatory 5% of base pay on a pre-tax basis. For purposes of ABP contributions, compensation taken into account is limited to a maximum annual salary dollar amount (currently, $141,000) established under state law.

Eligibility for ACTS

The Additional Contributions Tax Sheltered (ACTS) Program is a 403(b) tax deferred annuity plan. Eligibility is limited to employees of county colleges, state universities and colleges, and eligible employees of The Marie H. Katzenbach School for the Deaf. Through salary reduction agreements, employees are able to contribute on a tax-deferred basis with a variety of DSPs. The six DSPs and investment options under the ACTS are also available to the members of ABP.

Things to Consider

The decisions you make about your participation in the NJ ABP and/or ACTS plan could have a big impact on your financial security later in life – at retirement. It's important that you understand the plans offered, including benefits, features and options, and the fees and other costs that may affect your investment in the program.

- Think about your retirement objectives and how much you may need to save to achieve your goals.
- Determine whether the Public Employees Retirement System (PERS) or the ABP makes sense for you. For a comparison of the two programs, visit: **www.nj.gov/treasury/pensions/epbam/exhibits/pdf/ea0235.pdf.**
- If you are looking to save additional money for your retirement, consider enrolling in the voluntary ACTS program.
- Consider working with a financial representative from one of the DSP to create a long-term financial plan for retirement.

Enroll

To enroll in either the ABP or ACTS, you will need to establish an account with the authorized DSP(s) you select. Please see the contact information in the Designated Service Provider (DSP) Comparison Guide section of this brochure. **Please Note:** The New Jersey ABP selects one DSP as the default provider each year to accept contributions on behalf of plan participants who are employed, but have not completed a DSP Election Allocation form for the ABP.

For ACTS, you must also complete a Salary Reduction Agreement (SRA) and a DSP Election Allocation (DEA) form to make your investment allocations to the DSPs and to authorize the DSPs to receive your tax-d eferred contributions. Please see your Human Resources contact for the SRA and DEA form(s). You may also have to complete an Enrollment Form for each of your selected DSP(s).

ABP/ACTS Designated Service Providers (DSP)

With the ABP and ACTS, you can choose to make contributions to the following DSPs:

AXA Equitable
Voya Retirement Insurance and Annuity Company
Mass Mutual (formerly The Hartford)
MetLife
TIAA-CREF
VALIC
Prudential (for the ABP plan only)

Factors to Consider When Evaluating DSPs

Service: Consider a DSP committed to assisting you both during your working years and after you retire. You may want to look for the following:

- Personal, face-to-face counseling and assistance on planning for retirement and other financial needs
- A toll-free customer service telephone center
- Educational workshops and seminars; newsletters; quarterly and annual statements

- Interactive websites with secure online access for account information, transaction capability and up-to-the-minute market news and reports
- Interactive tools and calculators to help you assess your goals and track your progress

Investment Management Objectives: Since the ABP and ACTS are retirement programs, the emphasis should be on long-term results. Examine the prospectus for each investment option, specifically the types of investments, the objectives and risks involved, and the expenses and fees associated.

Expenses and Fees: Each investment option charges a fee for operational expenses and the cost of managing the investments. DSPs may also have expense charges for certain services such as offering investment advice and processing loans and distribution requests. You can obtain information on fees and expenses from each DSP.

Designated Service Provider (DSP) Comparison

The Designated Service Provider (DSP) Comparison on the following pages provides more information on each company's services, investment options and features.

DESIGNATED SERVICE PROVIDER COMPARISON GUIDE

	VALIC[A1]	AXA Equitable[B1]	Voya Financial® [C1]
CUSTOMER SERVICE CUSTOMER SERVICE			
Customer Service Center	1-800-448-2542	800-628-6673 - Available from 8:00 a.m. to 7:00 p.m. EST (Monday through Thursday) and 8:00 a.m. to 5:00 p.m. EST on Friday.	800-262-3862 Customer Service Associates are available Monday through Friday from 8:00 a.m. to 9:00 p.m. Eastern Time.
SERVICES			
Web-based	www.valic.com/njabp	www.axa.com/nj	NJABP.beready2retire.com
E-mail	nj.abp@valic.com	axa.nj@axa.us.com	Mala.Emera@Voya.com
Voice Response System	1-800-448-2542 1-800-248-2542 (for the hearing impaired)	800-755-7777	800-262-3862
On campus/ worksite representative	Call 1-877-889-1589 or visit www.valic.com/njabp and click on the "Contact Us" link at the top,right corner of the page to set up a personal meeting with your on-campus VALIC financial advisor.	Please call us at 1-866-752-0072 or email us through the website. You can also visit www.axa.com/nj for the list of our representatives by the institution to which they are assigned. Under "Plan Highlights" click on "Learn More" and then click on the tab "Managing Your Account".	Please call our local office in Woodbridge, NJ toll free (877) 873-0321. Our assigned Representatives have scheduled visits on-site at the ABP institutions and are available for face to face meetings. Please call the toll free number to schedule an appointment. Securities offered through Voya Financial Advisors, Inc., member SIPC.
INVESTMENT CHOICES BY ASSET CLASS (INCLUSIVE OF MORTALITY AND EXPENSE AND ANY APPLICABLE ADMINISTRATIVE FEES)			
	The prospectus contains the investment objectives, risks, charges and expenses, and other information about the investment company, which you should consider carefully before investing. Please read the prospectus carefully before investing or sending money. To obtain either a contract or underlying fund prospectuses, visit www.valic.com or call 1-800-428-2542 (press 1, then 3).	Please see the current EQUI-VEST® Vantage℠ ACTS 403(b) Prospectus and ABP 401(a) Program Summary, and any applicable supplements which contains detailed information including risks, charges, expenses, investment objectives, limitations and restrictions. Before purchasing, you should consider whether the features and benefits beyond tax deferral meet your needs and goals. For additional information, please visit www.axa.com/nj or call (866) 752-0072 to speak with a local AXA financial professional.	You should consider the investment objectives, risks, and charges and expenses of the variable product and its underlying fund options carefully before investing. The prospectus/prospectus summaries containing this and other information can be obtained by contacting your local representative. Please read the information carefully before investing.
Minimum Guaranteed Interest Option	The current declared rate is 2.50% with a minimum guarantee of 1.00%. The current rate will be established monthly.	The Guaranteed Interest Option has no M&E or individual fund expense. Lifetime Guaranteed Minimum Interest rate is 1.00% for all contracts issued since Aug. 27, 2012. The current Guaranteed Interest Rate can vary on a monthly basis. Contact an AXA Representative for the current rate or check www.AXA.com/NJ.	Voya Fixed Plus Account II – The current interest rate for Voya Fixed Plus Account II is 3.00%, expressed as an annual effective yield, and is guaranteed not to drop below 3.00% through 12-31-2015. Guarantees are based on the claims-paying ability of Voya Insurance and Annuity Company. Guarantees do not apply to the investment return or principal value of the separate account.
Stable Value Option (with net expense ratio disclosed)	Not Applicable	Not Applicable	Not Applicable
Money Market Fund (with net expense ratio disclosed)	Money Market I Fund 1.11% Money Market II Fund 0.90%	Money Market Fund 1.12%	Voya Money Market Portfolio – Class I 0.34%

DESIGNATED SERVICE PROVIDER COMPARISON GUIDE continued

	MassMutual (formerly The Hartford Retirement Plans Group[D1])	MetLife	TIAA-CREF	Prudential - ABP Members Only
Customer Service Center	800-528-9009 or online at www.massmutual.com/serve	800-543-2520	800-842-8412 or 609-243-6000	1-855-NJABP11 (1-855-652-2711)
SERVICES				
Web-based	www.massmutual.com/serve and for additional retirement planning tools visit www.gittermanwealth.com	www.njabp.metlife.com	http://www.tiaa-cref.org/njabp	www.prudential.com/njabp
E-mail	NJABP@gittermanwealth.com	For a contact list of MetLife Representatives by Campus, please visit: http://www.njabp.metlife.com/Your-Campus-Representative.5.htm	http://www.tiaa-cref.org/njabp Select "Contact Us" in upper right corner and select your campus	RSOfeedback@prudential.com
Voice Response System	800-528-9009	800-543-2520	800-842-2252	1-855-NJABP11 (1-855-652-2711)
On campus/ worksite representative	Non-commissioned Financial Advisors are available for individual consultations on campus or privately in your home. To schedule an appointment, please call 848-248-4405 or email NJABP@gittermanwealth.com.	For a contact list of MetLife Representatives by Campus, please visit: http://www.njabp.metlife.com/Your-Campus-Representative.5.htm	Noncommissioned Financial Consultants are available for face-to-face meetings. Call 800-842-8412 or 609-243-6000 for an appointment.	North Jersey: Lily Lau (732-236-6782) Lily.Lau@prudential.com Central Jersey: Bob Rooyakkers (732-587-8331) robert.rooyakkers@prudential.com South Jersey: Cornell Fields (908-461-9148) cornell.fields@prudential.com
INVESTMENT CHOICES BY ASSET CLASS (INCLUSIVE OF MORTALITY AND EXPENSE AND ANY APPLICABLE ADMINISTRATIVE FEES)				
	You should carefully consider the investment objectives, risks, charges and expenses of the group variable annuities and their underlying funds before investing. This and other information can be found in the prospectus or disclosure documents, where applicable. To obtain the applicable disclosure documents or underlying fund prospectuses call 1-800-528-9009. Read them carefully before you invest or send money.		You should consider the investment objectives, risks, charges and expenses carefully before investing. Please call 877-518-9161 or go to www.tiaa-cref.org for a prospectus that contains this and other information. Please read the prospectus carefully before investing.	Investors should carefully consider a fund's investment objectives, risks, charges and expenses before investing. For more complete information about the mutual funds available through your plan, please call 1-855-NJABP11 (1-855-652-2711) for a free prospectus, and if available the summary prospectus that contains this and other information about our funds. You should read the prospectus and the summary prospectus if available, carefully before investing. It is possible to lose money investing in securities.
Minimum Guaranteed Interest Option		Gold Track Select Registered Fixed Account Option (1.00% Minimum Guaranteed Interest Rate)	TIAA Traditional Principal is always guaranteed. All guarantees are subject to TIAA's claims-paying ability. Your balance in TIAA Traditional earns a total credited rate, which is comprised of a minimum guaranteed rate and, when declared, an additional dividend amount. Any declared additional dividend amount rate remains in effect through the following February. Additional amounts are not guaranteed for future years. Minimum guarantees by contract: 1% to 3% for RC, RCP contracts.	
Stable Value Option (with net expense ratio disclosed)	Hartford General "Fixed Interest" Account (No fee)	Not Applicable	TIAA Stable Value[F8]	The Stable Value Fund is designed to provide plan participants with safety of principal and competitive, stable guaranteed returns. The guaranteed interest rate is declared in advance, is reset quarterly, and is net of the total fee of 0.485%. The third quarter 2015 crediting rate is 2.43%. Principal and accumulated interest are fully guaranteed by the Prudential Insurance Company of America, a Prudential Financial company. The Fund invests in a well-diversified high-quality fixed income portfolio, with daily liquidity for your contributions, transfers and withdrawals.
Money Market Fund (with net expense ratio disclosed)	JP Morgan Prime Money Market Fund Reserve 1.06%	MSF BlackRock Money Market Portfolio 1.15%	CREF Money Market Account R3 0.32% TIAA Access Money Market T1 0.23%	

DESIGNATED SERVICE PROVIDER COMPARISON GUIDE continued

	VALIC	AXA Equitable[B1]	Voya Financial®
INVESTMENT CHOICES BY ASSET CLASS (INCLUSIVE OF MORTALITY AND EXPENSE AND ANY APPLICABLE ADMINISTRATIVE FEES) cont.			
Bonds[1]	Capital Conservation Fund 1.23% Core Bond Fund 1.12% Government Securities Fund 1.24% High Yield Bond Fund 1.31% Inflation Protected Fund 1.18% International Government Bond Fund 1.25% Strategic Bond Fund 1.23% SunAmerica 2020 High Watermark Fund 2.03% Vanguard Long-Term Investment Grade Fund 0.82% Vanguard Long-Term Treasury Fund 0.80%	EQ/Core Bond Index 1.11%[B4] Multimanager Core Bond 1.42%[B4]	Voya U.S. Bond Index Portfolio - I 0.86% Voya Intermediate Bond Portfolio - Class I 0.95% VY Pioneer High Yield Portfolio - Initial Class 1.17%
Asset Allocation[2]	Aggressive Growth Lifestyle Fund 1.20% Asset Allocation Fund 1.30% Conservative Growth Lifestyle Fund 1.22% Dynamic Allocation Fund 1.52% Moderate Growth Lifestyle Fund 1.20% Vanguard LifeStrategy Conservative Growth 1.00% Vanguard LifeStrategy Growth Fund 1.02% Vanguard LifeStrategy Moderate Growth Fund 1.01%	AXA Moderate Allocation 1.54%[B5]	Voya Solution Income Portfolio - Service Class 1.39%[C4] Voya Solution 2015 Portfolio - Service Class 1.43%[C4] Voya Solution 2025 Portfolio - Service Class 1.51%[C4] Voya Solution 2035 Portfolio - Service Class 1.57%[C4] Voya Solution 2045 Portfolio - Service Class 1.59%[C4] Voya Solution 2055 Portfolio - Service Class 1.59%[C4]
Balanced[3]	Vanguard Wellington Fund, Investor Shares 1.11%	AXA/Frnkln Balanced Managed Vol 1.44%	Voya Balanced Portfolio - Class I 1.11%
Large Cap Value[4]	Broad Cap Value Income Fund 1.45% Core Equity Fund 1.40% Dividend Value Fund 1.42% Large Cap Value Fund 1.16% Value Fund 1.45% Vanguard Windsor II Fund, Investor Shares 1.21%	EQ/JPMorgan Value Opportunities 1.40%[B6] AXA Lg Cap Val Managed Vol 1.26%[B6]	VY T. Rowe Price Equity Income Portfolio - Service Class 1.35% American Funds Washington Mutual Investors Fund[SM] - R-4 1.10% Fidelity VIP Contrafund - Initial Class 1.09%
Large Cap Blend[5]	Growth & Income Fund 1.45% Socially Responsible Fund 0.91% Stock Index Fund 0.94%	EQ/Common Stock Index 1.12% EQ/Equity 500 Index 1.02%	Voya U.S. Stock Index Portfolio - Inst 0.72%
Large Cap Growth[6]	American Beacon Holland Large Cap Growth Fund 1.76% Blue Chip Growth Fund 1.43% Capital Appreciation Fund 1.20% Growth Fund 1.40% Large Cap Core Fund 1.43% Large Capital Growth Fund 1.35% NASDAQ-100 Index Fund 1.13%	EQ/Calvert Socially Responsible 1.37% EQ/T. Rowe Price Growth Stock 1.50% AXA/Loomis Sayles Growth 1.55%	VY T. Rowe Price Growth Equity Portfolio - Initial Class 1.18%
Small/Mid/ Specialty[4]	Ariel Appreciation Fund 1.72% Ariel Fund 1.63% Health Sciences Fund 1.65% Invesco Balanced-Risk Commodity Strategy Fund 1.79% Mid Cap Growth Fund 1.20% Mid Cap Index Fund 0.96% Mid Cap Strategic Growth Fund 1.41% Mid Cap Value Fund 1.40% Science & Technology Fund 1.58% Small Cap Aggressive Growth Fund 1.59% Small Cap Fund 1.53% Small Cap Growth Fund 1.51% Small Cap Index Fund 1.00% Small Cap Special Values Fund 1.47% Small Cap Value Fund 1.30% Small-Mid Growth Fund 1.60%	EQ/Small Company Index 1.11% Multimanager Mid Cap Value 1.63% AXA 400 Managed Vol 1.28% EQ/GAMCO Small Company Value 1.48% EQ/Mid Cap Index 1.12% EQ/Morgan Stanley Mid Cap Growth 1.47% Ivy Funds VIP Energy 1.58% MFS® Utilities 1.44%	ASTON/Fairpointe Mid Cap Fund-Class N 1.57% Voya Russell™ Mid Cap Index Portfolio - I 0.89% Voya Index Plus MidCap Portfolio - Class I 0.95% Voya Russell™ Small Cap Index Portfolio - I 0.91% Oppenheimer Main Street Small- & Mid-Cap Fund/VA 1.25% VY American Century Small-Mid Cap Value Portfolio - Service 1.64%

DESIGNATED SERVICE PROVIDER COMPARISON GUIDE continued

	MassMutual (formerly The Hartford)	MetLife	TIAA-CREF	Prudential - ABP Members Only
INVESTMENT CHOICES BY ASSET CLASS (INCLUSIVE OF MORTALITY AND EXPENSE AND ANY APPLICABLE ADMINISTRATIVE FEES) cont.				
Bonds[1]	Dreyfus Bond Market Index 0.76% Loomis Sayles Bond Admin 1.55% JP Morgan Core Bond Fund 1.11% Templeton Global Bond 1.26%	Western Asset Management U.S. Government Portfolio 1.28% Barclays Aggregate Bond Index Portfolio 1.08% BlackRock Bond Income Portfolio 1.15% PIMCO Total Return Portfolio 1.52% Pioneer Strategic Income Portfolio 1.42% PIMCO Inflation Protected Bond Portfolio 1.35% Black Rock High Yield Portfolio 1.56% Lord Abbett Bond Debenture Portfolio 1.34% Western Asset Core Plus VIT Portfolio 1.65%	CREF Bond Market Account R3 0.37%[F9] CREF Inflation-Linked Bond Account R3 0.32%[F9] TIAA Access Bond Index T1 0.22%	Core Bond Enhanced Index/PIM Fund 0.25% Core Plus Bond/PIM Fund 0.51%
Asset Allocation[2]	RetireSMART 2015 1.45% RetireSMART 2025 1.45% RetireSMART 2035 1.51% RetireSMART 2045 1.50% RetireSMART In-Retirement 1.42%	American Funds® Balanced Allocation Portfolio 1.83% American Funds® Growth Allocation Portfolio 1.85% American Funds® Moderate Allocation Portfolio 1.82% MetLife Asset Allocation 100 Portfolio 1.81% MetLife Asset Allocation 20 Portfolio 1.67% MetLife Asset Allocation 40 Portfolio 1.67% MetLife Asset Allocation 60 Portfolio 1.70% MetLife Asset Allocation 80 Allocation Portfolio 1.76%	TIAA Access Lifecycle 2010 T1 0.49% TIAA Access Lifecycle 2015 T1 0.50% TIAA Access Lifecycle 2020 T1 0.51% TIAA Access Lifecycle 2025 T1 0.53% TIAA Access Lifecycle 2030 T1 0.54% TIAA Access Lifecycle 2035 T1 0.55% TIAA Access Lifecycle 2040 T1 0.56% TIAA Access Lifecycle 2045 T1 0.56% TIAA Access Lifecycle 2050 T1 0.56% TIAA Access Lifecycle 2055 T1 0.56% TIAA Access Lifecycle Retirement Income T1 0.48%	GoalMaker Portfolios*: Conservative C01: 0 -5 years, C02: 6-10 years, C03: 11-15 years, C04: 16 plus years Moderate M01: 0 -5 years, M02: 6-10 years, M03: 11-15 years, M04: 16 plus years Aggressive R01: 0 -5 years, R02: 6-10 years, R03: 11-15 years, R04: 16 plus years * The portfolios are based on generally accepted investment practices and take into account the principles of modern portfolio theory, in which allocations are adjusted in an effort to achieve maximum returns for a given level of risk. You may want to consider other assets, income and investments you may have before applying these models to your individual situation. The GoalMaker portfolios are subject to change including, for example, the replacement of investment options and adjustments in the allocations within the portfolios.
Balanced[3]		WMC Balanced Portfolio 1.33% 1919 Variable Socially Responsive Balanced Fund 1.69% MFS® Total Return Portfolio 1.60%	CREF Social Choice Account R3 0.33%[F2, F9]	Prudential IncomeFlex Target Balanced Fund 1.37% PIMCO All Asset Instl Fund[G2] 0.88% Vanguard Wellesley Income Fund Admiral Shares 0.26%
Large Cap Value[4]	American Century Equity-Income 1.54%	BlackRock Large Cap Value Portfolio 1.67% ClearBridge Variable Dividend Strategy Portfolio 1.61% WMC Core Equity Opportunities Portfolio 1.42% Invesco Comstock Portfolio 1.61% MFS® Value Portfolio 1.38% Pioneer Fund Portfolio 1.47% T. Rowe Price Large Cap Value Portfolio 1.54%	TIAA Access Large-Cap Value Index T1 0.16%	Large Cap Value/LSV Asset Management Fund 0.60%
Large Cap Blend[5]	Domini Social Equity 1.61% Dreyfus S&P 500 Index 0.86%	American Funds® Growth-Income Fund 1.34% WMC Large Cap Research Portfolio 1.50% ClearBridge Variable Appreciation Portfolio 1.54% Fidelity® Contrafund® Portfolio 1.68% MetLife Stock Index Portfolio 1.06%	CREF Stock Account R3 0.37%[F9] CREF Equity Index Account R3 0.29%[F9] TIAA Access S&P 500 Index T1 0.16%	QMA Large Cap Quantitative Core Equity Fund 0.65% Vanguard Institutional Index Fund I 0.12%
Large Cap Growth[6]	Franklin Growth 1.31%	American Funds® Growth Fund 1.40% BlackRock Capital Appreciation Portfolio 1.45% ClearBridge Aggressive Growth Portfolio 1.36% ClearBridge Variable Large Cap Growth Portfolio 1.65% Jennison Growth Portfolio 1.34% T. Rowe Price Large Cap Growth Portfolio 1.66%	CREF Growth Account R3 0.32%[F9] TIAA Access - T. Rowe Institutional Large Cap Growth T1 0.66% TIAA Access Large-Cap Growth Index T1 0.16%	Calvert Equity I 0.66%[G2] Fidelity Contrafund 0.64% Polen Capital Large Cap Growth Fund 0.64%
Small/Mid/ Specialty[4]	Dreyfus Midcap Index 0.86% Lord Abbett Value Opportunities 1.66% Victory Established Value 1.41% Dreyfus Small Cap Stock Index 0.86% Goldman Sachs Small Cap Value 1.79% Invesco Small Cap Equity 1.69% MFS New Discovery 1.74% Prudential Jennison Natural Resources Fund 1.54%	Delaware VIP® Small Cap Value Series 1.60% JPMorgan Small Cap Value Portfolio 1.55% Neuberger Berman Genesis Portfolio 1.63% MetLife Small Cap Value Portfolio 1.81% Russell 2000® Index Portfolio 1.16% ClearBridge Variable Small Cap Growth Portfolio 1.62% Invesco Small Cap Growth Portfolio 1.66% T. Rowe Price Small Cap Growth Portfolio 1.56% Invesco Mid Cap Value Portfolio 1.76% MetLife Mid Cap Stock Index Portfolio 1.41% Fidelity® VIP Mid Cap Portfolio 1.68% Frontier Mid Cap Growth Portfolio 1.65% Janus Aspen Enterprise Portfolio 1.73% Clarion Global Real Estate Portfolio 1.44%	TIAA Access Small-Cap Blend Index T1 0.23%[F7] TIAA Access - Vanguard Selected Value T1 0.54% TIAA Real Estate Account 0.87% [F4, F9]	QMA Mid Cap Quantitative Core Equity Fund 0.55% Small Cap Growth/RBC Fund 0.89% Small Cap Value/TBC AM Fund 0.94%

	VALIC	AXA Equitable[B1]	Voya Financial®
INVESTMENT CHOICES BY ASSET CLASS (INCLUSIVE OF MORTALITY AND EXPENSE AND ANY APPLICABLE ADMINISTRATIVE FEES) cont.			
Global International[4]	Emerging Economies Fund 1.54% Foreign Value Fund 1.39% Global Real Estate Fund 1.45% Global Social Awareness Fund 1.22% Global Strategy Fund 1.24% International Equities Index Fund 1.04% International Growth Fund 1.61% International Opportunities Fund 1.35%	EQ/International Equity Index 1.19%[B7] AXA Int Val Managed Vol 1.42%[B6, B7] EQ/MFS International Growth 1.63%[B7] AXA Int Core Managed Vol 1.46%	Voya International Index Portfolio - I 0.96% American Funds EuroPacific Growth Fund-Class R-4 1.30% Voya International Value Portfolio - Class I 1.40%
Others		Target 2015 Allocation 1.61%[B5] Target 2025 Allocation 1.57%[B5] Target 2035 Allocation 1.55%[B5] Target 2045 Allocation 1.54%[B5] EQ/Money Market 1.12%[B8] **Structured Investment Options** S&P 500 Price Return Index 0.00%[B9] 1 Year — 10% Segment Buffer Growth Potential with Some Downside Protection There is no additional fee for the SIO. However, prior to being invested in a Segment, funds will remain in a Segment Holding Account which is invested in the EQ/Money Market variable investment option and will be subject to the separate account charge (M&E). These fees will be waived to the extent necessary to avoid causing a negative return while in the Segment Holding Account. However, if the return on the Money Market is negative without these fees being deducted, the participant will receive the negative return. Once invested in a Segment, the separate account charge will no longer be applied.[B10] Please refer to the sample fee disclosures for more information.	Not Applicable
TRANSFERRING FUNDS WITHIN DESIGNATED SERVICE PROVIDER OPTIONS			
Restrictions and charges (other restrictions may apply, see prospectuses for details)	Fixed-Interest Option: Limited to 20% per year (applies only to Fixed Account Plus) From Variable Investment Options: None	None[B13]	Limited to 20% for any 12 month period (Voya Fixed Plus Account II). 100% transfer option for de minimus account balances. From Variable: None. However, the annuity contract(s) is not designed to serve as a vehicle for frequent trading in response to short-term fluctuations in the market.
TRANSFERRING FUNDS AMONG DESIGNATED SERVICE PROVIDERS WHILE EMPLOYED			
Restrictions and charges (other restrictions may apply, see prospectuses for details)	Fixed-Interest Option: Limited to 20% per year (applies only to Fixed Account Plus) From Variable Investment Options: None	None[B13]	Limited to 20% for any 12 month period (Voya Fixed Plus Account II). 100% transfer option for de minimus account balances. From Variable: None. None. However, the annuity contract(s) is not designed to serve as a vehicle for frequent trading in response to short-term fluctuations in the market.

DESIGNATED SERVICE PROVIDER COMPARISON GUIDE continued

	MassMutual (formerly The Hartford)	MetLife	TIAA-CREF	Prudential - ABP Members Only
INVESTMENT CHOICES BY ASSET CLASS (INCLUSIVE OF MORTALITY AND EXPENSE AND ANY APPLICABLE ADMINISTRATIVE FEES) cont.				
Global International[4]	American Funds EuroPacific Growth 1.49% Invesco Devel Mrkts 1.80% MFS International Value 1.49% Oppenheimer International Growth 1.53%	Harris Oakmark International Portfolio 1.61% MFS® Research International Portfolio 1.75% MSCI EAFE® Index Portfolio 1.21% Templeton Foreign VIP Fund 1.82% MFS® Emerging Markets Equity Portfolio 1.79% Templeton Developing Markets VIP Fund 2.41% American Funds Global Growth Fund 1.60% Oppenheimer Global Equity Portfolio 1.73%	CREF Global Equities Account R3 0.38%[F3, F9] TIAA Access - American Funds EuroPacific Growth R-5 T1 0.63% TIAA Access International Equity Index T1 0.16%[F7]	Dodge & Cox International Fund 0.64% International Blend/Lazard Fund 0.86% Oppenheimer Developing Markets Fund Y[G2] 1.07%
Others		MetLife Multi-Index Targeted Risk Portfolio 1.48% Pyramis® Managed Risk Portfolio 2.02%		
TRANSFERRING FUNDS WITHIN DESIGNATED SERVICE PROVIDER OPTIONS				
Restrictions and charges (other restrictions may apply, see prospectuses for details)	Participants may transfer the values of their account accumulations among the available investment choices and/or make allocation changes without restriction as to frequency (daily). However, the direct transfer of assets held in the Stable Value option (Hartford General "Fixed Interest" Account) to the Money Market Account (or vice versa), or to any other specified competing investment option, are prohibited unless such assets are first transferred into another available investment option for at least 90 days.	Additionally, a 90 day equity wash provision exists for transfers back into the fixed account. Transfers between the fixed account and any competing fund are prohibited.	Under the ABP 403(b) and ACTS 403(b) plans: - All investment accounts, including TIAA Traditional, are fully transferable between DSP's. - There are no charges for this service. Under the ABP 401(a) plan: - From TIAA Traditional: For current contracts limited to 84 monthly payments.[F10] - From TIAA Real Estate: Transfers may be made once per calendar quarter. - From Variable Accounts: None -There are no charges for this service.	You may transfer funds among available investment options at any time. Other restrictions may apply to the Prudential IncomeFlex Target Balanced Fund. Please see the IncomeFlex Target Balanced Fund Important Considerations document for additional details. The Stable Value Fund does not have any liquidity restrictions.
TRANSFERRING FUNDS AMONG DESIGNATED SERVICE PROVIDERS WHILE EMPLOYED				
Restrictions and charges (other restrictions may apply, see prospectuses for details)	Not Applicable. MassMutual imposes no surrender charges for transfers among the Designated Service Providers or upon separation from service.	Not Applicable	Under the ABP 403(b) and ACTS 403(b) plans: > All investment accounts, including TIAA Traditional, are fully transferable between DSP's. > There are no charges for this service. Under the ABP 401(a) plan: > From TIAA Traditional: For current contracts limited to 84 monthly payments. [F10] > From TIAA Real Estate: Transfers may be made once per calendar quarter. > From Variable Accounts: None > There are no charges for this service.	Prudential Retirement imposes no restrictions regarding transfers among Designated Service Providers. If you are invested in the Prudential IncomeFlex Target Balanced Fund please see the Important Considerations document for additional details. The Stable Value Fund does not have any liquidity restrictions.

	VALIC	AXA Equitable[B1]	Voya Financial®
SURRENDER OR WITHDRAWAL UPON RETIREMENT OR SEVERENCE FROM EMPLOYMENT			
Restrictions and charges (other restrictions may apply, see prospectuses for details)	None	None[B13]	Voya Fixed Plus Account II restrictions are waived due to death, severance from employment, financial hardship, purchase of annuity benefits or de minimus account balances. From Variable: None
INCOME OPTIONS			
Cash Withdrawals	Yes	Subject to plan restrictions	Subject to plan restrictions
Systematic Withdrawals	Yes	Subject to plan restrictions	Subject to plan restrictions
Interest-only payments	Yes, Fixed-Interest Option only	Yes	No
Minimum distribution	Yes	Yes	Yes
Fixed period payments	Yes	Yes	Yes
Single Life Annuity	Yes	Yes	Yes
Joint Survivor Annuities	Yes	Yes	Yes
Guaranteed Periods	Yes; Guaranteed period of 5, 10, 15, 20 years	Yes; 5, 10, 15 or 20 years	Yes; 5, 10, 15, 20 years
Fixed and variable income	Yes	Yes	Yes
LOAN PROVISIONS			
Available (check with DSPs for specific fees)	Yes	Yes	Yes Please note: loans will reduce your account balance, may impact your withdrawal value and limit participation in future growth potential. Other restrictions may apply.
GUARANTEED DEATH BENEFIT			
Guaranteed Death Benefit	Provides a guaranteed death benefit to your beneficiary. The guarantee states that your beneficiary will never receive less than the amount you have contributed to fixed and variable options, provided no withdrawals have been made from the account. Withdrawals will reduce your death benefit, depending on your account value at the time of withdrawal. These provisions may vary by state and contract. See your prospectus for details. All guarantees are backed by the claims paying ability of The Variable Life Insurance Company. The death benefit passes directly to your beneficiary, generally avoiding the costs and delays of probate. Depending on the circumstances, your beneficiary can leave all or a portion of the account balance on deposit. Generally, your beneficiary can make withdrawals at any time without charges. Federal law may require distributions within certain time frames.	Yes. Beneficiary will receive greater of 1) the account value less any outstanding loan balance plus accrued interest as of the date we receive satisfactory proof of the participant's death, any required instructions for the method of payment, information and forms necessary to effect payment or 2) the standard death benefit (total contributions less withdrawals on a pro rata basis or dollar for dollar) less any outstanding loan balance plus accrued interest.	Yes Guarantees are based on the claims-paying ability of Voya Retirement Insurance and Annuity Company. Guarantees do not apply to the investment return or principal value of the separate account.

DESIGNATED SERVICE PROVIDER COMPARISON GUIDE continued

	MassMutual (formerly The Hartford)	MetLife	TIAA-CREF	Prudential - ABP Members Only
SURRENDER OR WITHDRAWAL UPON RETIREMENT OR SEVERENCE FROM EMPLOYMENT				
Restrictions and charges (other restrictions may apply, see prospectuses for details)	Not Applicable	Not Applicable	There are no charges for withdrawals or surrenders from any account under RA, GSRA, RCP and TIAA Stable Value. For the ABP 401(a) Plan (RC contracts): There are no charges for withdrawals from TIAA Real Estate, CREF accounts, TIAA Access or TIAA Stable Value accounts. For the TIAA Traditional, there are no charges while using the 84 month transfer payout option. A lump sum payout option is available within 120 days of terminating employment, subject to a 2.5% surrender charge. [F11] There are no charges for other types of withdrawals from TIAA Traditional.	Prudential Retirement imposes no restrictions regarding surrender or withdrawal upon retirement or severance from employment. If you are invested in the Prudential IncomeFlex Target Balanced Fund please see the Important Considerations document for details. The Stable Value Fund does not have any liquidity restrictions.
INCOME OPTIONS				
Cash Withdrawals	Available, subject to Plan provisions.	Withdrawals may be made at any time so long as a participant has a triggering event that makes them eligible for a withdrawal.	Available; subject to plan rules [F5]	Available; subject to Plan Provisions
Systematic Withdrawals	Systematic withdrawals are available on a monthly, quarterly, semi-annual or annual basis.	Systematic withdrawals are available on: monthly, quarterly, semi-annual, or annual basis. Systematic withdrawals are available on: monthly, quarterly, semi-annual, or annual basis.	Available; subject to plan rules [F5]	Yes
Interest-only payments	Not Applicable	Not Applicable	Yes	No
Minimum distribution	Available	RDM program is available	Yes	Yes
Fixed period payments	Available	Available	Available; subject to plan rules [F5, F6]	Yes
Single Life Annuity	Available	Available	Yes	Yes
Joint Survivor Annuities	Available	Available	Yes	Yes
Guaranteed Periods	Available	Available	Yes; 10, 15, 20 year terms	Yes
Fixed and variable income	Available	Available	Yes. [F5, F6]	Yes
LOAN PROVISIONS				
Available (check with DSPs for specific fees)	Available	If permitted by plan	Yes	Yes
GUARANTEED DEATH BENEFIT				
Guaranteed Death Benefit	Return of account value	Before Age 75: greater of adjusted purchase payments or account value. After age 75: account value	> Contract in the accumulation phase or non-Lifetime Income Payout stage are 100% transferrable to beneficiaries at current contract value. > Contracts in Lifetime Payout that have chosen either a 10, 15 or 20 year beneficiary provision will have guaranteed payments continue to beneficiaries for the remainder of the chosen period minus elapsed time since payments were initiated.	No

[1] Bond Funds: Investing in bonds entails credit risk and interest rate risk. Credit risk is the risk of loss of principal and/or interest stemming from a borrower's failure to repay a loan or otherwise meet a contractual obligation. Interest rate risk is the risk that an investment's value will change due to a change in interest rates.

[2] Target Date Funds: sometimes called lifecycle funds, are funds of funds that change their investments over time to meet goals you plan to reach at a specific time, such as retirement. Typically, target-date funds are sold by date, such as a 2025 fund. The farther away the date is, the greater the risks the fund usually takes. As the target date approaches, the fund changes its balance of investments to emphasize conserving the value it has built up and to shift toward income-producing investments.

[3] Balanced Category: funds investing in stocks and bonds to provide both income and growth.

[4] Value Category: funds that primarily holds stocks that are deemed to be undervalued in price and that are likely to pay dividends.

[5] Blend Category: funds with portfolios that are made up of a mix of value and growth stocks.

[6] Growth Category: funds whose aim is to achieve capital appreciation by investing in growth stocks.

VALIC

[A1] Annuity contracts are issued by The Variable Annuity Life Insurance Company. Variable contracts distributed by its affiliate, AIG Capital Serivces, Inc., member FINRA.

[A2] An investment in money market funds is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. Although the funds seek to preserve the value of your investment at $1.00 per share, it is possible to lose money by investing in the funds.

For the last fiscal year, VALIC voluntarily waived fees or reimbursed expenses for the Money Market I Fund in the amout of 0.31% which resulted in Net Fund Expenses of 0.21%, and for the Money Money Market II Fund in the amount of 0.35% which resulted I net Fund Expenses of 0.20%. The waivers and/or reimbursements are voluntarily and may be discontinued at any time by VALIC.

[A3] The fund expenses and fees noted on the comparison guide for VALIC are as of February 2014, and are subject to change. In order to confirm current fund expenses and fees, you may obtain fund prospectuses by visiting www.valic.com or by calling 1-800-428-2542 (press 1, then 3).

Pursuant to an Expense Limitation Agreement, the fund advisor will waive fees and reimbursement expenses as shown in the column above. The expense waivers and fee reimbursements are voluntary and contractual and will continue through September 30, 2014 for VALIC Company I funds; December 31, 2014 for VALIC Company II funds; April 30, 2014 for American Beacon Holland Large Cap Growth Fund; June 30, 2014 for Invesco Balanced-Risk Commodity Strategy Fund; and indefinitely for SunAmerica High Watermark Funds.

The fund company may limit the number of trades in and out of the fund. Please see the individual prospectus for more information.

Annuity contracts typically include limitations, exclusions and expense charges which are described in the current Portfolio Director prospectus. Fees include Separate Account fees, which range from 0.35% to 0.85% depending on the contract, and Annual Net Fund Expenses, which range from 0.15% to 1.28% for the variable options. The current Annual Net Fund Expense is the current Annual Total Fund Expense less contractual expense waivers or reimbursements. Fees are subject to change based on expense waivers and reimbursements.

AXA Equitable

[B1] The EQUI-VEST Vantage variable annuity is issued by AXA Equitable Life Insurance Company (NY, NY) and is distributed by an affilate, AXA Advisors, LLC. Contract form #s:2012-TSAGAC 403(b) and 2012GAC-401(a).

[B2] AXA Equitable reserves the right to not permit transfers into the Guaranteed Interest Option in the first participation year. Guarantees are based on the claims-paying ability of AXA Equitable Life Insurance Company.

[B3] Fixed Maturity Options (FMOs) are available for single sum transfers or rollover contributions only. These are offered with maturity dates generally ranging from one to 10 years, each offering a guaranteed interest rate when held to maturity. Withdrawals and transfers from FMOs prior to maturity will result in a market value adjustment, which may increase or decrease your account value in the affected FMOs.

[B4] Bond investments are subject to interest rate risk so that when interest rates rise, the prices of bonds can decrease and the investor can lose principal value.

[B5] You will incur higher costs with this portfolio than if you were to invest directly in the underlying portfolios. However, not all of the underlying portfolios may be available as investment options in your contract. An investor investing directly in the underlying portfolios would not receive the asset allocation and rebalancing services provided by AXA Equitable Funds Management Group, LLC. An investment in Target Date Allocation portfolios is not guaranteed and it is possible to lose money, including at or after the target date.

[B6] Investing in value stocks is based upon a portfolio's manager subjective assessment of fundamentals of the companies he believes are undervalued. This style of investing may increase the volatility of the portfolio and may not produce the intended results over short or long time periods. Larger, more established companies may not be able to attain higher growth rates of smaller companies, especially during extended periods of economic expansion.

[B7] International securities carry additional risks including currency exchange fluctuation and different government regulations, economic conditions or accounting standards.

[B8] An investment in the EQ/Money Market Portfolio is neither guaranteed nor insured by the U.S. government, the Federal Deposit Insurance Corporation or any other government agency. Although the portfolio seeks to preserve the value of your investment at $1.00 per unit, it is possible to lose money by investing in the portfolio.

[B9] The S&P Price Return Index comprises 500 of the largest companies in leading industries of the U.S. economy. Larger, more established companies may not be able to attain potentially higher growth rates of smaller companies, especially during extended periods of economic expansion. Standard & Poor's®, S&P 500® and Standard & Poor's 500™ are trademarks of Standard & Poor's Financial Services, LLC, ("Standard & Poor's"). The Structured Investment Option is not sponsored, endorsed, sold or promoted by Standard & Poor's and Standard & Poor's does not make any representation regarding the advisability of investing in the Structured Investment Option.

[B10] The Structured Investment Option tracks the S&P 500 Price Return Index so if the index goes up at the end of the Segment's investment period (which lasts one year), amounts in the Segment earn the same rate of return as the Index up to the Segment's "Performance Cap Rate." If the S&P 500 Price Return Index goes down at the end of the Segment's investment period, a -10% Segment Buffer protects against the first 10% of losses. While you are protected from some downside risk, if the negative return is in excess of the Segment Buffer, there is risk of substantial loss of principal. AXA Equitable may, upon advanced notice, discontinue, suspend, or change Segment offerings. The Structured Investment Option prospectus contains more information on Segment offering limitations and restrictions. The Structured Investment Option does not involve an investment in any underlying portfolio. Instead, it is an obligation of, and subject to, the claims-paying ability of AXA Equitable Life Insurance Company.

[B11] Fees and expenses are current as of 5/1/15 and include any fee waivers and/or expense reimbursements. To see "gross" fees and expenses which do not reflect fee waivers or expense reimbursements, please see the prospectus.

[B12] The Guaranteed Interest Option has no M&E or individual fund expense.

[B13] If transfer restrictions were to be enforced, AXA Equitable will notify you at least 45 days in advance.

Voya

[C1] Insurance products, annuities and funding agreements are issued by Voya Retirement Insurance and Annuity Company ("VRIAC"), Windsor, CT. VRIAC is solely responsible for its own financial condition and contractual obligations. Plan administrative services provided by VRIAC or Voya Institutional Plan Services LLC ("VIPS"). VIPS does not engage in the sale or solicitation of securities. All companies are members of the Voya® family of companies. **Securities distributed by Voya Financial Partners LLC (member SIPC) or third parties with which it has a selling agreement**. All products and services may not be available in all states.

[C2] The current rate for the Voya Fixed Plus Account II is 3.00%, expressed as an annual effective yield, and is guaranteed not to drop below 3.00% through 12/31/2016.

[C3] An investment in a money market fund is not insured or guaranteed by the Federal Deposit Insurance Corporation or any other government agency. Although the fund seeks to preserve the value of your investment at $1.00 per share, there is no assurance it will be able to do so. While the fund's objective includes the preservation of capital, it is possible to lose money by investing in the fund.

[C4] There is no guarantee that any investment option will achieve its stated objective. Principal value fluctuates and there is no guarantee of value at any time, including the target date. The "target date" is the approximate date when you plan to start withdrawing your money. When your target date is reached, you may have more or less than the original amount invested. For each target date Portfolio, until the day prior to its Target Date, the Portfolio will seek to provide total returns consistent with an asset allocation targeted for an investor who is retiring in approximately each Portfolio's designation Target Year. Prior to choosing a Target Date Portfolio, investors are strongly encouraged to review and understand the Portfolio's objectives and its composition of stocks and bonds, and how the asset allocation will change over time as the target date nears. No two investors are alike and one should not assume that just because they intend to retire in the year corresponding to the Target Date that that specific Portfolio is appropriate and suitable to their risk tolerance. It is recommended that an investor consider carefully the possibility of capital loss in each of the target date Portfolios, the likelihood and magnitude of which will be dependent upon the Portfolio's asset allocation. On the Target Date, the portfolio will seek to provide a combination of total return and stability of principal. Stocks are more volatile than bonds, and portfolios with a higher concentration of stocks are more likely to experience greater fluctuations in value than portfolios with a higher concentration in bonds. Foreign stocks and small and midcap stocks may be more volatile than large cap stocks. Investing in bonds also entails credit risk and interest rate risk. Generally investors with longer timeframes can consider assuming more risk in their investment portfolio. The Voya Index Solution Portfolios℠ are actively managed and the asset allocation adjusted over time. The portfolios may merge with or change to other portfolios over time. Refer to the prospectus for more information about the specific risks of investing in the various asset classes included in the Voya Index Solution Portfolios.

Mass Mutual

[D1] Effective January 1, 2013, Massachusetts Mutual Life Insurance Company ("MassMutual") acquired The Hartford's Retirement Plans Group ("RPG") business. MassMutual has no affiliation, and the RPG business no longer has any affiliation, with The Hartford Financial Services Group, Inc. or any of its subsidiaries. MassMutual has been appointed by Hartford Life Insurance Company ("HLIC") to provide all administrative services necessary to support the insurance contracts issue by HLIC in connection with the RPG business.

[†] These are the Total Annual Fund Operating Expenses for each underlying fund as of its most recent prospectus. Total Annual Fund Operating Expenses are the expenses that are deducted from fund assets, including management fees, Rule 12b-1 distribution and/or service fees, and other expenses. Actual fees and expenses for the underlying funds vary daily. As a result, the fees and expenses for any given day may be greater or less than the Total Annual Fund Operating Expenses listed above in the table. The column under "Gross" lists each underlying fund's Total Annual Fund Operating Expenses before any fee waivers or reimbursements. The column under "Net" represents each underlying fund's Total Annual Fund Operating Expenses after any fee waivers or reimbursements. More detail concerning each underlying fund's fees and expenses is contained in the prospectus for each fund.

[††] We deduct the mortality, expense risk and administrative charge from the assets of the Separate Account on a daily basis at the annual rate shown above. If the mortality, expense risk and administrative charge under a Contract is insufficient to cover actual costs incurred by us, we will bear the loss. If the mortality, expense risk and administrative charge exceeds these costs, we will keep the excess as profit. We may use these profits, as well as fees and payments received from the fund families, for any proper corporate purpose, including, among other things, payment of sales expenses, including our expenses of paying compensation to broker-dealers, financial institutions and other persons for selling the Contracts. We expect to make a profit from the mortality, expense risk and administrative charge.

[†††] We receive these fees and payments with respect to the Funds that are offered as variable investment options to your plan through your Contract (sometimes referred to generally as "revenue sharing" payments). We consider these fees and payments, among a number of other factors, when deciding to include a Fund in the Investment Option Menus. Virtually all of the Funds on the Investment Option Menus make these payments to us and/or our affiliates. For more information about these fees and payments please refer to our Disclosure Statement - Reasonable Contract or Arrangement under ERISA Section 408(b)(2).

MetLife

[E1] The net expense ratio is less applicable fee waivers or expense reimbursements the investment adviser and/or administrator may have agreed upon, either voluntary or by contractual agreement; the gross expense ratio is not. Fee waivers and reimbursements may be modified or terminated at any time. Additional information can be found in the Fund's prospectus and/or other disclosure documents regarding effective dates and/or if waivers or reimbursements are voluntary or by contractual agreement. Absent waivers or reimbursements, the performance would have been lower.

TIAA-CREF

[F1] As with all the TIAA-CREF Variable Annuity accounts, the funds you invest in the CREF Money Market Account are neither insured nor guaranteed by the FDIC or any other U.S. Government agency.

[F2] Because its social criteria excludes some investments, the fund may not be able to take advantage of the same opportunities or market trends as do funds that do not use such criteria.

[F3] There are special risks associated with international investing, including erratic market conditions, economic and political instability, and fluctuations in currency exchange rates.

[F4] Not available in California. The real estate industry is subject to various risks, including potential environmental problems and liability.

[F5] Federal tax penalties may apply for early withdrawals. Under RAs, GRAs, and RCs, availability is subject to the provisions of your institution's plan.

[F6] Fixed Period payments may be available subject to federal tax law and/or your institution's rules. Payment periods for TIAA Traditional under GRAs are from 5 to 30 years; and for CREF variable annuity accounts, TIAA Access variable annuity accounts and TIAA Real Estate account, from 2 to 30 years. Not available in RC.

[F7] Shares held less than 60 calendar days may be subject to a 2.00% redemption fee. Please see the prospectus for details. The fund performance shown does not reflect the deduction of this fee. Had the fee been deducted, returns would have been lower.

[F8] TIAA Stable Value is fully liquid with no restrictions or surrender charges. 90-day equity wash rule applies if competing funds exist. Transfers in may not be made for 30 days following a transfer out. Plans allowing transfers to other approved vendors include a multivendor risk charge within the TIAA Stable Value Contract Fee. Pre-scheduled recurring transfers (including automated rebalancing associated with asset allocation programs) and transfers resulting from TIAA-CREF advice sessions are exempt from equity wash rules and the 30-day restriction.

[F9] Fund Expenses effective as of 6/30/15.

[F10] Limited to $10,000 or entire account made over 10 annual transactions.

[F11] For RA and GRA contracts, paid in 10 annual installments over 9 years and 1 day. There are no surrender or withdrawal costs for this service.

[F12] Effective as of 9/1/15.

All fund fee and expense information as of 6/30/15.

TIAA-CREF Individual & Institutional Services, LLC, Member FINRA and SIPC, distributes securities. Advisory services provided by Advice & Planning Services, a division of TIAA-CREF Individual & Institutional Services, LLC, a registered investment adviser.

Prudential

[G1] The DCP Stable Value Fund is a trust product that is composed of a group annuity contract issued by The Prudential Insurance Company of America (PICA) and a portfolio of assets owned by the New Jersey State Employees Deferred Compensation Plan or its designee. Guarantees apply during the term of the group annuity contract. The Fund is not issued or guaranteed by the U.S. government or by any state government or agency. Transfers into the Fund may be made at any time. Transfers out of the Fund may be made to other investment options that are accepting contributions at such time. If in the future the Plan adds an investment option(s) with characteristics similar to the DCP Stable Value Fund, transfers to such new option(s) may be subject to restrictions. The Prudential Insurance Company of America, Newark, New Jersey, is a Prudential Financial company.

Shares of the registered mutual funds are offered through Prudential Investment Management Services LLC (PIMS), Three Gateway Center, 14th Floor, Newark, NJ 07102-4077. PIMS is a Prudential Financial company. Prudential Retirement Consultants are registered representatives of PIMS.

[G2] Registered Mutual Fund

Annuity contracts contain exclusions, limitations, reductions of benefits and terms for keeping them in force. Contract form # GA-2020-TGWB4-0805-NJ or state variation.

APPENDIX F – RETIREMENT PLAN ENROLLMENT FORMS

KEAN UNIVERSITY
INQUIRY OF PENSION MEMBERSHIP

PART A

1. **Are you retired from a New Jersey State-Administered Retirement Plan?** ☐ Yes ☐ No
   If yes, check the retirement plan from which you retired and indicate the date of your retirement, then skip to PART B.

   ☐ ABP ☐ PERS ☐ PFRS ☐ SPRS ☐ TPAF

   Retirement date: _____ Type of Retirement: ☐ Disability ☐ Other

2. **Do you currently contribute to a State-Administered Retirement Plan?**

   ☐ Yes ☐ No
   If no, skip to question 3.

   If yes, check retirement plan: ☐ ABP ☐ PERS ☐ PFRS ☐ SPRS ☐ TPAF

   Your most recent contribution to this retirement account occurred on: _____
   Month/Year

   What was your employment status? ☐ Full-time ☐ Part-time/Adjunct*
   Name of your location: _____

   **If you were/are an adjunct*, have you filled out an *Election of Retirement Coverage* form?

   ☐ Yes ☐ No ☐ I do not know

3. **If you do not currently contribute to a State-Administered Retirement Plan, have you ever contributed to one in the past?**

   ☐ Yes ☐ No
   If yes, check the retirement plan you contributed to in the past:

   ☐ ABP ☐ PERS ☐ PFRS ☐ SPRS ☐ TPAF

   Did you withdraw your funds from your past retirement plan? ☐ Yes ☐ No

PART B

With my signature below, I certify that the information I provided above is the truth to the best of my knowledge. **Please be advised additional pension forms may be required.**

Sign: _____ Date: _____

Print Name: _____ SS#: _____-_____-_____

Email: _____ Phone: _____

ABP-10-0001-1215

STATE OF NEW JERSEY DEPARTMENT OF THE TREASURY
DIVISION OF PENSIONS AND BENEFITS
PO BOX 295, TRENTON, NJ 08625-0295

FOR DIVISION USE ONLY

ALTERNATE BENEFIT PROGRAM

ENROLLMENT APPLICATION

(Please do not complete this form until you read the reverse side.)

PART I *Please print clearly or type.* MEMBER INFORMATION

1. Name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. _____
FIRST MIDDLE LAST

2. Date of Birth _____
MONTH DAY YEAR

3. Address _____
STREET

_____
CITY STATE ZIP CODE

4. Daytime Telephone No (_____) _____ **5. Social Security Number** _____

6. Have you ever been a member of a New Jersey Administered Pension Fund? ☐ Yes ☐ No

If yes, check fund and indicate membership number: ☐ ABP ☐ PERS ☐ TPAF ☐ PFRS ☐ SPRS

Membership number: _____ Are you retired from this Pension Fund? ☐ Yes ☐ No

7. Are you eligible for immediate vesting in the ABP? *(eligibility criteria on reverse side)*

☐ Yes ☐ No If yes, identify how you qualify. _____

_____ _____
SIGNATURE OF APPLICANT DATE

PART II CASH DISTRIBUTION (VESTED MEMBERS ONLY)

A member of the Alternate Benefit Program (ABP) becomes eligible to commence distributions at any age upon severance from employment or retirement. Members may receive benefits in the form of an annuity or cash distribution. Annuity benefits will be calculated by the Designated Service Provider (DSP) based upon the account accumulation, life expectancy, and the distribution option selected. Cash distributions to members under the age of 55 are limited to their employee contributions and accumulations. The remaining employer contributions and earnings are available for distribution upon attaining age 55. Participation in the Alternate Benefit Program shall terminate and the individual shall be considered retired once he or she has elected to receive a cash distribution of the value of his or her accounts in a direct payout as a cash distribution, a rollover, or an annuity (or a combination of these distributions). The member is considered retired and is not eligible to enroll in any New Jersey State-administered retirement system, nor are they eligible to reenroll in the Alternate Benefit Program. I hereby acknowledge that I have been counseled regarding my election to withdraw funds from my mandatory 401(a) account.

PART III CERTIFICATION OF EMPLOYING AGENCY

To be completed by the employer.

Title of Position _____ Employed: ☐ 10 ☐ 12 months Appointment Date _____/_____/_____

Employing Institution _____ Loc. # _____ Annual Base Salary $ _____

Full Time Employee	☐ Yes	☐ No	Academic Position	☐ Yes	☐ No
Bachelor's Degree	☐ Yes	☐ No	Administrative Position	☐ Yes	☐ No
Immediately Vested	☐ Yes	☐ No	Adjunct/Part-time Faculty	☐ Yes	☐ No

I certify that this employee and position meets the eligibility criteria for the retirement system as provided by law. I acknowledge that I am subject to penalty for falsifying or permitting to be falsified any record, application, form, or report of the retirement system in an attempt to defraud the system pursuant to N.J.S.A. 43:3C-15. *(Two Signatures Required)*

_____ _____ _____
SIGNATURE OF CERTIFYING OFFICER TITLE DATE

_____ _____ _____
SIGNATURE OF CERTIFYING OFFICER'S SUPERVISOR TITLE DATE

GENERAL INFORMATION

ELIGIBILITY — All full-time faculty and administrative personnel required to possess a Bachelor's Degree are eligible for enrollment in the Alternate Benefit Program (ABP). Adjunct Faculty and Part-Time Instructors are also eligible for enrollment in the ABP under the provisions of Chapter 89, P.L. 2008. Other employees hired in a temporary position are not eligible. Employees earning less than 50% of the normal base salary are not eligible. Employees with F or J visas are not eligible. **Note:** A retiree from any New Jersey State-administered retirement system is *ineligible to participate* in the Alternate Benefit Program.

VESTING ELIGIBILITY CRITERIA — A member is immediately vested if he/she owns a retirement contract that contains both employer and employee contributions that is based upon employment in the field of higher education **or** transfers an active or vested New Jersey State-administered retirement system account to the ABP. The retirement contract must be in force, that is, the employee is entitled to receive benefits at a future date. The member is also immediately vested if he/she is an active or vested member of a State-administered retirement system of any state in the United States.

INDIVIDUALS AGE 60 OR OLDER — To be covered by the group life and disability insurance programs, you must submit to a medical examination to prove insurability. A medical examination will be arranged for you. Upon advice from the insurance carrier that you have proved insurability, you will be covered.

SERVICE CREDIT — Pension membership credit begins to accrue from the date you become eligible for enrollment in the Alternate Benefit Program.

INVESTMENT CARRIER SELECTION — ABP members must complete an *Alternate Benefit Program Carrier Election and Allocation Form* and the application forms of each investment carrier selected.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

Parts I & II are to be completed by the employee. Part III is to be completed by the employer.

ITEMS 1 - 5 — Please complete all items.

ITEM 6 — If you were recently a member of the New Jersey Teachers' Pensions and Annuity Fund (TPAF), the Police and Firemen's Retirement System (PFRS) or the Public Employees' Retirement System (PERS) and did not withdraw your contributions from that retirement system, you may remain in, or transfer into, the PERS and waive participation in the Alternate Benefit Program (ABP). You may obtain a proper transfer form from your personnel office. However, if you elect to participate in the ABP, this *Enrollment Application* must be completed and submitted with the appropriate application to transfer contributions to the ABP.

ITEM 7 — See vesting eligibility criteria above. If you answer yes, employer and employee contributions vest immediately. If you answer no, employer and employee contributions are remitted to the one investment carrier you select. However, the employer contributions are not vested until your 13th consecutive month of employment. If you terminate employment prior to your 13th month, the employer contributions are returned to your employer.

GROUP LIFE INSURANCE AND DESIGNATION OF BENEFICIARY — The *Designation of Beneficiary* is no longer a part of this application. Upon enrollment a new ABP member's estate is automatically designated as the beneficiary for any death benefit. New members should update their beneficiary information by completing an *ABP Designation of Beneficiary* form and submitting it to the Division of Pensions and Benefits.

You may change your beneficiary designation for the group life insurance at any time. The change must be filed with the Division of Pensions and Benefits and supersedes any previous designation on file with the Division. The *ABP Designation of Beneficiary* form is available from the employer or on the Alternate Benefit Program Home Page of the Division of Pensions and Benefits Web site: *www.state.nj.us/treasury/pensions/abp1.shtml*

This does not change your beneficiary designation for your annuity. Contact your individual investment carrier(s) for changes to your annuity.

IN THE EVENT THAT YOU CANNOT COMPLETE THE *ABP ENROLLMENT APPLICATION* ONLINE USING THE EMPLOYERS' PENSIONS AND BENEFITS INFORMATION SYSTEM (EPIC), please mail a completed copy of this *Enrollment Application* to:

Division of Pensions and Benefits
Defined Benefit & Defined Contribution Plans Reporting Bureau
PO Box 295
Trenton, NJ 08625-0295

KEAN UNIVERSITY
Salary Reduction/Allocation Agreement Form - 2017

Name: _____ SSN: _____
Email: _____ Tel: _____
Date of Hire: _____ Date of Birth: _____

SALARY REDUCTION AGREEMENT

It is hereby agreed by and between the above named employee and Kean University (employer) that with respect to amounts earned on or after _____, 20____, the employee base biweekly salary will be reduced by the amounts indicated below.

This agreement shall be legally binding and irrevocable to each of the parties hereto while employment continues; provided, however, that either party may terminate this Agreement as of the end of any biweekly pay period, so that it will not apply to salary subsequently earned, by giving at least thirty days' written notice of the date of termination; and provided, further, **that no more than two agreements for such salary reduction may be made, by giving at least thirty days' written notice of the change, within any taxable year**, and provided further that if the University suspends the salary reduction authorized by this agreement because the employee has reached the maximum amount allowed by law under IRC Code Section 402(g), 415 or 414(v), (if applicable), this agreement shall be reinstated as of the beginning of the next taxable year.

PLEASE CHECK ALL THAT APPLY

- ☐ Start Initial Contributions
- ☐ Change the Service Provider
- ☐ Change the Amount of Contributions
- ☐ Suspend Contributions

SELECT FUND

- ☐ Alternate Benefit Program (ABP)
- ☐ SRA (403b Plan for ABP Members Only)
- ☐ ACTS (403b Plan for PERS/TPAF/PFRS Members)

ELECTION AND ALLOCATION

Please note that you may select any number of service providers and allocate the amount of the contributions to each one. (Select only one carrier if you are a newly enrolled ABP member in delayed vesting status.) *The participants must establish a valid account directly with the service provider(s) before completing this form.*

Select the Service Provider	Select Mandatory % for ABP Only*	Select Voluntary % for SRA/ACTS
☐ AXA/Equitable	_____	_____
☐ Mass Mutual (The Hartford)	_____	_____
☐ Met Life (Citistreet)	_____	_____
☐ Prudential	_____	N/A
☐ TIAA**	_____	_____
☐ VALIC	_____	_____
☐ VOYA Financial (ING)	_____	_____

Select Annual Maximum

- ☐ $18,000 (Under Age 50)
- ☐ $24,000 (Age 50 and Up)

*For the ABP plan, total of percentages for all selected service providers must equal 5%. Employer (8%) contributions will be allocated based on this selection.
** Please check which TIAA-CREF product you are contributing to (GSRA or RA): • GSRA • RA (pre-1995 ABP members only)

I elect to allocate my total employee tax-sheltered contributions as indicated above. I have read and understand the information on the back of this form.

_____ _____
Employee Signature Date

_____ _____
Certifying Officer Signature Date

_____ _____
Supervisor of Certifying Officer Signature Date

Contributions and Remittances to Service Providers

All employee contributions will be withheld over the course of the calendar year (26 pay periods for 12 month employees, 22 pay periods for 10 month employees).

The employer agrees to remit periodically to the service provider selected by the employee, the sum of such contributions. The University will function as the employees' intermediary in the processing of all required contributions to the designated service provider(s). Employees are responsible for monitoring their personal investment portfolio by reviewing their service provider's quarterly statement to ensure the timeliness and accuracy of remittances to their investment choices. Employees are to report immediately any discrepancies, including the omission of the service provider's quarterly statement, to the Office of Human Resources. Employees are also solely responsible for their personal tax situation and the impact of any deferrals.

Maximum Contributions

The annual maximum contribution amounts for Supplemental Retirement Accounts (including SRA(k), and ACTS) are as follows :

· $18,000 —Annual Contribution Maximum for individuals under age 50
· $24,000 —Annual Contribution Maximum for individuals age 50 and over

Your annual maximum contribution amount for plan year 2017 will automatically be set to $18,000 (or $24,000 if you are age 50 or older).

Additional catch up limits may apply. If you have any questions or concerns regarding your supplemental retirement account, please feel free to contact Yrelys Tapanes, Benefits Manager, at 908-737-3313 or ytapanes@kean.edu.