PEP*flex*

The Flexible Benefits Plan of Pepperdine University

Effective September 1, 2011

Dear Pepperdine Colleague:

There are many benefits to working at Pepperdine University—the influence of our distinctive mission, the positive work environment, the professional development opportunities, the wellness programs, the beautiful settings, the access to an outstanding academic community, and more.

As a part of these benefits, the University offers a flexible benefit plan called PEP*flex*, which is designed to allow eligible employees the opportunity to choose coverage that best suits their individual and family needs. We also provide a generous holiday and vacation package; access to many facilities, activities, and services; and a tuition remission program to help defray the cost of higher education for eligible employees, their children and spouses.

The following material describes the University's flexible benefit plan. PEP*flex* has been designed to give you access to quality care and to offer a choice of coverage options so that you can select the plan that best meets your needs. PEP*flex* provides access to the following benefits:

- Health
- Dental
- Vision
- Life
- Disability
- Long-term care
- Psychological counseling

In addition to coverage options, PEP*flex* provides you with tax savings through before-tax contributions and Flexible Spending Accounts. PEP*flex* puts many of the decisions regarding your benefits in your hands. This booklet describes the PEP*flex* benefits choices and gives instructions for enrollment for eligible employees so that you can use them to your best advantage.

These benefits are a part of our effort to attract, develop, reward, and retain a quality workforce. We hope they send the message that you are valued!

Sincerely,

Lauren W. Cosentino
Associate Vice President
Human Resources, Insurance and Risk

PEP*flex* lets you prescribe your benefits!

PEP*flex* is more than an assortment of traditional benefits. Some restrictions apply, but for the most part you design your own benefits package. Please read this booklet carefully before you enroll. Each year, during Open Enrollment, PEPflex allows you to select benefits which most closely match your own needs and preferences.

To make sure you get the benefits you need, you must complete and submit an online enrollment to Human Resources before the enrollment deadline. If you do not enroll, the University will automatically give you "default benefits." Default benefits are described in this booklet.

With PEPflex, you are given a set of core benefits with an opportunity to choose from a variety of options in other benefit categories. For example, under health coverage, you have three plans offered by Blue Cross and a Kaiser HMO option. Your options are discussed in this booklet.

Core Benefits

Your core benefits include:

- Life Insurance
- Accidental Death & Dismemberment Insurance
- Business Travel Accident Insurance
- Long Term Disability Insurance
- Psychological Counseling Services
- Health Advocate Program

Medical Benefits

Your choice of medical benefits include:

- Blue Cross POS, a Point of Service plan (hereinafter Blue Cross POS)
- Blue Cross EPO, a Prudent Buyer Exclusive Plan (hereinafter Blue Cross EPO)
- Blue Cross HMO, a Health Maintenance Organization (hereinafter CaliforniaCare HMO)
- Kaiser Health Plan, a Health Maintenance Organization (hereinafter Kaiser HMO)

Optional Benefits

You may elect optional coverage for:

- Dental Care
- Vision Care
- Optional Term Life Insurance
- MetLife Critical Illness Plan
- MetLaw Pre-paid Legal Plan
- Flexible Spending Accounts (covering unreimbursed Health and Dependent Care expenses)
- VPI Pet Insurance

Additional Benefits

Some benefits you receive from Pepperdine University are not included in the flexible benefits program. These benefits include Social Security, holidays, vacation, sick pay, service awards, tuition assistance, credit union membership, a retirement plan, a wellness program, and a professional development program.

If you have questions this booklet does not answer, please contact Human Resources. Faculty and staff members who are hired after Open Enrollment will receive PEPflex information at orientation.

ELIGIBILITY FOR YOU AND YOUR DEPENDENTS

Eligible Employees

- If you are an active, regularly assigned, full-time staff employee, working a minimum of 30 hours per week (except where applicable law requires a lesser number of hours), you are eligible to enroll in PEP*flex*.
- If you are an active, regularly assigned staff employee in an approved "9-12 month" position, working a minimum of 30 hours per week, you are eligible.
- If you are an active, regularly assigned, full-time faculty member employed under a regular (non-adjunct) faculty contract, serving in at least a half-time appointment (.5 FTE) each academic year, you are eligible.

Eligible Dependent

As an eligible employee, you may be allowed to carry family members on your PEPflex plan.

Here are some guidelines:

- Your legally married spouse is eligible unless in active service in the armed forces.
- Your domestic partner legally registered with the State of California under AB205 is eligible.
- Your children under age 26 are eligible for coverage. Your children include your legally adopted children and children who are placed in your physical custody for adoption. Your children also include each of your stepchildren, and children for whom you or your spouse have been appointed legal guardian by a court of law. Special rules apply for children with disabilities. Excluded from coverage under the plan are adult children under age 26 if such child is eligible to enroll in an eligible employer-sponsored health plan other than the plan offered by Pepperdine University.

If you and your spouse both work at Pepperdine University, you may each be covered separately as employees. Eligible children may be covered by only one of you.

Note: Plan coverage is actually governed by more formal legal plan documents. Applicable laws and insurance contracts may also affect coverage. While every effort has been made to provide clear and accurate information, in the event of any discrepancy between these materials and the official plan documents, the plan documents or contracts will govern.

Please do not interpret any statement in this booklet to mean that your participation in the University's benefits program is a guarantee of continued employment or is intended to be an employment contract of any form. The University reserves the right to change, suspend, amend, or end the benefits program and the terms on which benefits, if any, will be available to its employees. The President and the Executive Vice President of the University, acting together, shall have the right to amend the Plan at any time and to any extent that they deem advisable; provided, however, that the Board of Regents shall retain the exclusive authority to terminate the plan.

Health care providers are not agents of Pepperdine University. Health care providers are solely responsible for the delivery of health care services. Pepperdine University is not liable for acts or omissions of any health care provider or plan you have chosen.

GUIDE TO ENROLLMENT

To enroll in PEPflex follow these steps:

- Carefully consider your benefit options.
- Map out your benefit choices on the worksheet included in this booklet.
- Complete your online enrollment prior to the deadline.

To enroll yourself and your eligible dependents in PEPflex, you must complete your online enrollment before the enrollment deadline, indicating your choice of medical plan and any optional benefits you select. List all eligible dependents you wish to cover. By completing the form, you will authorize the necessary payroll deductions for coverage.

An Annual Commitment

When you enroll in PEPflex, you are determining your benefits course for the plan year which is normally 12 months. Your benefit choices will be set until August 31, 2012.

Remember, unless you have a Qualified Family Status Change (see listing in next column), you may not change your benefits plan until the next Open Enrollment period for coverage beginning September 1, 2012.

When Coverage Begins

If you are signing up during the Open Enrollment period, your benefit choices will normally take effect on September 1, 2011. If you or your enrolled dependents are hospital confined on this day, please contact Human Resources to inquire about your specific situation.

If you are a new full-time faculty or staff member, your benefits coverage will usually start on the first day of the month coinciding with or immediately following your date of full-time employment.

Annual Re-enrollment

During the Open Enrollment period each year, you may elect to change your medical plan and add or delete optional benefit choices from your benefits package. At the Open Enrollment period, you may also add or delete dependent coverage. (Some restrictions may apply.) This is the only time during the plan year that you can change your election, unless you have a Qualified Family Status Change, or qualify for Special Enrollment Circumstances. In other words, you will not be able to switch options or drop out of a plan until September 1, 2012, unless you experience a Qualified Family Status Change, or qualify for Special Enrollment Circumstances.

Qualified family status changes include:

- Marriage, divorce, legal separation, legal dissolution or death of your legal spouse or domestic partner
- Birth, adoption, placement for adoption, or death of your dependent child
- Change in a dependents' status (dependent becomes eligible to enroll in employer sponsored coverage, etc.)
- Your spouse starts or stops working
- Your spouse changes from part-time to full-time status or vice versa
- Your spouse takes an unpaid leave of absence
- Your spouse loses or gains health coverage
- Change in residence or worksite (see out-of-area medical benefits, 7)

If you have a Qualified Family Status Change, you can revise your benefits only in ways that are consistent with that change. For instance, if one of your covered children gains access to their own employer coverage, you would delete his or her coverage.

Your written request to make plan changes must be submitted to Human Resources within 30 days of the qualifying event.

HOW PEP*flex* WORKS

Core Benefits

Pepperdine University provides a set of fixed benefits called "core benefits." Core benefits are the same for all participating employees. Core benefits are paid 100% by the University. The core benefits ensure that every eligible faculty and staff member has a basic level of health and welfare coverage such as life and accidental death and dismemberment insurance, long term disability income protection, and psychological counseling services.

Effective September 1, 2011—core benefits include:

- Employee Group Term Life Insurance covering you for two times your base annual salary[1]
- Employee Accidental Death & Dismemberment (AD&D) Insurance covering you for two times your base annual salary[1]
- Business Travel Accident Insurance provides a benefit equal to five times your base annual salary
- Employee Long Term Disability Insurance protection for 2/3 of your base monthly salary up to a maximum benefit of $10,000 per month
- Employee and Dependent Psychological Counseling Services
- Health Advocate Program

Core benefits do not include medical coverage, dental coverage, vision care benefits, optional term life insurance, or flexible spending accounts.

Your cost will be affected by your choices in the following categories:

Optional Benefits

- Choice of medical plan and level of coverage
- Choice of dental plan and level of coverage
- Vision coverage
- Optional term life insurance
- Flexible spending accounts
- MetLife Suite of Voluntary Benefits

[1]At age 70, the amount will be reduced to 65% of the original benefit, at age 80, it will be reduced to 50% at the original benefit.

Husband/Wife Employees

(Eligible employees who are husband/wife, both employed by Pepperdine University)

If you and your spouse both work at Pepperdine University, you will generally be covered separately as employees. However, if you also have eligible children you wish to cover along with your spouse, you, your spouse and children may choose to be covered under just one of you with the other waiving individual medical coverage. Enrolling as a single-family unit will allow you to take full advantage of family deductible maximums and other out-of-pocket costs. Each of you may also choose your own coverage under different plans; however, eligible children may be covered by only one of you.

PEP*flex* MEDICAL OPTIONS

Good health is a precious thing. It is up to you to make sure you and your family receive the medical care you need. The University health plans are designed to help you with your health care expenses. However, the University offers health plans that encourage you to receive care in the most economical way possible. This keeps health care affordable for you and the University. Your plan coverage should not be a factor in getting appropriate health care.

How the Plans Compare

Regardless of which medical plan you choose, the same types of expenses generally are covered.

Some examples are:

- Hospital room and board
- Surgeon's fees
- Outpatient services
- Doctor's office visits
- X-ray, lab tests, other types of diagnostic tests
- Prescription drugs

With each plan, you will pay some of the expenses. The plans vary on the amount of cost sharing which will be your responsibility. Cost sharing is directly influenced by whether or not you choose in-network providers, preferred providers, or out-of-network providers each time you need care.

"**In-network**" refers to providers such as primary care physicians, specialists, and hospitals who participate in an HMO network in your service area. You and your covered dependent(s) must select a primary care physician from the provider directory. The primary care physician of your dependent(s) may or may not be different from yours.

"**Preferred Providers**" refers to physicians, health care facilities and other health care providers who belong to the Blue Cross PPO Network. Providers are listed in the PPO provider directory. In addition to cost savings, Blue Cross PPO Providers bill Blue Cross for you. The Blue Cross EPO and POS plan use this network.

"**Out-of-network**" refers to any doctor or other health care provider you choose who does not participate in the Blue Cross HMO or PPO provider network. Therefore, the provider is not listed in the plan directory.

You are responsible for a percentage of costs or co-payment, plus any charges that are more than the covered expense, plus any applicable deductibles.

DESCRIPTIONS

Following is a brief description of each of your medical plan options.

CaliforniaCare HMO

An Individual Practice Association (IPA) or a Medical Group model Health Maintenance Organization (HMO) that requires you to choose a CaliforniaCare HMO primary care physician from within their network, use only their facilities and reside within the service area. When you enroll in the CaliforniaCare HMO, you choose your primary care physician from the provider directory. You go directly to the physician's private office for care. Your primary care physician provides the treatment you need, authorizes any needed tests or medications, or refers you to a specialist. Preventive care is included. No claim forms are required. The prepaid basic plan includes a $20 office visit co-payment, 100% hospitalization benefit. There is no annual deductible.

Blue Cross EPO

Health plan coverage requires you to receive your health care services from only licensed health care professionals that belong to the Blue Cross Prudent Buyer (PPO) network or the Blue Cross Behavioral Health Network (BHN) for treatment of mental illness or substance abuse. This plan includes a $20 office visit co-payment, 90% hospitalization and other services coverage. You do not need to receive a referral when you use a Blue Cross PPO provider, however, Blue Cross must authorize a referral outside the network, or for substance abuse treatment, except in emergencies. Hospital admissions (except in emergencies) must be pre-authorized by Blue Cross.

You do not need to make payment for services, except for the office co-payment charge, when you receive care from a Blue Cross PPO health care professional. The Blue Cross PPO health care professional will file a claim for you and then bill you for the remaining portion of the charges.

You may receive an authorized referral when there is no Blue Cross PPO health care professional within a 25-mile radius of your home that can perform the services you need. Please note that Blue Cross must authorize the services and you must receive a physician's referral from your Blue Cross PPO doctor.

Blue Cross POS

A Point-of-Service plan is a hybrid of an HMO and an indemnity plan. In-network benefits work similar to an HMO. When you enroll in Blue Cross POS, you are required to choose a primary care physician from the HMO provider directory. Your primary care physician coordinates your care. You are required to live within the service area and use the network's facilities. This plan includes a $20 office visit co-payment, 100% hospitalization coverage. In-network benefits are not subject to a deductible and there are no claim forms.

You and your covered dependent(s) may elect to go "outside" of the HMO network each time you seek medical care. You decide whether to have your primary care physician refer you to a specialist and receive in-network benefits or make your own appointment with a specialist of your choice and receive benefits under the Preferred Provider Option (PPO) or out-of-network. If you go under the Preferred Provider Option (PPO) or out-of-network in choosing a provider, you will still be covered by the plan, but you will pay a greater share of the cost of many services. Also, certain services, such as preventive care, are not covered. Blue Cross POS coverage includes a 80% Preferred Provider Option (PPO) plan benefit and a 70% out-of-network benefit after satisfying an annual deductible. The plan is subject to reduction in benefits and/or additional deductibles if you or your covered dependents are admitted to a non-Blue Cross contracted hospital or ambulatory surgical center or did not comply with the certification process for each admission resulting in an increase in your out-of-pocket expense. This does not apply to the in-network HMO option. Claim forms are required under the out-of-network option for payment to the provider and reimbursement for services paid by you.

Providers for Blue Cross HMO, EPO, and POS plans can be found at www.anthem.com/ca

Kaiser

A staff model Health Maintenance Organization (HMO) that requires you to use only Kaiser facilities and physicians and to reside within the service area. Treatment is coordinated by your primary care physician in a Kaiser health center. Preventive care is included. No claim forms are required. The prepaid basic plan includes a $20 office visit co-payment and 100% hospitalization.

There is no annual deductible.

"Out-of-Area" Medical Benefits

If you live outside the service area or transfer outside the CaliforniaCare HMO, Blue Cross EPO, POS or Kaiser service areas, arrangements have been made for an out-of-area medical plan. Contact Human Resources for more information.

Waiver of Medical Benefits

If you have medical plan coverage through a spouse or other employer and you wish to retain that medical coverage as your primary source of medical coverage for yourself and eligible dependents (spouse and/or children), **you must complete the Medical Plan Waiver form for yourself and any dependents. You must also provide proof of the other coverage along with the form.**

Carefully review your medical plan choices to determine which one best fits your needs.

MEDICAL PLAN HIGHLIGHTS

	Kaiser	CaliforniaCare
	HMO	**HMO**
Plan Concept	A Health Maintenance Organization requires that you use their facilities and reside within their service area. No claim forms are required.	A Health Maintenance Organization requires that you use their facilities and reside within their service area. No claim forms are required.
Deductible (Calendar Year) Individual/Family	Deductible	Deductible
Coinsurance or Co-pays* • Office Visits • Hospitalization • Surgical • Prescription Drugs (including dental Rx's through participating pharmacies only)	 $20 100% 100% $10/Rx for generic, $20/Rx for brand name	 $20 100% 100% $10/Rx for generic, $25/Rx for brand name at participating pharmacy; selective formulary applies or $45/Rx non formulary
Out-of-Pocket Maximum The Coinsurance Out-of-Pocket Maximum refers to expenses you have paid toward eligible expenses	N/A	N/A
Co-payment Maximum (refers to calendar year limit of co-payments for office visits emergency room, etc.)	$1,500/individual $3,000/two-party	$1,500/individual $3,000/two-party $4,500/family
Lifetime Maximum	Unlimited	Unlimited

**Including Mental Health and Substance Abuse Care*

Blue Cross	Blue Cross POS		
EPO	Point-of-Service		
	HMO	PREFERRED	OUT-OF-NETWORK
Blue Cross EPO members mus receive health care services from Blue Cross PPO (Prudent Buyer) network providers,unless they receive authorized referrals or need emergency and/or out-of-area urgent care.	The POS (Point-of-Service) plan requires you to choose a Blue Cross HMO primary care physician- and reside within the service area. You receive a higher benefit when services are authorized by the Blue Cross HMO primary care physician or preferred provider. You may elect to go out-of-network- and receive a lesser benefit.		
$100/$300	No Deductible	$350/$700	$750/$1,500
$20 90% 90% $10/Rx for generic, $25/Rx for brand name at participating pharmacy; selective formulary applies or $45/Rx non formulary	$20 100% 100% $10/Rx for generic, $25/Rx for brand name at participating pharmacy; selective formulary applies or $45/Rx non formulary	80% 80% 80% $10/Rx for generic, $25/Rx for brand name at participating pharmacy; selective formulary applies or $45/Rx non formulary	70% 70% 70% $10/Rx for generic, $25/Rx brand name. Member pays the retail participating pharmacies co-pay plus: 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. (30 day supply.)
$1,000 + deductible N/A	N/A $1,500/individual $3,000/family	$2,000/individual. After your out-of-pocket maximum is reached, the coverage pays 100% for the balance of the calendar year N/A	$3,000/individual + deductibles and amounts in excess of reasonable and customary. N/A
Unlimited	Unlimited	Unlimited	Unlimited

CORE BENEFITS MONTHLY RATES

Benefit	Description	Your Monthly Cost
Life Insurance	Two times your base annual salary[1]	-0-
Accidental Death & Dismemberment Insurance	Two times your base annual salary[1]	-0-
Business Travel Accident Insurance	Five times your base annual salary	-0-
Long Term Disability	66⅔% of your base monthly salary up to a maximum benefit of $10,000 per month	-0-
Psychological Counseling	Provides assessment and counseling sessions and is separate from your chosen medical plan	-0-
Health Advocate Program	A program to help you navigate and facilitate medical and administrative issues in the health care system	-0-

Pepperdine provided benefits at no cost to you

MEDICAL BENEFITS

Select one Medical Option

Medical Choices Single Coverage (level 1)	Blue Cross POS	$111.19
	Blue Cross EPO	$26.43
	CaliforniaCare HMO	$12.45
	Kaiser HMO	$11.09
Medical Choices Employee + family (levels 2 or 3)	Blue Cross POS	$555.97
	Blue Cross EPO	$211.46
	CaliforniaCare HMO	$124.51
	Kaiser HMO	$110.89
[2]Medical Waiver		-0-

These benefits will be paid with pre-tax payroll deduction

[1]At age 70, the amount will be reduced to 65% of the original benefit, at age 80, it will be reduced to 50% of the original benefit.

[2]You may waive medical coverage if you wish to use other medical coverage as your primary coverage. In order to waive coverage, you must complete a medical waiver form and provide proof of other coverage.

OTHER OPTIONAL BENEFITS MONTHLY RATES

Benefit	Description	Your Monthly Cost
Dental Choices single coverage (level 1)	Dental Waiver Option	-0-
	Dental Plan Election: Delta PPO/Indemnity	$ 8.07 level 1
	DeltaCare USA HMO	$ 3.57 level 1
Dental Choices employee + dependents (levels 2 & 3)	Delta PPO/Indemnity	$21.07 level 2 $44.95 level 3
	DeltaCare USA HMO	$ 7.10 level 2 $10.91 level 3
Vision Option	VSP Signature Plan	$10.36 level 1 $15.08 level 2 $27.08 level 3
Optional Life Insurance	Available for employees, your legal spouse and children	Cost varies according to age and amount selected
Legal Plan	MetLaw Prepaid Legal	$16.50
MetLife Critical Illness	Available for employees, your legal spouse and children	Cost varies according to age

PEP*flex* DENTAL OPTIONS

Your dental plan is designed to help you maintain good dental health by covering a large portion of the cost for most dental services. PEPflex offers three dental options including a "dental waiver" from which to choose.

Following is a brief description of two of your dental plan options.

Delta Dental is a traditional indemnity plan with a PPO (Preferred Provider Organization) option. Under this plan you may choose any dentist you wish. Delta Dental offers you the option of using a Preferred Provider from a list of participating Delta Dentists. By using the Preferred Dentists, you will automatically receive a higher benefit including a waived deductible. The maximum annual benefit is $2,000/insured.

DeltaCare USA HMO is a managed dental program which provides dental benefits through specific providers as listed in the materials. If you select this plan, you must use only these providers to receive benefits. There is no annual deductible, and no claim forms. However, co-payments range from $0 to $300 for certain procedures.

DENTAL PLAN HIGHLIGHTS

	Delta		DeltaCare USA HMO
	Preferred Option	**Premier**	
Plan Concept	Delta Dental offers you the choice of using their Preferred Providers *or* any dentist you choose. **By using the Preferred Dentists, as listed in the brochure, you will automatically receive a higher benefit as illustrated below.** The following is a brief benefit comparison highlighting the Delta Preferred Option benefits and the Delta Premier benefits. All Delta dentists provide and complete claim forms at no charge.		This is a Pre-Paid Dental Plan and care is provided by Network dentists. If you select the plan, you must use these providers to receive benefits. Refer to the brochure for locations and benefits information.
Annual Deductible	None	$50 Basic & Major Services combined (No deductible for Diagnostic & Preventive & Orthodontia); $150 Maximum Family Deductible.	No Annual Deductible—Certain procedures require a co-payment.
Annual Benefit Maximum	$2,000	$2,000	None
Orthodontia Maximum (Lifetime)	$2,000	$2,000	None
Coinsurance & Co-pays			
Preventive & Diagnostic	100%	100%	100%
Basic & Restorative & Oral Surgery	95%	80%	Co-pays vary according to procedure ($0 to $280)
Major Services	50%*	50%*	Co-pays vary according to procedure ($10 to $300)
Implants (pre-authorization required)	50%*	50%*	No Coverage
Orthodontics	50%*	50%*	Co-payments vary

**Waiting period may apply for prosthodontic, orthodontic and implant benefits.*

VISION CARE PLAN

Your vision care plan is designed to encourage you to maintain good vision through regular examinations. Regular vision examinations not only determine the need for corrective eyewear, but also may detect the presence of general health problems in their early stages.

VSP Signature Vision Care Plan is similar to an indemnity plan with a PPO (Preferred Provider Organization) option. The plan offers two ways for you to receive services and benefits. You have the option of receiving services at a participating in-network provider or an out-of-network provider. Your benefits are paid at a higher rate by using the VSP providers. Benefits for an eye exam and lenses are available every 12 months. Frames are available every 24 months. Claim forms are not required within the network. However, a claim form is required for out-of-network services. Vision care does not have to be coordinated through your primary care physician from your medical plan.

VISION CARE HIGHLIGHTS

VSP Signature Plan Highlights		
Plan Concept	VSP offers you the choice of using their Preferred Providers or any optometrist you choose. By using an optometrist from the network listing you receive a vision exam and lenses with a $20 co-payment and receive a $130 allowance for frames. No claim form is required within the network. However, preauthorization and claim forms are required out-of-network.	
Benefits Every 12 Months For:	**In-Network**	**Out-of-Network**
Examination	You pay $20 co-payment	Plan Reimburses up to $45
Lenses (single to trifocal)	Included	Plan Reimburses from $45 to $85
Frame (benefit every 24 months)	$130 allowance	Plan Reimburses up to $47
Contact Lenses (in lieu of lens and frame benefit)	Plan allows up to $130 toward the cost	Plan Reimburses up to $105

PEP*flex* METLIFE SUITE OF VOLUNTARY BENEFITS

The MetLife Suite of Voluntary benefits is designed to provide voluntary benefit options that compliment the PEPflex benefit program.

MetLaw Legal Plan Highlights

Concept	MetLaw provides you, your spouse and dependents with fully covered legal services from experienced attorneys at a low monthly group rate. When you use a Plan Attorney for covered services, there are: • No deductibles • No co-payments • No waiting periods • No claim forms • No limits on usage

MetLife Critical Illness Plan Highlights

Concept	If you experience one of the covered conditions within any category and meet all of the group policy and certificate requirement you will receive a lump-sum benefit payment to use as you see fit. This payment can help you keep your family finances on track if you experience a covered condition.		
Covered Conditions	MetLife Critical Illness Insurance covers the following medical conditions and groups them into three distinct categories:		
	Category 1 incorporates certain **cancer**-related conditions	**Category 2** incorporates certain **heart**-related conditions	**Category 3** incorporates certain **other** conditions
	• Full Benefit Cancer • Partial Benefit Cancer* • Bone Marrow Transplant	• Heart Attack • Stroke* • Coronary Artery Bypass Graft* • Heart Transplant	• Major Organ Transplant (other than bone marrow and heart) • Kidney Failure
Coverage Options	**Employee**	**Spouse**	**Dependent Chi1d(ren)**
	Category Benefit Amount of $10,000	$10,000 (same option as employee) provided the employee has qualified and enrolled for coverage.	$10,000 per dependent child provided the employee has qualified and enrolled for coverage.

MetLife VPI Pet Insurance Highlights

Concept	VPI Pet Insurance provides benefits for veterinary treatments related to accidents and illness, including cancer. Medical policies cover diagnostic tests, X-rays, prescriptions, surgeries, hospitalization and more. Optional CareGard wellness coverage is available for preventive care. For more information or to enroll, call 1-800-GET-MET8 or visit www.metlife.com/mybenefits.

**See brochure for details.*

FLEXIBLE SPENDING ACCOUNTS

The Tax Saver Option will be continued as in the past. This option allows you to pay certain health care and dependent care expenses with tax-free money (on a pre-tax basis). You need to enroll each calendar year to take advantage of these savings.

You will be mailed enrollment materials in the Fall of 2011. Remember, this is an optional benefit. Your Flexible Spending Accounts will be effective January 1, 2012, for the balance of the calendar year. The Internal Revenue Services (IRS) allows changes to your benefits during the year only if you have a Qualified Family Status Change.

HUMAN RESOURCES SUMMARY NOTICE OF PRIVACY PRACTICE

This is a summary of the Human Resources notice of privacy practices and describes how the department may use and disclose your protected health information and how you can access that information. Please review it carefully. For a complete, detailed account of the University's notice of privacy practices, please refer to "Pepperdine University's Notice of Privacy Practices," available upon request or on Pepperdine University's Intranet website at *http://www.pepperdine.edu/provost/policies*

The main objective of the HIPAA privacy rule is to provide a uniform and simplified minimum standard for the privacy of individually identifiable health information. As such, health plan members have certain rights regarding their protected health information.

- The right to receive notice of the group health plan's privacy practices
- The right to access, inspect, or copy any Protected Health Information (PHI) in your file
- The right to request amendment of erroneous or incomplete information
- The right to obtain an accounting made of disclosures of PHI
- The right to request restrictions of use or disclosure
- The right to request confidential communications
- The right to provide consent or authorization for the Benefits Department to assist you with understanding documents containing PHI
- The right to make a complaint to the Department of Health & Human Services and to the Group Health Plan whenever you feel as though your HIPAA rights have been violated.

The University will tolerate no retaliatory acts against an employee who exercises his/her HIPAA rights by filing a complaint.

Privacy Practices of the Plan Sponsor

- If you believe your HIPAA rights have been violated, you may contact the University's HIPAA Privacy Officer at (310) 506-6464. For all other concerns, please continue to contact the Benefits Department at (310) 506-4397.
- Staff members in the Benefits Department participate in ongoing training of privacy policies and procedures for handling PHI.
- A review of the physical area will be completed annually to insure that there is limited access to both computer & paper files containing any protected health information.
- The Benefits Department has a system of written disciplinary policies for workforce members who violate the privacy rules.
- Business associates of Pepperdine University who may handle your PHI are required to provide a written statement confirming that they are in compliance with HIPAA regulations.
- A written log sheet will be utilized to track access to files containing PHI.
- Individual Employee files will not contain PHI.

The Benefits Department staff, accountable to the Associate Vice President, Human Resources, Insurance and Risk, is committed to serving the Pepperdine Community with the utmost respect for "Protected Health Information."

NOTICE REQUIREMENT

Women's Health and Cancer Rights Act of 1998

Beginning in 1999, Federal law requires a group health plan to provide coverage for the following services to an individual receiving plan benefits in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and;
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The group health plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Insured plans and HMOs are subject to any applicable state laws mandating mastectomy and related benefits in addition to the federal Act's requirements.

Newborns' and Mothers Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Assembly Bill 38 requires that, if ordered by a plan physician, care of the mother and newborn includes a follow-up visit for mothers and newborns who have been discharged within 48 hours after delivery (or 96 hours if delivery is by cesarean section), to take place within 48 hours after discharge.

SPECIAL ENROLLMENT CIRCUMSTANCES

Notice of Special Enrollment Rights and Waiver of Health plan:

If you are declining enrollment for yourself or your dependents (including spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in the Pepperdine health insurance plan, provided that you request enrollment within 30 days after the other coverage ends. If you waive spouse health insurance (if you are already married) and do not have other health insurance and then have a new dependent as a result of birth, adoption, or placement for adoption, you may be able to enroll your spouse, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption, or placement for adoption.

Conditions of Special Enrollment

- When coverage was declined or waived, employee or dependent stated in writing that other coverage was the reason for waiver.
- If the other coverage was COBRA coverage, then the COBRA coverage must be exhausted for the special enrollment to apply.
- If the other coverage was not COBRA coverage, then the other coverage must terminate because of one of the following:

  Employer contributions towards the coverage has been terminated, or

  Loss of eligibility under the other coverage, such as:
  - Termination of employment or eligibility, or reduction in work hours
  - Legal separation
  - Divorce
  - Death

Loss of eligibility does not include:

- Loss of coverage due to the failure of the individuals to pay premiums on a timely basis, or
- Termination of coverage for cause, such as fraudulent claims and/or intentional misrepresentation of material fact in connection with the plan.

IMPORTANT NOTICE

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Pepperdine University and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Pepperdine University has determined that the prescription drug coverage offered by the Blue Cross and Kaiser plans are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Pepperdine University prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your coverage with Pepperdine University and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many

other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

Contact Human Resources for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Pepperdine University changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

OPEN ENROLLMENT DEADLINE

Review all the material you have received or which is available from Human Resources upon request before making your decision. Share this information with your family. **Your completed online enrollment must be done by August 13. The effective date for coverage is September 1, 2011.**

NEW EMPLOYEES

Generally, newly eligible employees must complete the appropriate online enrollment within 31 days following the date of hire.

Failure to enroll before the specified deadlines will result in default benefits.

DEFAULT BENEFITS

If you do not complete your online enrollment before the enrollment deadline, the University will provide you with "default benefits" for the plan.

Default core benefits include:

- Long-term disability coverage for 66.67% of your base monthly salary to a maximum benefit of $10,000 per month
- Term life insurance equal to two times your base annual salary[1]
- Accidental death & dismemberment insurance equal to two times your base annual salary[1]
- Business travel accident insurance equal to five times your base annual salary
- Health Advocate
- Psychological counseling services

Medical Plan benefits will be defaulted based on your current enrollment. You will be continued in your current medical plan at the same level of coverage you now maintain.

New employees who do not enroll in a medical plan within 31 days (some plans allow up to 45 days) of their initial eligibility date will be placed in the Kaiser HMO plan with single coverage unless they complete a Medical Plan Waiver form during the initial eligibility period.

Your dental enrollment or "opt-out" option will be defaulted based on your current enrollment choice.

New employees who fail to enroll in a dental plan within 31 days of their initial eligibility date will be defaulted into the "opt out" option and will not have an opportunity to enroll in a dental plan until the next open enrollment period. (Some restrictions may apply.)

It is to your advantage to take an active role in the enrollment process so that you receive the benefits you need. Remember, you will not have an opportunity to make any plan changes until September 1, 2012.

Note: Be sure to complete the appropriate online enrollment for the plans you have chosen.

[1]*At age 70, the amount will be reduced to 65% of the original benefit, at age 80, it will be reduced to 50% at the original benefit.*

How to complete the election worksheet

This worksheet form is provided to assist you in plan selection and cost determination. To determine your monthly cost, check your plan and enter the rate indicated for the level of coverage you select.

LEVEL 1 Single employee coverage

LEVEL 2 Employee coverage + 1 dependent

LEVEL 3 Employee coverage + 2 or more dependents

The first area lists coverage provided and paid by the University. No election is necessary.

Pre-tax deductions

1. The medical section lists the four medical options and your monthly cost.

Check the box indicating your choice of plan and enter the appropriate amount for the level of coverage you choose.

2. The dental section allows you to waive the dental coverage or to choose one of the two plans available.

Check the box indicating your choice and enter the appropriate amount for the level of coverage you choose.

3. There is one vision option. If you choose to participate, check the box and enter the appropriate amount for the level of coverage you choose.

4. Add monthly costs from lines (1), (2) and (3) to determine your total monthly cost and enter on line (4).

After-tax deductions

5. Optional life insurance is available to you and your family. Read the information provided in the brochure available in Human Resources upon request. You may request coverage in increments of $10,000. Rates are age-based. Calculate the correct amount and enter in the cost column. The total should be entered on the line indicated (5).

6. Your total monthly payroll deduction will equal the sum of lines (4) and (5).

Open enrollment – Be sure to review your information under the Benefit Enrollment section within the My Information section of WaveNet at wavenet.pepperdine.edu. Indicate any changes you would like to make in your medical and/or dental plan dependent coverage, vision, or life insurance beneficiary.

New employees – Be sure to complete the appropriate online enrollment for the plans you have chosen.

If you need assistance with the enrollment process, please contact:

Christine Hannick, *Benefits Specialist*	**ext. 7358**
Angie Pedersen, *Workers' Compensation and Wellness Program Specialist*	**ext. 4190**
Michelle del Giudice, *Senior Associate Director*	**ext. 4194**
Lauren Cosentino, *Associate Vice President, Human Resources, Insurance and Risk*	**ext. 6224**
Human Resources	**(310) 506-4397**

Special appreciation to University Communications for their work in developing this enrollment guide.

Your 2011-2012 Pepperdine University PEP*flex* Work Sheet

Instructions: The University provides certain benefits at no cost to you; other benefits are available on a pre-tax or after-tax basis. You may choose one plan in each category by placing a ☑ in the box by the plan of your choice. Enter the appropriate cost on the line indicated.

University Provided Benefits

Life Insurance *(2 x base annual salary)*
AD&D Insurance *(2 x base annual salary)*
Business Travel Accident Insurance *(5 x base annual salary)*
Long Term Disability Insurance
Psychological Counseling Services
Health Advocate

-0-

See explanation for "Levels" on the top of page 20.

$_____

Pre-tax Deductions	Level 1	Level 2	Level 3	
MEDICAL- Choose one plan		**Choose one level of coverage**		Enter your Monthly Cost
❑ Blue Cross POS	$111.19	$555.97	$555.97	
❑ Blue Cross EPO	$26.43	$211.46	$211.46	
❑ CaliforniaCare HMO	$12.45	$124.51	$124.51	
❑ Kaiser HMO	$11.09	$110.89	$110.89	
❑ Medical Waiver	-0-	-0-	-0-	$_____ Monthly cost **(1)**
DENTAL - Choose one plan		**Choose one level of coverage**		
❑ Delta/PPO	$8.07	$21.07	$44.95	
❑ DeltaCare USA HMO	$3.57	$7.10	$10.91	
❑ Dental Waiver	-0-	-0-	-0-	$_____ Monthly cost **(2)**
VISION		**Choose one level of coverage**		
VSP Signature	$10.36	$15.08	$ 27.08	$_____ **(3)**
TOTAL *Add monthly costs*		Add	Add	$_____ **(4)**

After-tax deductions

OPTIONAL BENEFITS*

MetLaw Prepaid Legal	$ 16.50	$_____
Critical Illness insurance for:		
❑ Employee	_____	$_____
❑ Spouse	_____	$_____
❑ Child(ren)	_____	$_____
Optional Life insurance for:		
❑ Employee	_____	$_____
❑ Spouse	_____	$_____
❑ Child(ren)	_____	$_____
TOTAL		$_____ **(5)**

GRAND TOTAL *Enter the amount of cost based on your choices from lines (4) & (5)* $_____ **(6)**

* To determine your cost refer to rate information in the brochure provided by the company.

GLOSSARY OF TERMS

Base annual salary - Annual earnings for plan purposes excluding overtime, bonuses, and other forms of special compensation.

Beneficiary - The person, persons, trust, etc., named by you to receive life insurance benefits in the event of your death.

Benefits - Payment in addition to an employee salary, which generally includes medical insurance, life insurance, paid sick time, etc.

Calendar year - January 1 through December 31.

Coinsurance - The percent of eligible expenses you pay other than as a deductible or co-payment. For example, if plan pays 80%, member pays 20% as the coinsurance amount.

Co-payment (or co-pay) - The amount you pay up-front to receive in-network services.

Deductible - The amount you pay for yourself and/or each covered dependent in a calendar year before benefits are payable.

Dependent - Family members who are carried on one or more of your insurance plans. Please see eligibility rules included in this booklet.

Emergency - An injury, illness, or condition, generally life threatening that requires immediate medical attention.

Enrollment - Registration to become an official member of a group.

EPO - Exclusive Provider Option.

Family maximum deductible - Applies if you choose coverage for yourself and your eligible dependents. Each covered dependent is subject to the individual deductible each year. However, once the total out-of-pocket expenses reach the family maximum deductible, no additional deductibles will be required that calendar year.

HMO - Health Maintenance Organization.

In-network - Services provided by or received from HMO providers participating in the chosen plan.

Lifetime maximum benefit - The maximum total payable benefit that you or your dependent(s) can receive while covered under the plan. Each person covered under the plan has an individual lifetime maximum benefit.

Medically necessary - Required in the judgment of the claims administrator to treat your condition, according to plan provisions. This specific service or item must be the most efficient and economical approach that can be safely provided.

Network - A group of health care professionals, facilities, and hospitals in a specific geographic area, which have agreed to provide a wide range of health care services on a contractual basis.

Network manager - The organization (such as Blue Cross) that provides administrative and management services of the network, with which they have a contractual relationship. Network manager services include credentialing, evaluation of practice patterns, Member Services, claims payment, and provider relations.

Open enrollment period - The time each year during which you select your PEP*flex* benefits for the following plan year. At this time you may join a health plan, discontinue or add dependent coverage, or add optional benefits plans.

Out-of-network - Services received from non-network providers.

Out-of-pocket maximum - The maximum amount you have to pay in a calendar year toward each covered person's eligible medical expenses under the health care plan options. When expenses for your covered charges reach the out-of-pocket maximum, the plan begins to pay 100% of most covered expenses for you and your covered dependent(s) for the rest of the calendar year. The out-of-pocket maximum does not include the deductible, unreimbursed expenses, excess of Reasonable & Customary charges, or any penalties for not obtaining a preauthorization. The medical plan out-of-pocket maximum does not apply to some Psychological & Nervous and Alcoholism/ Chemical Dependency coverage.

Plan year - September 1, 2011, through August 31, 2012.

POS - Point-of-Service plan.

PPO - Preferred Provider Option.

Preauthorization - A treatment plan submitted to the claims administrator prior to treatment that itemizes the recommended services and associated costs.

Preferred Providers - Physicians, health care facilities and other health care providers who belong to a network.

Primary care physician - A physician participating in one of the networks who is the primary source for in-network care and referrals.

Provider - One who provides health care; e.g. a doctor, nurse practitioner, hospital, clinic, laboratory, etc.

Reasonable and customary (R&C) -
In conformance with fees usually charged by the provider, and within the range of usual fees charged for the same procedure by similar institutions or persons in the same geographic area, as determined by the claims administrator.

Second surgical opinion - An opinion of a second doctor of the advisability of elective surgery. The second opinion is based on examination of the patient after surgery has been recommended but before the surgery is performed.

Single Coverage - Coverage for employee only.

Usual and prevailing - See reasonable and customary.

UD1105058