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Your benefits begin on the first day you are actively at work as a full-time or part-time Visa eligible employee. This means at least 30 hours a week as a full-time employee or at least 20 hours per week as a part-time Visa employee.

**What benefits am I eligible for as an U.S. employee, who can I cover and who pays?**
As an eligible U.S. employee, you may participate in:

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<td><strong>Dental plans</strong></td>
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<td><strong>Vision plans</strong></td>
<td>All U.S. eligible</td>
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<td>• Base plan*</td>
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<td>(LPFSA, Cigna Choice Fund Plan participants</td>
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<td>only)</td>
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<td><strong>Employee Assistance Program</strong> (EAP)*</td>
<td>All U.S. eligible</td>
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<td></td>
<td>employees</td>
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<td>You</td>
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* You’re automatically enrolled in these benefits.
Starting Your Health Care Coverage

**How do I enroll in my new hire benefits?**
You’ll receive an email from TRI-AD with a link to Visa Benefits Online to enroll in your benefits within seven to ten business days of your hire date. You have 31 days from your hire date to enroll in coverage.

If it has been more than ten business days:
- Go to [Visa Benefits Online](#) to make your new hire elections **within 31 days** of your hire date.
- Be sure to submit your elections by clicking “I’m Done” and print a copy of your confirmation page.

You must enroll in benefits within 31 days of your start date. **If you do not enroll by the deadline, you’ll be enrolled in the default coverage (see below).** If you’re unable to register on the site, please submit an AskHR request for assistance.

**What if I’m hired during or after the open enrollment period?**
If you’re hired during the open enrollment period, you’ll need to ensure that you actively make your benefit elections for the remainder of the 2016 calendar year and 2017. Your 2016 elections will not roll over to 2017.

If you don’t actively make your benefit elections for 2017, you may not have the coverage you expect. You must enroll for both years to ensure the correct coverage.

**What happens if I don’t enroll within 31 days of my date of hire?**
If you don’t enroll by the deadline, you’ll receive the following default coverage for 2017:

- Cigna Choice Fund (High Deductible Health Plan) medical plan, employee only
- Cigna DPPO dental plan, employee only
- VSP Base vision plan, employee only
- Basic life and AD&D insurance, 2x base annual pay ($50,000 minimum up to maximum of $2.5M)
- Short-Term Disability coverage
- Long-Term Disability coverage, option one – taxable benefit plan
- Employee Assistance Plan (EAP)

Your portion of the contributions for these coverages will be automatically deducted from each paycheck as of your date of hire.
How much will my benefits cost me per pay period?
The per-pay period deductions for medical, dental and vision benefits are listed [here](#). All other deductions are outlined on [Visa Benefits Online](#) during your enrollment process. Once you’re enrolled, review your Confirmation Statement for detailed information based on your elections.

How do I enroll my dependents if I don’t have their Social Security Number?
If you don’t have a Social Security Number for a dependent, use a pseudo (dummy) Social Security Number that starts with either 777 or 888 as the first three digits. Newborn children do not require Social Security Numbers.

Once you have a permanent Social Security Number, please log back in to the [Visa Benefits Online](#) to update the Social Security Number(s).

**Note:** Pseudo SSNs are for enrollment purposes only. Benefit carriers will not process claims for dependents with a pseudo (dummy) Social Security Number.

What if I’m covered under another benefits program outside of Visa and do not need coverage under the Visa benefits program?
If you’re covered under another benefits program, you can waive (decline) participation in most Visa benefits programs.

If you waive (decline) medical or dental coverage, you’re eligible to receive a medical credit of $12.50 per pay period and/or a dental credit of $5 per pay period. This credit will be included in your paycheck and is considered taxable income.

To receive the waiver credit, if eligible, you must waive your coverage at [Visa Benefits Online](#). The credit will be reflected on your confirmation statement.

When will my benefits be effective?
If you’re a new hire, your coverage begins on your first day as an active employee. Please allow approximately two weeks for your submitted elections to be updated with the vendors. Please allow 7-10 business days, after you submit your elections, to receive ID cards in the mail, where available.

If you’re making benefit changes due to experiencing a qualifying family status change, your benefit election changes will take effect according to the effective date of the family status change event.

Open enrollment changes are effective January 1 of the following plan year.
I just enrolled in my benefits, how soon can I or my covered dependent(s) see a provider?
If you need medical attention before you receive ID cards, you may seek medical attention immediately, however your provider may require you to pay out of pocket. If you save your receipts, you may file a claim with your insurance carrier for reimbursement of eligible expenses back to your first day as an active employee.

What if I have other (dual) coverage?
The Visa-sponsored plan(s) is always primary for active Visa employees. The Visa-sponsored plan may be the secondary payer for your dependent(s), but it will only pay the difference between what you receive from the other plan and the amount it would pay if it were the only plan.

The Visa-sponsored Cigna plan pays nothing if the other plan provides benefits equal to or higher than the Cigna plan’s benefits. The Visa-sponsored Cigna plan does not duplicate benefits paid by other health plans.

The Kaiser Permanente plans may coordinate benefits for employees and dependents with other coverage.

Contact Member Services (see the back of your ID card for the phone number) for more information.

When can I add or drop coverage for myself or a dependent?
You can make a change to who is covered under your current elections during open enrollment, or you may add a new dependent or remove an existing dependent when you have a family status change. Family status changes may include open enrollment of a spouse/domestic partner’s plan, commencement/termination of a spouse/domestic partner’s employment, marriage, divorce or birth/adoptions of a child.

You must submit your new elections through Visa Benefits Online within 31 days of your eligible family status change (i.e. marriage date, date of birth of newborn, etc.). Family status changes that affect your paycheck contributions will be effective the first full pay period following the date you submit your changes online. No refunds will be made.

All changes must be consistent with your “family status” change. For example, if you get married, you may add your new spouse or cancel your coverage if you enroll on to your spouse’s plan. Or if you have a newborn, you may add your newborn to your existing coverage, but you may not cancel your coverage. For additional details, please make sure that you review the individual health insurance Summary Plan Descriptions and the family status change chart.
I had a qualified change in family status and need to update my benefit elections. How do I do it and how long do I have to make the change?

You have 31 days to submit your elections once you experience a qualifying life change in family status. To make changes to your benefits, visit Visa Benefits Online within 31 days of the eligible family status change event.

Family Status Changes that are not reported within 31 days will not be allowed. You will need to wait until the next open enrollment period, unless you experience a different family status change event, to make benefit changes.

When can I make a change to my current benefit elections, i.e., change/switch medical, dental and vision plans?

You may not switch or change plans midyear, even if you have a “family status” event, unless you experience a HIPAA “special enrollment rights” (SER) event or you have moved out of a service area and are no longer eligible for your current plan. You may switch plans annually during open enrollment.

I’m moving to another state/county/service area. How will my medical benefits be impacted?

If you have moved out of a service area and are no longer eligible for your current medical plan, you’ll be able to make new benefit elections. You’ll receive an email from TRI-AD, our benefit administrator, within five business days of your address being updated in Workday, allowing you to switch plans.

Your relocation should be communicated and approved by your manager and updated in Workday. If your home location is not updated in Workday, you won’t be eligible to reenroll.

How can I change my primary care physician (PCP) or primary care dentist (PCD)?

You can change your PCP or PCD by contacting Member Services (see the back of your ID card for the phone number). Most changes are effective on the 1st of the following month.

How can I save on prescription drug copays?

There are three simple ways to save on prescription drugs:

- **Use generic prescriptions when available.** Typically, you pay less for generic drugs than for brand-name drugs. Consult with your doctor to find alternatives to brand name drugs.

- **Use 90-day supply.** You can obtain a 90-day supply for any maintenance drugs and save. You’ll need a new prescription, so be sure to contact your medical carrier to understand the process.

- **Use an in-network pharmacy.** Find a network pharmacy near you by visiting your medical carrier’s website. Be sure to update the pharmacy with your medical ID card.
How do I find out what’s covered or not covered by my health insurance?
To find out what’s covered or not covered by your health insurance, contact Member Services (see the back of your ID card for the phone number) or review the Summary Plan Descriptions located in the Benefits Library of BenefitSource.

How do I update my home address with the health insurance carriers?
Update your home address/phone number through Workday. All carriers will be automatically updated within two weeks.

How do I find in-network physicians, pharmacies or medical facilities?
To locate doctors, dentists, pharmacies or medical facilities within your plan, access your insurance carrier’s website directly. You can also call Member Services (see the back of your ID card for the phone number). You can find a listing of all the carriers and policy numbers on BenefitSource.

What identification (ID) cards will I receive if I am newly enrolled?
- All medical plans: You’ll receive an ID card within three weeks of enrollment.
- Dental PPO: No ID cards are issued for the Cigna Comprehensive Dental Plan. You’ll need to print a claim form from BenefitSource and provide it to your dentist.
- Dental HMO: You’ll receive a dental card with the name of your primary care dentist (PCD) on it within three weeks of enrollment.
- Vision: No ID cards are issued for VSP vision. Just tell your VSP provider that you’re a VSP member and provide your date of birth and Social Security Number.

NOTE: It can take up to 21 days from the date you enroll before your medical, prescription drug and dental plan elections become part of the plan’s records. If you have an emergency prior to receiving your ID card, you can print a temporary ID card from your chosen carrier’s website. If your doctor requires you to pay out of pocket, keep your receipts and submit a claim to your carrier for reimbursement once you’re actively enrolled.

I lost my medical/dental card. How do I get a new one?
You can request a new card by calling your insurance carrier’s Member Services. The Benefits Guide has a list of carrier contacts.

What do I do if I have an unresolved claim issue?
Call your insurance carrier’s Member Services (see the back of your ID card for the phone number) for questions about what’s covered, pre-authorization, changing your PCP, ordering new cards and resolving claim issues.
I plan to travel abroad for personal reasons and am currently enrolled in a Visa medical plan. Am I covered with our current domestic medical insurance?
Regardless of the medical plan (Cigna or Kaiser Permanente), medical services incurred outside of the United States and its designated territories are excluded, unless the charges are for emergency services. Routine or non-emergency care is not covered outside of the U.S. Refer to the Summary Plan Description for more information.

In an emergency (life-threatening) situation, seek medical care immediately. You must call your medical plan administrator (Cigna or Kaiser Permanente) within 24 hours of admission into a hospital, or as soon as possible. You’ll be responsible for paying for the services received. Upon your return home, submit a claim for reimbursement.
Dependent Eligibility

Who can I cover under my benefit plans?
Your eligible dependents include:

- Your legal spouse or qualified domestic partner
- Your dependent child(ren) up to age 26
- Your domestic partner's children, provided you have a domestic partner on file.
- A child for whom you have a court order to provide medical care or a Qualified Medical Child Support Order (QMCSO)
- A child for whom you or your spouse/domestic partner is a court-appointed guardian prior to the child reaching age 18

For medical, dental and vision:
- Your eligible child(ren) up to age 26 (coverage will cease at the end of the calendar year in which the child(ren) reaches age 26)
- An unmarried disabled child(ren) over age 26; proof of incapacity is required and the child(ren) must have been disabled prior to age 19

For child life and/or family AD&D:
- Your unmarried dependent child(ren) supported by you up to age 19 (up to age 25 if the child(ren) is a full-time student with at least eight credits from an accredited educational institution and not employed full-time)
- Your unmarried dependent child(ren) over age 19 if they're dependent upon you for support due to a physical or mental disability; the child(ren) must have been previously enrolled for life and/or AD&D (proof of disability is required once a year)

How do I cover my domestic partner?
For information on domestic partner coverage, go to the Domestic Partner FAQ page.

When should I indicate that my dependent is a student?
You'll be able to indicate your child(ren)'s full-time student status during the annual open enrollment process or within 31-days of their 19th birthday. During the workflow process on the Visa Benefits Online portal, you'll have an opportunity to certify the appropriate dependent(s) as full-time on the dependent page.
Life and AD&D Insurance

Is Basic Life AD&D Insurance coverage changing?
For 2017, your Visa paid basic life and AD&D insurance is increasing to 2x your base pay, up to a maximum of $2,500,000, with a minimum coverage of $50,000. Amounts over $50,000 will be subject to imputed income. This means that you’ll pay taxes on the premium that Visa pays for any amount of coverage over $50,000. You have the option of choosing your current $50,000 coverage if you don’t wish to pay imputed income.

Can I change my optional life insurance election without providing evidence of good health?
During open enrollment, you may increase your current optional life insurance election by one multiple of your salary without providing evidence of good health, as long you didn’t previously waive coverage and as long as you’re not increasing from 2x your annual salary to any higher level.

How do I change my beneficiary?
To change the beneficiary of your life or accident insurance coverage, please access the beneficiary tile on visabenefitsonline.com to makes changes, and submit online.
Flexible Spending, Limited Purpose Spending and Dependent Care Accounts (FSA)

How do I submit a flexible spending account (FSA), Limited Purposed Flexible Spending Account (LPFSA) and/or dependent care flexible spending account (DCFSA) claim?

Spending account claims can be submitted through Visa Benefits Online.
- Log in and select Reimbursement Plan Accounts.
- Select Enter a New Claim.

Paper claims can also be faxed to 760-233-4741. You can find the paper claim form on BenefitSource. For more information, click here.

How do I sign up for direct deposit for my spending accounts?
Direct deposit can be set up through Visa Benefits Online.
- Log in and select Reimbursement Plan Accounts.
- Select Manage Direct Deposit.

I enrolled in a spending account. When should I expect to receive my debit card?
A debit card is automatically issued once the enrollment is processed. You should expect to receive it within three weeks after you enroll. If you don’t receive your debit card in the mail, please contact TRI-AD at 888-844-1372 to cancel the original debit card and have a new card issued.

Can I make changes to the amount of my FSA, LPFSA and/or DCFSA election?
If you experience a qualifying change in family status, you can make certain allowable changes to your benefits through Visa Benefits Online within 31 days of the family status change event.

Family status changes may include open enrollment in a spouse/domestic partner’s plan, commencement/termination of a spouse/domestic partner’s employment, marriage, divorce or birth/adoptive of a child. Visit Family Status Changes for more information. Note: Family status changes that are not reported within 31 days won’t be allowed. You’ll need to wait until the next open enrollment period unless you experience another family status event to enroll in benefits.

How do I get claim forms and account information for my spending account(s)?
If you elect to contribute to a flexible spending account (health or dependent care), TRI-AD, our administrator, will send you a welcome kit that includes claim forms. You may also log on to Visa Benefits Online to file your claims, download claim forms or check your account status.
How do I get reimbursed?
Health care FSA and LPFSA - you have two options:

- **Debit card:**
  - You receive a debit card when you sign up for the health care FSA program to pay for eligible health care expenses.
  - The debit card enables you to access funds directly from your FSA account at the point of service.
  - It significantly reduces or eliminates the traditional hassle of submitting paper claims and waiting for reimbursement.
  - This means that you don’t pay out of pocket twice for the same copayment or deductible, such as paying cash for services (in addition to your payroll deduction), completing and submitting a claim form and waiting for the reimbursement check.
  - You can use your FSA Visa debit card at any eligible health care merchant location that accepts debit cards.
  - Helpful hint: When utilizing the card, please process the transaction as a “credit” purchase and sign the receipt, not as a “debit” purchase needing a PIN.

- **Manual claim form:**
  - You may utilize the [mail/fax in claim form](#) to be reimbursed for your qualified health care expenses.

- **Dependent care expenses:**
  - You may [mail/fax in a claim form](#) to be reimbursed up to your current account balance.
  - Click [here](#) to download a claim form.
  - Follow the instructions on the form and submit.

**NOTE:** Regardless of payment options, keep all receipts for substantiation due to IRS regulations.

You may also submit your claims at any time online at [http://benefitsource.visa.com/main.jsp](http://benefitsource.visa.com/main.jsp). The deadline for submitting claims with dates of service occurring in 2016 is March 31, 2017. Claims will be processed daily.

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**How do I get a FSA or LPFSA debit card for my dependent(s)?**

You may request an additional debit cards online at [Visa Benefits Online](#) for your eligible dependent.

**Does the FSA have a contribution limit?**

Yes, the 2017 contribution limit for LPFSA participation is $2,500. You must decide before the beginning of the plan year how much you want to contribute. You may change the contribution if you experience a qualifying family status change, or during open enrollment.

**Can I roll over funds in a FSA?**

Yes, you may carry over up to $500 of unused funds to the following year. Funds in excess
FREQUENTLY ASKED QUESTIONS
U.S. BENEFITS – HEALTH & WELLNESS

of the $500 carryover limit will be forfeited.

**What is a limited purpose FSA (LPFSA)?**
A limited purposed FSA is available only to employees who participate in the Cigna Choice Fund high deductible health plan (HDHP). The account allows reimbursement of dental and vision expenses. You may participate in this benefit in addition to the health savings account (HSA) that comes with the Cigna Choice Fund Plan.

**Does the LPFSA have a contribution limit?**
Yes, the 2017 contribution limit for LPFSA participation is $2,500. You must decide before the beginning of the plan year how much you want to contribute. You may change the contribution if you experience a qualifying family status change, or during open enrollment.

**What expenses are eligible under a LPFSA?**
A limited purpose FSA covers qualified out-of-pocket expenses for dental or vision care provided to you, your spouse or your dependents. Typical eligible expenses include:

- **Qualified dental expenses:** cleanings, fillings, crowns, braces
- **Qualified vision expenses:** contact lenses, eyeglasses, eye exams, vision correction procedures

**Note:** Expenses reimbursed under your limited purpose FSA cannot be reimbursed under any other plan or program, including an HSA. Only your eligible out-of-pocket expenses may be reimbursed. Plus, expenses reimbursed under this FSA may not be deducted when you file your tax return.

**Can I roll over funds in a LPFSA?**
Yes, you may carry over up to $500 of unused funds to the following year. Funds in excess of the $500 carryover limit will be forfeited.
What happens when I leave Visa?

COBRA
I’m terminating my employment. What are my options to continue under the Visa-sponsored benefit plans?
You and/or your eligible dependents (qualified beneficiaries) may continue coverage under the Visa-sponsored medical, dental and vision insurance and flexible spending coverage pursuant to COBRA.

COBRA requires Visa to offer continuation of the currently enrolled coverage to employees, their spouses, former spouses and dependent children when group health coverage would otherwise be lost due to specific events. COBRA continuation coverage is more expensive than the amount you pay for group health coverage because we pay a portion of the cost of your coverage.

You and your covered dependents are eligible for COBRA as qualified beneficiaries, i.e., individuals covered by a group health plan on the day before a qualifying event occurred that caused him or her to lose coverage. You can elect COBRA for one or all of your qualified beneficiaries, i.e., you can enroll yourself, you and your covered dependents, or just your covered spouse/dependent(s).

An enrollment packet will be mailed to your last known home address and you have a 60-day period to elect COBRA coverage.

When will I receive COBRA information if I leave Visa?
If you’re currently enrolled in the COBRA-eligible benefit plans and your employment ends, TRI-AD (COBRA administrator) will notify you and/or your covered dependents of your COBRA rights. This notification will be completed by mail at your last known address and will include your enrollment form and the COBRA participant rates.

You have a 60-day period to elect to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary within the grace period. The timeframes for COBRA election are defined by the Department of Labor and exceptions cannot be made.

What are the COBRA rates?
Visit BenefitSource to review the current COBRA rates.
Are there alternatives to COBRA for health coverage?
Yes. We recommend you consider all options to obtain other health coverage before you make a decision to elect COBRA. There may be more affordable or more generous coverage options for you and your family through other group health plans (such as a spouse’s plan), the Health Insurance Marketplace or Medicaid.

Under the Health Insurance Portability and Accountability Act (HIPAA), loss of Visa-sponsored medical, dental and vision insurance and flexible spending coverage eligibility may provide you the right to special enroll (enroll without waiting until the next open season for enrollment) in other group health coverage (such as a spouse’s plan). For example, if you lose eligibility for the Visa-sponsored medical, dental and vision insurance and flexible spending coverage, this may allow you to special enroll in a spouse's plan. Typically, you or your dependent must have had other health coverage when you previously declined coverage in the plan in which you now want to enroll and you must request the special enrollment within 30 days from the loss of the job-based coverage.

Losing your job-based coverage is also a special enrollment event in the Health Insurance Marketplace (Marketplace). The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance and copayments), and you can see what your premium, deductibles and out-of-pocket costs will be before you make a decision to enroll.

Eligibility for COBRA continuation coverage won't limit your eligibility for Marketplace coverage or for a tax credit. You can apply for Marketplace coverage at HealthCare.gov or by calling 800-318-2596 (TTY 855-889-4325). To qualify for special enrollment in a Marketplace plan, you must select a plan within 60 days before or 60 days after losing your job-based coverage. In addition, there is an annual open enrollment period where anyone can enroll in Marketplace coverage. Visit HealthCare.gov or call 800-318-2596 (TTY 855-889-4325) to learn more.

Through the Marketplace, you can also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can apply for and enroll in Medicaid or CHIP any time of year. If you qualify, your coverage begins immediately. Visit HealthCare.gov or call 800-318-2596 (TTY 855-889-4325) for more information or to apply for these programs. You can also apply for Medicaid by contacting your state Medicaid office and learn more about the CHIP program in your state by calling 877-KIDS-NOW (543-7669) or visiting insurekidsnow.gov.

If you or your dependent elects COBRA continuation coverage, you'll have another opportunity to request special enrollment in a group health plan or a Marketplace plan if you have a new special enrollment event, such as marriage, the birth of a child or you've exhausted your continuation coverage.
To exhaust COBRA continuation coverage, you or your dependent must receive the maximum period of continuation coverage available without early termination (typically 18-months). Keep in mind that if you choose to terminate your COBRA continuation coverage early with no special enrollment opportunity at that time, you’ll generally have to wait to enroll in other coverage until the next open enrollment period for the new group health plan or the Marketplace.

**If I have additional questions about COBRA continuation, who should I contact?**
You can contact TRI-AD at 855-295-VISA or via email at visabenefitservices@tri-ad.com to assist with your COBRA continuation questions.

**I am interested in early retirement what are my healthcare options?**
Please refer to BenefitSource for more information on early retirement and retirement eligibility and benefits.

Review the Visa Early Retiree Medical Plan information carefully, as the early retiree health care plans are different from the active employee plans (such as deductibles, co-insurance, out-of-pocket maximums, etc.). If you choose to enroll in a Visa early retiree medical plan and you pay the premium in the time allowed, your coverage will revert back to the date your active coverage ended. If you see a doctor before you’re enrolled in the early retiree medical plan, you’ll need to pay out of pocket and seek reimbursement from your provider after your coverage is in place.

**What happens when my employment with Visa ends (other than retirement)?**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Status at Termination</th>
<th>COBRA Eligible</th>
<th>Conversion</th>
<th>Portability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Coverage ends at the end of the calendar month in which your active employment ends</td>
<td>Benefit is eligible for COBRA continuation at 102% of the cost</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Dental</td>
<td>Coverage ends at the end of the calendar month in which your active employment ends</td>
<td>Benefit is eligible for COBRA continuation at 102% of the cost</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Vision</td>
<td>Coverage ends at the end of the calendar month in which your active employment ends</td>
<td>Benefit is eligible for COBRA continuation at 102% of the cost</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Plan Type</td>
<td>Coverage Details</td>
<td>Conversion/Portability Options</td>
<td></td>
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<tr>
<td>Basic Life and AD&amp;D</td>
<td>Insurance coverage ends on the date you terminate employment</td>
<td>You may apply to convert or port your life insurance coverage to an individual policy within 31 days after coverage ends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optional Life and AD&amp;D</td>
<td>Insurance coverage ends on the date you terminate employment</td>
<td>You may apply to convert or port your life insurance coverage to an individual policy within 31 days after coverage ends</td>
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</tr>
<tr>
<td>Business Travel Accident (BTA)</td>
<td>Insurance coverage ends on the date you terminate employment</td>
<td>You may apply to convert or port your life insurance coverage to an individual policy within 31 days after coverage ends</td>
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<tr>
<td>Short-Term Disability (STD)</td>
<td>Coverage ends on the date you terminate employment unless you are on an approved STD or LTD leave of absence</td>
<td>You may apply to convert or port your life insurance coverage to an individual policy within 31 days after coverage ends</td>
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<tr>
<td>Long-Term Disability (LTD)</td>
<td>Coverage ends on the date you terminate employment unless you are on an approved STD or LTD leave of absence</td>
<td>Not applicable</td>
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<tr>
<td>Health Savings Account (HSA)</td>
<td>You may no longer make contributions to the HSA, unless</td>
<td>Not applicable</td>
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<tr>
<td>Benefit</td>
<td>Description</td>
<td>401k</td>
<td>Other Benefits</td>
<td></td>
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<tr>
<td>Dependent Care FSA</td>
<td>Participation and eligibility end the date you terminate; if you were pre-approved for any course(s) and started the course(s) before you terminated, you’re eligible to complete the course(s) and submit for qualified expenses.</td>
<td>Not applicable</td>
<td>You may apply to port your legal plan policy coverage to an individual policy within 31 days after coverage ends; you must contact Hyatt Legal Plans’ Client Service Center, at 1-800-821-6400, within 31 days of your termination.</td>
<td></td>
</tr>
<tr>
<td>Group Legal</td>
<td>Participation ends the end of the month in which you terminate.</td>
<td>Not applicable</td>
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<tr>
<td>401k</td>
<td>Your participation and eligibility for the 401k ends; however, the vested value of your 401k accounts is payable.</td>
<td>Not applicable</td>
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<tr>
<td>Educational Assistance Program</td>
<td>Your participation and eligibility end the date you terminate; if you were pre-approved for any course(s) and started the course(s) before you terminated, you’re eligible to complete the course(s) and submit for qualified expenses.</td>
<td>Not applicable</td>
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<td></td>
<td>Reimbursement (policy guidelines still apply)</td>
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<tr>
<td><strong>Paid Time Off (PTO)</strong></td>
<td>The value of your unused PTO is payable up to the 248-hour limit</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

**Definitions:**
- COBRA eligible – allows you to continue enrollment in the benefit post-employment; you are responsible for paying premium costs at 102% of the group rate
- Portability – allows you to convert the group life policy to a term life policy
- Conversion – allows you to convert the group life policy to a whole life policy
Other Benefits

**Can employees enroll in the group legal plan at any time during the year?**
Employees can enroll in the group legal plan as a new hire or during open enrollment.

**Where can I find information about the group legal plan, including a provider directory?**
Information on the group legal plan, including the Summary Plan Description, highlights and contact information, can be found on BenefitSource.