STEVENS
INSTITUTE OF TECHNOLOGY
1870

2027
Benefits Guidebook



Welcome to your 2027 Benefits Guide

Among the things that make Stevens a great place to work is the organization's commitment to our staff, which is demonstrated by offering an extensive employee benefits package. As an eligible employee, you may enroll in one of the most comprehensive benefit programs in higher education.

Stevens provides you with a wide range of benefit options to help you meet your changing benefit needs, and we are committed to providing you with great products that are among the best available in our market.

This benefits guidebook highlights our many benefit programs and provides you with an easy to read resource for your benefit enrollment.

If you have any questions about your coverage options, please contact Stevens Human Resources at 201-216-5122 or benefits@stevens.edu.

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Plan Rules, Dates & Eligibility

PLAN YEAR

The plan year for the Stevens Institute of Technology benefit programs begins on January 1 and ends December 31.

ELIGIBILITY*

If you are a regular employee scheduled to work at least 30 hours per week, you are eligible to enroll in benefits based on the chart below:

Benefit	Coverage Effective Date	Eligible Dependents
Medical, Dental, Vision, Supplemental Health Benefits and Flexible Spending Accounts	First of the month coincident with or next following your date of hire	• Legal spouse • Natural, adopted (or placed for adoption), step children and children for whom you are the legal guardian, regardless of full-time student status, tax status, marital status or residence, up to end of the year in which they turn age 26 for medical. Coverage ends at the end of the month in which the dependent child turns age 26 for dental and vision.
Basic Life and Accidental Death & Dismemberment (AD&D), Supplemental Life and Spouse Life	Date of Hire	Legal Spouse Only
Long Term Disability	First of the month following 12 months of continuous employment	Not Eligible
NJ Temporary Disability Benefit (NJ TDB) (for NJ work based employees)	As defined by NJ TDB law	Not Eligible
NY Disability Benefits Law (DBL) & Paid Family Leave (PFL) (for NY work based employees)	As defined by NY DBL/PFL law	Not Eligible
Short-Term Disability (STD) (for employees not covered by NJ TDB or NY DBL)	Date of Hire	Not Eligible
Business Travel Accident (for salaried employees only)	Date of Hire	Not Eligible

Medical, dental and vision benefits end at the end of the month in which your employment or benefit eligibility terminates. Coverage for all other benefits ends on your date of termination or the date you are no longer eligible for benefits.

**Under the Affordable Care Act (ACA), you may be eligible for medical coverage as a part-time employee if you work, on average, 30 hours per week during the applicable measurement period.*



CHANGING YOUR BENEFITS

Employees may only enroll in our benefit plans during your initial benefits eligibility period or the annual open enrollment. As such, your benefit choices for medical/prescription drugs, dental, vision, and your contributions to flexible spending accounts are binding. Your elections take effect immediately following the applicable waiting period and cannot be changed until the next annual enrollment period (in fall 2027 for a January 1, 2028, effective date), unless you experience a qualifying life status change.

Below is a list of a few events that would permit you to make a change midyear:

- Marriage
- Birth, adoption or placement for adoption of an eligible child
- Divorce, legal separation or annulment of marriage
- Employee or dependent loss of coverage on another plan
- Death of dependent
- Loss of dependent status
- Becoming eligible for Medicare or Medicaid during the plan year

30 Days

For any qualifying life events, you must inform Human Resources within 30 calendar days (60 calendar days for changes related to Medicaid, CHIP eligibility or a dependent aging off of the plan) and provide proof of the event. Benefit changes requested due to a "change of mind" are not permissible until the next annual enrollment period.

Medical Benefits

MEDICAL & PRESCRIPTION DRUG PLAN OPTIONS

Vendor: Aetna

Group Number: 251896

Carrier Contact#: (888) 266-5519

Provider Network
Core, Plus, HDHP: Aetna Choice POS II (Open Access) EPO: Aetna Select (Open Access)

Employee Per Paycheck Cost: Refer to page 28 for pre-tax medical contributions.

Plan Highlights

You have a choice of four plans: Core, Plus, EPO and a High Deductible Health Plan (HDHP) with an HSA. Claim forms are not required when utilizing network participating providers. Providers who participate in Aetna's network accept negotiated rates which reduce your claim costs and out of pocket expenses.

- There is no cost for preventive care visits with network participating physicians in all medical plan options.
- You are not required to select a Primary Care Physician (PCP) and referrals are not needed to seek services from a specialist.
- Out of network benefits are available if you enroll in the Core, Plus or HDHP plans.

How the Core, Plus and EPO Plan Deductibles Work

All in-network facility charges, including inpatient and outpatient surgery, are subject to the plan's in-network deductible. Once the deductible is satisfied, the plan will pay a percentage of the negotiated rate, referred to as coinsurance. Office visits, emergency room visits and urgent care visits are not subject to the plan's deductible.

After each family member meets their individual deductible, the plan will pay subsequent claims (up to the allowable charge, if out-of-network) less any copayment or coinsurance amounts. After the total family deductible has been met, each individual's claim will be paid by the plan (up to the allowable charge, if out of network) less any copayment and coinsurance amounts. No one family member will ever be charged more than their individual deductible. Every dollar that is applied to any one family member's individual deductible is also applied to the overall family deductible.

How the HDHP Deductible Works

All in-network services except preventive care, including prescription drugs, accumulate towards the plan's deductible. All family members contribute towards the family deductible. No individual in a family will have met the deductible until the entire family deductible is met. Once the deductible is met, coinsurance applies for all subsequent services for the remainder of the plan year.

Prescription Drugs

The prescription drug plan for all four medical plans is administered through Aetna. For information on quantity limits, step therapy and/or pre-certification requirements prescription drugs, please contact Aetna or visit their website at www.aetna.com.

To check how a medication is covered, use Aetna's drug search tool. Choose plan year **2027**, then choose **Advanced Control Plan - Aetna**.

In the HDHP, prescription drugs are subject to the plan's deductible. After your deductible is satisfied, you are responsible for paying 30% of the full discounted cost of your prescription drug medication.

Mail Order Drug Program

The mail order program benefits employees who are on maintenance medications for chronic conditions such as diabetes, asthma and high blood pressure (or any medication you take on a regular basis). By ordering prescriptions by mail, you can receive a 3-month supply of prescriptions delivered directly to your home for two times the retail pharmacy copayment (Core, Plus and EPO plans only). You can order prescriptions for mail order online via www.aetna.com.

Finding a Provider:

To find a participating provider near you, please call Aetna at the phone number at the top of this page, or visit www.aetna.com. Choose the Aetna Choice POS II (Open Access) for plans with in-network and out-of-network benefits and the Aetna Select (Open Access) for plans with in-network benefits only. Both networks access the same providers.

	Medical / RX Highlights						
	Core Plan		Plus Plan		EPO Plan	HDHP	
Medical Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network Only	In-Network	Out-of-Network
Annual Deductible (Individual /Family)	$500/$1,000	$1,500 / $3,000	$250/$500	$1,000 / $2,000	$1,000 / $2,000	$2,000 / $4,000	$3,000 / $6,000
Coinsurance (Plan Pays)	90%	70%	100%	80%	80%	70%	50%
Out-of-Pocket Max (Individual /Family)	$2,500 / $5,000	$4,000 / $8,000	$2,000 / $4,000	$2,500 / $5,000	$3,500 / $7,000	$3,500 / $7,000	$5,000 / $10,000
Preventive Care	100%	70% after deductible	100%	80% after deductible	100%	100%	50% after deductible
Office Visit Primary Care	$25 copay	70% after deductible	$20 copay	80% after deductible	$20 copay	$20 copay after deductible	50% after deductible
Office Visit Specialist	$40 copay	70% after deductible	$20 copay	80% after deductible	$20 copay	$20 copay after deductible	50% after deductible
Telemedicine (CVS Health)	100%	Not Covered	100%	Not Covered	100%	100%	Not Covered
Outpatient Diagnostic X-rays & Laboratory Tests	90%	70% after deductible	Lab: 100% X-ray: 100% after deductible	80% after deductible	80% after deductible	70% after deductible	50% after deductible
Complex Imaging Services	90% after deductible	70% after deductible	100% after deductible	80% after deductible	80% after deductible	70% after deductible	50% after deductible
Emergency Room	$150 copay		$100 copay		$100 copay	70% after deductible	
Urgent Care	$50 copay	70% after deductible	$40 copay	80% after deductible	$40 copay	70% after deductible	50% after deductible
Ambulance	100%		100%		100%	100% after deductible	
Hospital Services Inpatient & Outpatient Surgery & Facility Charges	90% after deductible	70% after deductible	100% after deductible	80% after deductible	80% after deductible	70% after deductible	50% after deductible
Prescription Drug Coverage							
Retail 30-day supply) Preferred Generic Preferred Brand Non-Preferred Brand	$10 copay $25 copay $40 copay	50% of submitted cost after applicable in-network cost share	$10 copay $25 copay $40 copay	50% of submitted cost after applicable in-network cost share	$10 copay $25 copay $40 copay	70% after deductible	Not Covered
Mail Order (90-day supply) Preferred Generic Preferred Brand Non-Preferred Brand	2x retail copay		2x retail copay		2x retail copay		

This chart summarizes the benefits provided under the Aetna benefit plans. For more information, please refer to the formal plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

Health Savings Account

For High Deductible Health Plan (HDHP) Participants Only

The HDHP is the underlying medical plan while the HSA is a tax advantaged bank account. To contribute to or accept the Stevens contribution into the HSA, you must be enrolled in the HDHP medical plan.

HSA Specifics

- An HSA is a bank account that can only be offered to participants enrolled in the High Deductible Health Plan, as defined by the IRS.
- Contributions to the bank account are made with pre-tax dollars and deposited into an interest bearing account. The employee and/or employer can make contributions to the bank account.
- The maximum annual contribution (employee & employer combined) for 2027 is:
  - $4,500 for single coverage
  - $9,000 for family coverage
  - Employees over the age of 55 may contribute an additional $1,000
- Stevens' annual contribution is $825 per employee, $1,650 per employee and one or more dependent. The combined employee and Stevens contribution cannot exceed the federal maximum.
- Funds in the account may be invested, similar to a 403(b). You must keep a $1,000 minimum cash balance in your HSA; any funds above $1,000 may be invested.
- An HSA is portable. All money in the account belongs to the employee.
- Funds may be withdrawn from the account for qualifying healthcare expenses, tax free, on behalf of employees, spouses and tax dependents.
- Qualifying healthcare expenses include those listed in IRC section 213(d) on the IRS website, similar to Healthcare FSA eligible expenses. This includes dental care, vision care and over-the-counter drugs.
- Funds may be rolled over year to year. You can use it for qualified expenses or save it!
- You cannot be enrolled in a non-HSA qualified medical plan (including a Healthcare FSA, Medicare or a spouse's or parent's non-HSA qualified medical plan) and make contributions to an HSA or receive employer HSA contributions.
- At age 65, funds can be used to pay for COBRA, Long Term Care, and certain Medicare premiums or withdrawn without penalty (subject to ordinary income tax).
- Non-qualified withdrawals are subject to ordinary income tax and a 20% penalty.



Using the HSA and High Deductible Health Plan

You can use the money in your HSA to pay the medical plan deductible and coinsurance.

- Present your medical ID card. You should not pay your provider at time of service (except pharmacy).
- You and your provider will receive an explanation of benefits (EOB) detailing your payment obligation.
- The provider will send you an invoice based on the payment obligation detailed in the EOB.*
- Once the deductible has been met, the HDHP will cover in-network services at 70%, where applicable.
- Prescription drug coverage is subject to the plan's deductible before coinsurance applies.

HSA Vendor: Inspira Financial

Member Services: (844) 729-3539

Stevens Annual HSA Contribution: $825 single/ $1,650 family

Employee Maximum HSA Contribution: $3,675 single/ $7,350 family

Maximum Total Annual HSA Contribution: $4,500 single/ $9,000 family

* Payment methods

- Pay with HSA debit card
- Pay out-of-pocket and reimburse yourself using HSA funds.
- Pay out-of-pocket and save HSA funds for future healthcare expenses.



Comparing Your Medical Plan Options

Choosing a medical plan means balancing what you pay from each paycheck against what you pay when you use care. The examples on the next three pages estimate what three sample households would pay in 2027 under each plan at low, medium and high levels of use.

HOW TO READ THE EXAMPLES

- **Total annual cost** = your annual payroll contributions + your estimated out-of-pocket costs – Stevens' HSA contribution (HDHP only).
- Contributions shown are for the $55,001 – $100,000 salary band (semi-monthly contribution × 24 pay periods). Each example page also lists annual contributions for every salary band, so you can substitute your own.
- Out-of-pocket costs use 2027 in-network plan provisions and the estimated costs of care shown below. Your actual costs depend on the care you use and what your providers charge.
- These are illustrations only. They are not a guarantee of cost or coverage.

ESTIMATED COST OF CARE USED IN THE EXAMPLES

Service	Estimated cost
Preventive care visit	Covered in full
Primary care visit	$150
Specialist visit	$250
Urgent care visit	$200
Emergency room visit	$2,500
Lab test	$100
MRI / CT scan	$1,200
Outpatient surgery	$6,000
Inpatient hospital stay	$25,000
Generic Rx (30-day)	$15
Preferred brand Rx (30-day)	$350

AT A GLANCE: TOTAL ANNUAL COST

Household / use	Core	Plus	EPO	HDHP
Employee only				
Low use	$2,788	$3,618	$1,268	**$275**
Medium use	$3,728	$4,178	$2,658	**$2,634**
High use	$4,783	$4,488	$4,208	**$3,285**
Employee + spouse				
Low use	$7,878	$9,987	$2,885	**$402**
Medium use	$8,843	$10,767	$4,455	**$4,101**
High use	$10,528	$10,937	**$6,505**	$6,762
Employee + family				
Low use	$11,671	$14,583	$3,874	**$1,031**
Medium use	$12,736	$15,443	$5,524	**$4,880**
High use	$16,276	$15,943	$10,354	**$7,391**

Salary band $55,001 – $100,000. Shaded = lowest total annual cost in each row. Totals subtract Stevens' HSA contribution for the HDHP.

Example 1

EMPLOYEE ONLY COVERAGE

Alex is single and generally healthy, but wants to see how each plan would work if a year turned out to be more expensive than expected.

CARE USED IN EACH EXAMPLE

Service	Low	Medium	High
Preventive care visit	1	1	1
Primary care visit	1	3	4
Specialist visit	1	2	6
Urgent care visit	–	1	–
Emergency room visit	–	–	1
Lab test	–	2	4
MRI / CT scan	–	1	1
Outpatient surgery	–	–	1
Generic Rx (30-day)	6	12	12
Preferred brand Rx (30-day)	–	6	12

ANNUAL CONTRIBUTIONS BY SALARY BAND

Salary band	Core	Plus	EPO	HDHP
$55,000 & under	$2,426	$3,141	$1,043	$180
$55,001–$100,000	**$2,663**	**$3,518**	**$1,168**	**$610**
$100,001–$150,000	$2,975	$3,940	$1,308	$715
$150,001–$200,000	$3,332	$4,376	$1,465	$846
Over $200,000	$3,610	$4,439	$1,641	$903

Employee Only coverage, semi-monthly contribution × 24. Highlighted row is the band used below. Stevens HSA contribution (HDHP): $825 per year.

ESTIMATED ANNUAL COST ($55,001 – $100,000 SALARY BAND)

	Core Plan	Plus Plan	EPO Plan	HDHP
Annual payroll contributions	$2,663	$3,518	$1,168	$610
Stevens HSA contribution	–	–	–	($825)
Estimated out-of-pocket costs				
Low use	$125	$100	$100	$490
Medium use	$1,065	$660	$1,490	$2,849
High use	$2,120	$970	$3,040	$3,500
Total annual cost				
Low use	**$2,788**	**$3,618**	**$1,268**	**$275**
Medium use	**$3,728**	**$4,178**	**$2,658**	**$2,634**
High use	**$4,783**	**$4,488**	**$4,208**	**$3,285**

What this means

In these examples, the HDHP has the lowest total annual cost at every level of use in this salary band. The Plus Plan has the lowest out-of-pocket costs when care needs are high, but you pay more for it through your paycheck.

Out-of-pocket estimates use 2027 in-network deductibles, copays, coinsurance and out-of-pocket maximums and the estimated costs of care on page 10. The Core, Plus and EPO plans have an individual deductible within the family deductible; the HDHP family deductible must be met before the plan pays (except preventive care). Actual costs will vary.

Example 2

EMPLOYEE + SPOUSE COVERAGE

Jordan and their spouse are deciding which plan fits their household. In the high-use example, Jordan's spouse has a hospital stay.

CARE USED IN EACH EXAMPLE

Service	Low	Medium	High
Preventive care visit	2	2	2
Primary care visit	2	5	7
Specialist visit	1	2	8
Urgent care visit	–	1	–
Emergency room visit	–	–	1
Lab test	–	2	4
MRI / CT scan	–	1	1
Inpatient hospital stay	–	–	1
Generic Rx (30-day)	6	12	12
Preferred brand Rx (30-day)	–	6	12

ANNUAL CONTRIBUTIONS BY SALARY BAND

Salary band	Core	Plus	EPO	HDHP
$55,000 & under	$6,550	$8,568	$2,468	$442
$55,001–$100,000	**$7,728**	**$9,867**	**$2,765**	**$1,412**
$100,001–$150,000	$8,633	$11,051	$3,096	$1,692
$150,001–$200,000	$9,669	$12,254	$3,468	$2,003
Over $200,000	$10,417	$12,435	$3,884	$2,137

Employee + Spouse coverage, semi-monthly contribution × 24. Highlighted row is the band used below. Stevens HSA contribution (HDHP): $1,650 per year.

ESTIMATED ANNUAL COST ($55,001 – $100,000 SALARY BAND)

	Core Plan	Plus Plan	EPO Plan	HDHP
Annual payroll contributions	$7,728	$9,867	$2,765	$1,412
Stevens HSA contribution	–	–	–	($1,650)
Estimated out-of-pocket costs				
Low use	$150	$120	$120	$640
Medium use	$1,115	$900	$1,690	$4,339
High use	$2,800	$1,070	$3,740	$7,000
Total annual cost				
Low use	**$7,878**	**$9,987**	**$2,885**	**$402**
Medium use	**$8,843**	**$10,767**	**$4,455**	**$4,101**
High use	**$10,528**	**$10,937**	**$6,505**	**$6,762**

What this means

The lowest-cost plan changes with the level of use: low use – HDHP; medium use – HDHP; high use – EPO. The Plus Plan has the lowest out-of-pocket costs when care needs are high, but you pay more for it through your paycheck.

Out-of-pocket estimates use 2027 in-network deductibles, copays, coinsurance and out-of-pocket maximums and the estimated costs of care on page 10. The Core, Plus and EPO plans have an individual deductible within the family deductible; the HDHP family deductible must be met before the plan pays (except preventive care). Actual costs will vary.

Example 3

EMPLOYEE + FAMILY COVERAGE

The Taylors have two children. In the medium and high examples, the children need urgent care and specialist visits, and in the high example a parent has a hospital stay.

CARE USED IN EACH EXAMPLE

Service	Low	Medium	High
Preventive care visit	4	4	4
Primary care visit	2	7	11
Specialist visit	1	2	8
Urgent care visit	–	2	2
Emergency room visit	–	–	1
Lab test	–	2	4
MRI / CT scan	–	1	1
Outpatient surgery	–	–	1
Inpatient hospital stay	–	–	1
Generic Rx (30-day)	6	12	12
Preferred brand Rx (30-day)	–	6	12

ANNUAL CONTRIBUTIONS BY SALARY BAND

Salary band	Core	Plus	EPO	HDHP
$55,000 & under	$9,256	$11,984	$3,352	$586
$55,001–$100,000	**$11,521**	**$14,463**	**$3,754**	**$2,041**
$100,001–$150,000	$12,870	$16,198	$4,205	$2,394
$150,001–$200,000	$14,414	$18,032	$4,710	$2,720
Over $200,000	$15,574	$18,303	$5,274	$2,902

Employee + Family coverage, semi-monthly contribution × 24. Highlighted row is the band used below. Stevens HSA contribution (HDHP): $1,650 per year.

ESTIMATED ANNUAL COST ($55,001 – $100,000 SALARY BAND)

	Core Plan	Plus Plan	EPO Plan	HDHP
Annual payroll contributions	$11,521	$14,463	$3,754	$2,041
Stevens HSA contribution	–	–	–	($1,650)
Estimated out-of-pocket costs				
Low use	$150	$120	$120	$640
Medium use	$1,215	$980	$1,770	$4,489
High use	$4,755	$1,480	$6,600	$7,000
Total annual cost				
Low use	**$11,671**	**$14,583**	**$3,874**	**$1,031**
Medium use	**$12,736**	**$15,443**	**$5,524**	**$4,880**
High use	**$16,276**	**$15,943**	**$10,354**	**$7,391**

What this means

In these examples, the HDHP has the lowest total annual cost at every level of use in this salary band. The Plus Plan has the lowest out-of-pocket costs when care needs are high, but you pay more for it through your paycheck.

Out-of-pocket estimates use 2027 in-network deductibles, copays, coinsurance and out-of-pocket maximums and the estimated costs of care on page 10. The Core, Plus and EPO plans have an individual deductible within the family deductible; the HDHP family deductible must be met before the plan pays (except preventive care). Actual costs will vary.

Aetna Health Your Way™

The Aetna Health Your Way wellness program is included in your health plan, at no additional cost to you.
It will help you make small, everyday changes for your well-being. Adult members can earn up to $100 a year in gift cards by completing simple, fun and engaging activities. To get started, sign into your www.aetna.com account and click on the **"Health** & **Wellness"** tab.


Health assessment


Easily Access Health Data


Digital Coaching Support


Incentives


Health Education Resources


Holistic approach


Adventure Challenges


Apps and devices

Aetna Concierge

Your Aetna Concierge is here for you. They'll listen, understand your needs and find solutions that are right for you.

A concierge can help you:

- Get answers about a diagnosis
- Select a doctor
- Learn about your coverage
- Plan for upcoming treatment
- Find health care solutions that fit your needs
- Learn how to use our online tools to make the right decisions
- Find network providers based on your medical needs
- Assist you in scheduling appointments

Plan for health expenses

No more "surprises" - your concierge can show you:

- How to estimate costs before you make an appointment
- What doctors cost in-network versus out-of-network
- Differences between inpatient and outpatient care, including costs
- Your options and cost estimates in advance to help you make smarter decisions

Available Monday through Friday from 8 AM to 6 PM ET

Log in at Aetna.com and chat online

Call 888-889-1457

Employee Assistance & Wellbeing Support Program



Available to all employees and their families.

This resource helps employees and their immediate family members find solutions that restore peace of mind and work-life balance. The program includes

- 3 counseling visits per person, per event, per year
- 5 telehealth wellbeing coaching visits per year
- Professional support including unlimited financial information, tax consultations, family budgeting and estate planning
- Assistance to identity-theft support with legal specialists as well as fraud-resolution services
- Access to the digital portal, mobile app, & monthly webinars

The program can help you with such issues as:

- Reducing stress
- Overcoming an addiction
- Stopping violence
- Learning to relax
- Marital and family conflicts
- Workplace issues
- Grief and loss

FOR MORE INFORMATION
800-344-9752
guidanceresources.com
Web ID: NYLGBS

Mental Health & Emotional Wellbeing

There are many options available for members to address mental health and emotional well-being. Visit health.aetna.com/mental-health-virtual-care to take advantage of these resources.

Aetna Supplemental Health Benefits

An unexpected illness or injury can disrupt every facet of your life, including your physical, emotional and financial well-being. Regular expenses, big and small, can add up. These voluntary benefits, insured by Aetna, are designed to provide additional protection for you and your family through fixed cash benefits paid directly to you. You must elect coverage for yourself in order to elect coverage for your eligible dependents. All three plans are HSA compatible.

ACCIDENT INSURANCE

Accident insurance pays a fixed cash benefit for a broad range of injuries and treatments resulting from a covered accident, on or off the job, and the money can be used however you see fit. There are no copays, deductibles, coinsurance or network requirements. Coverage continues after the first covered accident and protects you for future covered accidents.

Covered injuries and services include:

- Fractures and dislocations
- Concussions and burns
- Torn knee cartilage and ruptured discs
- Cuts requiring stitches
- Emergency room, urgent care and ambulance
- Hospital stays and surgery

See the Accident Plan Highlights page for benefit amounts.

Covered Individual	Monthly Rate
Employee	$5.80
Employee + Spouse	$10.28
Employee + Child(ren)	$12.22
Family	$16.70

Health Screening Benefit

The Accident plan pays $50 per covered person, once per plan year, when they complete an eligible health screening, such as those listed below. If you also enroll in Critical Illness, that plan pays another $50 per covered person each year.

Covered health screenings include:

- Routine health check-up exam
- Blood chemistry panel / complete blood count
- Cholesterol (lipoprotein) profile
- Fasting blood glucose / Hemoglobin A1C
- Mammography / breast sonogram
- Pap smear / ThinPrep pap test
- Prostate specific antigen (PSA) test
- Colonoscopy / virtual colonoscopy
- Skin cancer screening
- Bone mass density measurement
- Chest x-ray
- Electrocardiogram (EKG) / stress test
- Eye exam / hearing test / dental exam
- Immunizations (including HPV)
- Test for sexually transmitted infections
- Successful completion of a smoking cessation program
- See the plan certificate for the full list.

ACCIDENT PLAN HIGHLIGHTS

The Accident plan pays the fixed amounts below for covered injuries and treatment. Each benefit is payable once per accident unless noted. See the Aetna plan summary for the full schedule.

Benefit	Amount
Initial care	
Ground / air ambulance	$400 / $1,600
Emergency room or hospital	$200
Physician's office or urgent care	$100
Walk-in clinic or telemedicine	$75
Follow-up visits (up to 10)	$75
X-ray / lab	$50 / $50
Medical imaging (MRI, CT)	$150
Physical, occupational or speech therapy (up to 10)	$75
Chiropractic care (up to 10)	$75
Hospital care	
Hospital admission (non-ICU / ICU)	$1,000
Daily hospital stay: non-ICU / ICU	$200 / $400
Surgery	
Hernia / torn knee cartilage	$250 / $750
Ruptured disc	$750
Open abdominal, thoracic or cranial	$1,250

Benefit	Amount
Injuries	
Fractures (based on bone)	$400 – $4,000
Dislocations (based on joint)	$400 – $3,000
Concussion	$150
Traumatic brain injury (moderate / severe)	$600
Lacerations with stitches	$100 – $600
Burns (second / third degree)	$500 – $10,000
Coma	$10,000
Accidental death and dismemberment	
Accidental death: employee	$50,000
Spouse / child	$25,000 / $12,500
Common carrier: employee	$100,000
Loss of limb, sight, speech or hearing	$15,000
Loss of finger or toe	$2,000
Wellness	
Health screening (see page 16)	$50

Accident coverage is available on and off the job, is portable if you leave Stevens and includes a waiver of premium after 30 days of continuous absence due to an accidental injury.

Aetna Critical Illness Insurance

NEW FOR 2027

Critical Illness insurance pays a lump-sum cash benefit directly to you if you or a covered family member is diagnosed with a covered illness. You can use the money however you like, from medical bills to everyday expenses while you recover. Coverage is voluntary: you pay the full cost through payroll deductions.

COVERAGE AMOUNTS AND FEATURES

- **Employee:** $10,000 or $20,000
- **Spouse and children:** 50% of the employee amount
- Guaranteed issue at every open enrollment for both amounts, including spouse and child coverage: no health questions to enroll
- Pre-existing condition limitation waived
- Benefits for a second, different covered illness (100%) and for a recurrence of the same illness after 90 days (100%)
- $50 health screening benefit per covered person each plan year, in addition to the Accident plan (same list of screenings)
- Coverage is portable if you leave Stevens
- HSA compatible
- Children under age 31 can be covered

COVERED CONDITIONS

Condition	% of coverage amount
Cancer (invasive)	100%
Carcinoma in situ (non-invasive)	25%
Heart attack	100%
Stroke	100%
Coronary artery bypass surgery	25%
Major organ failure	100%
End-stage renal (kidney) failure	100%
Paralysis; loss of sight/speech/hearing	100%
Coma; severe burns	100%
Benign brain tumor	100%
Lupus; MS; muscular dystrophy	100%
Occupational HIV	100%
Childhood conditions*	100%

**Cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, poliomyelitis and spina bifida (covered children).*

MONTHLY RATES (BASED ON EMPLOYEE'S AGE)

	$10,000 coverage				$20,000 coverage			
Age	Employee	EE + Spouse	EE + Child(ren)	Family	Employee	EE + Spouse	EE + Child(ren)	Family
<20	$2.59	$4.03	$2.59	$4.03	$3.49	$5.60	$3.49	$5.60
20–24	$2.84	$4.42	$2.84	$4.42	$3.99	$6.37	$3.99	$6.37
25–29	$3.19	$4.93	$3.19	$4.93	$4.69	$7.40	$4.69	$7.40
30–34	$3.63	$5.62	$3.63	$5.62	$5.57	$8.77	$5.57	$8.77
35–39	$4.40	$6.73	$4.40	$6.73	$7.10	$10.99	$7.10	$10.99
40–44	$5.64	$8.65	$5.64	$8.65	$9.58	$14.83	$9.58	$14.83
45–49	$7.99	$11.97	$7.99	$11.97	$14.28	$21.48	$14.28	$21.48
50–54	$11.78	$17.45	$11.78	$17.45	$21.87	$32.43	$21.87	$32.43
55–59	$16.86	$25.12	$16.86	$25.12	$32.02	$47.77	$32.02	$47.77
60–64	$24.13	$35.41	$24.13	$35.41	$46.56	$68.35	$46.56	$68.35
65–69	$34.16	$50.05	$34.16	$50.05	$66.63	$97.63	$66.63	$97.63
70+	$46.57	$65.58	$46.57	$65.58	$91.44	$128.68	$91.44	$128.68

Rates are monthly, are the same for tobacco and non-tobacco users, and increase as you move into a new age band. Spouse and child coverage is 50% of the employee amount.

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity pays a fixed cash benefit directly to you when you or a covered family member is admitted to the hospital for a covered illness or injury, including newborn stays. You can use the money for whatever you need, from deductibles and copays to child care, transportation and everyday household expenses.

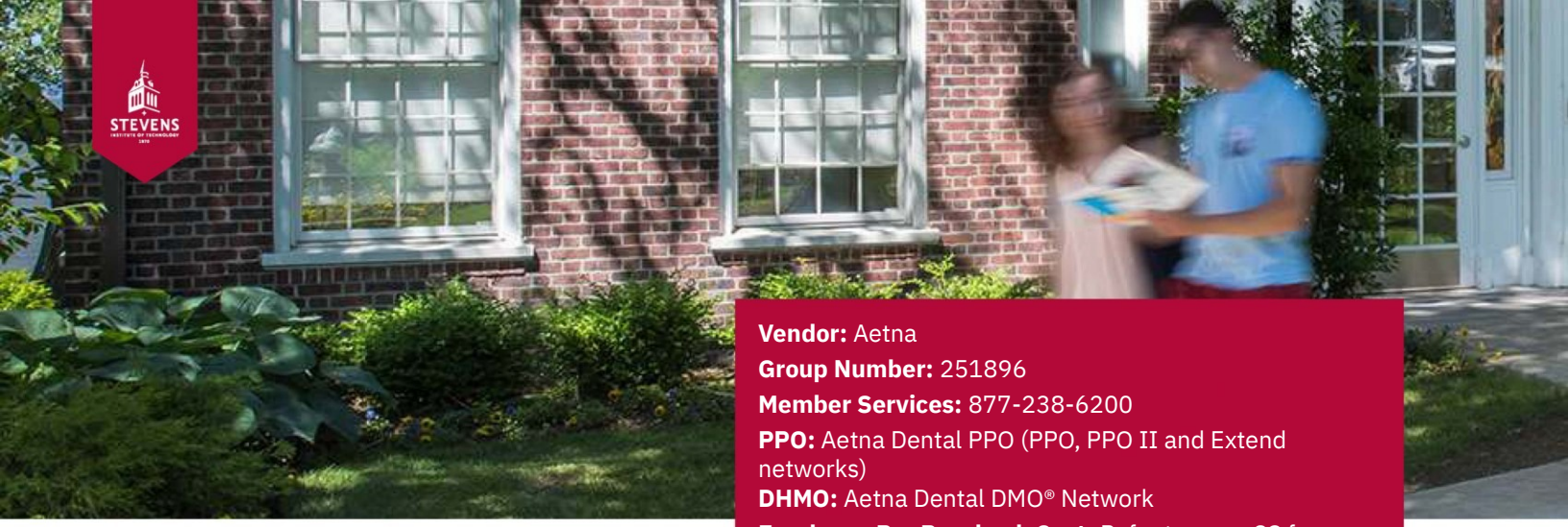
If you are hospitalized for more than 30 days in a row, your premium is waived for up to 6 months. Stays due to complications of pregnancy are covered like any other illness.

Please note the above descriptions are only a brief summary. Refer to the Aetna benefit summaries for more details on your coverage, election options and rates.

Hospitalization Benefit Type	Benefit Amount
Hospital Stay – Admission Lump sum for the first day of a non-ICU or ICU stay. Limited to 1 per plan year.	$1,000
Hospital Stay – Daily (non-ICU) Begins on day 2 of your stay. Up to 365 days per plan year.	$50 per day
Hospital Stay – Daily (ICU) Begins on day 2 of your stay. Up to 365 days per plan year.	$50 per day
Substance Abuse, Mental Disorder or Rehabilitation Unit Stay Daily benefit. Up to 365 days per plan year.	$50 per day
Newborn Hospital Stay (including NICU) Admission benefit plus a daily benefit beginning on day 2.	$1,000 admission $50 per day

Covered Individual	Monthly Rate
Employee	$12.41
Employee + Spouse	$24.97
Employee + Child(ren)	$20.17
Family	$32.73





Vendor: Aetna
Group Number: 251896
Member Services: 877-238-6200
PPO: Aetna Dental PPO (PPO, PPO II and Extend networks)
DHMO: Aetna Dental DMO® Network
Employee Per Paycheck Cost: Refer to **page 29** for pre-tax dental contributions

Dental Benefits

Stevens offers a choice of two dental plans: a PPO and a DHMO. These plans offer a wide range of dental benefits, from routine preventive and basic care to major services and orthodontia.

PPO Plan

In the PPO plan, you may use any licensed dentist, but your out-of-pocket cost will be lower if you use a dentist in Aetna's Dental PPO network (which includes the PPO, PPO II and Extend networks). Claim forms are not required when you use in-network dentists, and network dentists accept negotiated rates, which reduce your costs. If you choose a non-network dentist, the plan reimburses based on the 80th percentile of billed charges in your area, and you may be billed for the difference.

All services except preventive services are subject to the plan's annual deductible. All benefits paid by the plan accrue toward the plan's calendar year maximum of $2,500. Each family member has their own calendar year maximum.

Virtual Dental Care and Dental/Medical Integration

Members have access to virtual dental care. Log in to www.aetna.com to connect with a virtual dental provider.

Aetna's Dental/Medical Integration program provides outreach and enhanced dental benefits for members who are pregnant or have diabetes or certain heart conditions.

DHMO Plan

As a DHMO member, you must select a Primary Care Dentist (PCD) from the Aetna DMO® network and use your PCD for all dental services; your PCD will refer you to a specialist when needed. You pay the fixed copays in the DMO schedule of benefits, with no deductible, no annual maximum and no office visit copay. Orthodontia is covered for adults and children with a $1,750 treatment copay. To enroll, you must live or work in the Aetna DMO service area.

If you do not choose a PCD, Aetna will assign one near your home ZIP code. To select or change your PCD, call Aetna Member Services or log in at www.aetna.com. If you want the freedom to see any licensed dentist, choose the PPO plan.

DHMO service area: The DHMO is not available everywhere. Aetna does not have a DMO network in South Carolina, and some ZIP codes in other states are outside the DMO service area. Before you enroll, search the Dental DMO network at www.aetna.com to make sure there are DMO dentists near you. If there are not, choose the PPO plan.



Finding a Provider:

To find a participating dentist near you, call Aetna Member Services at the number on the previous page, or visit www.aetna.com and search the Dental PPO network (PPO plan) or the Dental DMO® network (DHMO plan).

	Dental Highlights		
	PPO Plan		DHMO Plan
	In-Network Aetna Dental PPO	Out-of-Network	In-Network
Annual Deductible Individual/Family	$25 / $75	$50 / $150	No Deductible or Office Visit Copay
Annual Maximum Benefit (Excludes Preventive and Diagnostic Services)	$2,500	$2,500	No Annual Maximum
Preventive Services	100%, no deductible	100%, no deductible	No Charge
Basic Services Fillings, Endodontic Treatment and Periodontic Treatment	80%	80%	Copays apply (refer to the DMO Benefits Summary for applicable copays)
Major Services Crowns and Dentures	50%	50%	Copays apply (refer to the DMO Benefits Summary for applicable copays)
Orthodontia (Child & Adult)	50%, $2,000 Lifetime Maximum	50%, $2,000 Lifetime Maximum	$1,750 Treatment copay

This chart summarizes the benefits provided under the Aetna benefit plans. For more information, please refer to the formal plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

Vision Benefits

Stevens offers a vision plan administered through Vision Service Plan (VSP). VSP's network consists of private practice doctors as well as certain retail chain locations.

You have the option of seeing any provider within VSP's network or you can use a non-network provider.

Claim forms are not required when utilizing in-network providers. Network participating providers accept negotiated rates which reduce your claim costs and out of pocket expenses. If you choose a non-network provider, the plan will reimburse you based on the below summary.

Visit www.vsp.com and click on the "Benefits & Claims" section to submit a claim. For more detailed benefits information or to search for a provider, visit www.vsp.com. Refer to page 29 for pre-tax vision contributions.

LightCare

Allows members to use their frame allowance towards ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts. Not available at Walmart® Optical or Sam's Club® Optical.

Finding a Provider:

To find a participating VSP vision provider near you, please call VSP at 800-877-7195 or visit www.vsp.com.

	VSP	
	In-Network Benefits	Out-of-Network Benefits
Frequency of Services* Examination Lenses Frames	 Every 12 months Every 12 months Every 24 months	 Every 12 months Every 12 months Every 24 months
Examination	$10 copay	Up to $45 allowance
Materials	$25 copay	See lens and frame allowances
Lenses Single Bifocal Trifocal	Included in Prescription Glasses	 Up to $30 allowance Up to $50 allowance Up to $65 allowance
Frames	* $200 frame allowance plus 20% savings on the amount over your allowance * $200 Walmart®/Sam's Club® and regional retail chains frame allowance * $110 Costco® frame allowance	Up to $70 allowance
Contacts Lenses Maximum allowance for conventional lenses	* Elective - Up to $150 allowance; copay does not apply * Medically Necessary - Covered in full - Fitting and Evaluation - Up to $60 copay	* Elective - Up to $105 allowance * Medically Necessary - Up to $210 allowance

**You cannot get a full set of glasses and contact lenses in the same 12 month period*
This chart summarizes the benefits provided under the VSP benefit plans. For more information, please refer to the formal plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

Life and Accidental Death & Dismemberment (AD&D) Benefits

Life and AD&D benefits are an important part of your financial security, especially if others depend on you for support. Stevens covers 100% of the premium for basic life and AD&D, insured by New York Life. You also have the option of purchasing supplemental life insurance.

BASIC LIFE AND AD&D

As an eligible employee, Stevens provides you with company paid basic life and AD&D insurance in an amount that equals one time (1x) your annual earnings up to a maximum of $150,000. Under current IRS provisions, imputed income applies to the value of employer-provided life insurance coverage greater than $50,000. Imputed income is the IRS term for the value of any benefit or service that should be considered income for the purposes of calculating federal taxes. If this applies to you, you will see a line item on your paycheck.

SUPPLEMENTAL LIFE

If you need additional protection beyond the basic life insurance provided to you, you may purchase supplemental life for yourself. If you elect this coverage, you will be responsible for paying 100% of the cost on a post-tax basis through payroll deductions. Premiums are based on your age.

SPOUSE LIFE INSURANCE

If you purchase supplemental life for yourself, you can purchase life insurance for your spouse in increments of $5,000 up to a maximum of $250,000 (cannot exceed 50% of your supplemental life benefit).

	Coverage Amount	Benefit Maximum	Guaranteed Issue*
Basic Life/ AD&D	1x annual earnings	$150,000	Full Benefit Amount
Supplemental Life	1, 2, 3, 4 or 5x annual earnings	$1,000,000	$400,000
Spouse Life	Increments of $5,000	$250,000 (cannot exceed 50% of employee's voluntary life benefit)	$25,000

**If enrolling when initially eligible for benefits, you are automatically approved up to the guaranteed issue amount without being subject to Evidence of Insurability (EOI). Any employee amount elected over the guaranteed issue amount or outside the initial eligibility period is subject to EOI. For 2027 open enrollment only, current employees may enroll in or increase Supplemental Life up to $400,000 without EOI.*



Disability Benefits

The disability benefits, insured by New York Life, help provide financial protection if you become disabled and cannot work. These disability benefits also work with other sources of coverage to replace a percentage of your earnings. As a result, the disability payments you receive will be reduced by any benefits you are eligible to receive from social security, workers' compensation, retirement benefits or any other disability coverage to which you are entitled.

SHORT TERM DISABILITY (STD)

STD is available to employees who regularly work a minimum of 30 hours per week.

The STD benefit provides a percentage of your salary or wages up to a maximum equivalent to the NJ state mandated maximum benefit ($1,158 per week in 2027) after being on leave for 7 days due to your own non-work related illness or injury.

**Employees who work at least 20 weeks with Stevens in the state of NJ are eligible to receive NJ mandated disability benefits.*

**Employees who work in New York are covered by New York Disability Benefits Law (DBL) and Paid Family Leave (PFL), insured by New York Life, as required by New York State law.*

LONG TERM DISABILITY (LTD)

If you are disabled for at least 180 days, you may qualify for Long Term Disability benefits. The plan provides a benefit of 60% of your salary up to a maximum of $10,000 per month. LTD benefits are generally payable up to Normal Social Security Retirement Age; however, if you become disabled at or after age 65, benefits are payable according to an age-based schedule.

	Monthly LTD Benefit
Gross Monthly Income	$2,000
Benefit Amount	**60%**
Monthly LTD Benefit	$1,200

Your LTD premiums may be paid by Stevens or you. If Stevens pays the premium, you are responsible for federal and/or state taxes on any benefits you receive. If you pay the premium, benefits are not subject to federal and/or state income taxes.



When Am I Considered Disabled under the LTD plan?

You are considered disabled and eligible to receive LTD benefits if because of an injury or illness, you are unable to perform the material and substantial duties of your own occupation and you are unable to earn 80% or more of your pre-disability earnings. After 24 months, you are considered disabled when, due to the same injury or illness, you are unable to perform the material and substantial duties of any occupation for which you are reasonably fitted by education, training or experience, and you are unable to earn 80% or more of your pre-disability earnings.

Flexible Spending Accounts

Stevens allows employees to redirect a portion of their pay, through pre-tax payroll deductions, into flexible spending accounts (FSAs). Your FSA benefits are administered by Benefit Resource, Inc. The money that goes into your FSA is deducted from your pay before taxes are calculated. There are two types of FSAs available.

HEALTHCARE FSA

You may contribute up to $3,500 into a Healthcare FSA (or up to the IRS maximum if different than what is noted in this benefits guide). This type of FSA allows you to pay for eligible out-of-pocket healthcare expenses on a pre-tax basis. Examples of eligible expenses for you, your spouse and your tax dependent children (through the end of the year in which they attain age 26) include:

- Deductibles
- Copays
- Coinsurance
- Dental Care / Orthodontia
- Eye Glasses / Contact Lenses
- Over-the-Counter Medications
- Hearing Exams / Hearing Aids

LIMITED HEALTHCARE FSAs

If you (and/or Stevens) are contributing to an HSA and you are interested in contributing to a healthcare FSA, you can only elect to contribute on a "limited" basis. A "limited" healthcare FSA is used to reimburse out of pocket dental and vision expenses. Only the portion of the qualified dental and/or vision expense that is not covered by any other coverage can be reimbursed through a Limited FSA.

HEALTHCARE FSA CARRYOVER PROVISION

If you have a balance in your Healthcare FSA or Limited Purpose Healthcare FSA at the close of the 2027 plan year, your unused balance, up to $700, will be carried forward into the 2028 plan year with no impact to your 2028 elected contribution (or up to the IRS maximum if different than what is noted in this benefits guide). Any unused 2027 balance, over the carryover limit, will be forfeited.

DEPENDENT CARE FSA

You may contribute up to $5,000 ($2,500 if you are married and file your taxes separately) into a Dependent Care FSA. This type of FSA allows you to pay for eligible day care expenses on a pre-tax basis for your child (under age 13 or over age 26, if disabled), disabled spouse or elderly parent (whom you claim on your taxes). Examples of eligible expenses include:

- Payments to Day Care Centers
- After-School Care
- Summer Day Camp
- Preschool Costs (up to, but not including, kindergarten)
- Elder Care

Stevens has adopted the 2 1/2 month grace period. You can request reimbursement for expenses incurred between January 1, 2027 and March 15, 2028, against your 2027 balance. Unused funds will be forfeited.

You have until April 30, 2028 to file a claim.

Retirement Savings Plans

Stevens realizes the importance of saving towards retirement and has established a 403(b) plan.

Please visit www.tiaa.org/Stevens to enroll in Stevens' retirement plans, change retirement contribution elections, or find more information on the plans, investment fund options, fund performance, and prospectus information.

403(b) ELIGIBILITY

All full-time regular employees, except for certain staff positions, are eligible to contribute to the 403(b) plan from their date of hire.

403(b) EMPLOYEE CONTRIBUTIONS

Through payroll deductions, you may contribute a percentage of your eligible pay on a pre-tax and/ or post-tax basis up to the lesser of the annual IRS benefit maximum or 100% of compensation (some restrictions apply for highly compensated employees).

You may invest your contributions and Stevens matching contributions in a variety of investments.

You may stop or change your contributions at any time throughout the year.

You may contribute up to $25,500 per year and if you are over 50, you can also make catch-up contributions of up to $8,500 (or up to the IRS maximum if different than what is noted in this guide).

403(b) EMPLOYER MATCH

Faculty, Exempt Staff or Campus Police Employees: If you make elective deferrals of at least 5% of your eligible earnings the University will make a matching contribution from 6% - 10% depending on your age as of July 1st.

Union Employees: A University fixed contribution equal to 2% of your eligible earnings will be remitted to TIAA on your behalf. If you choose to make elective deferrals of 1 %, a 3% University match will be made. If you elect to defer 4% - 10%, a University match in the amount equal to your deferral will be made (maximum 10%).

Non-Exempt Employees (not Union): A University fixed contribution equal to 2% of your eligible earnings will be remitted to TIAA on your behalf. If you choose to make an elective deferral of 1 % or more, a maximum 3% University match will be made.

SAVINGS EXAMPLE

Consider this example of pre-tax savings through the 403(b) plan versus post-tax through some other savings method.

	Pre-Tax Contribution	After-Tax Contribution
Gross Pay	$4,000	$4,000
Minus Pre-Tax Contributions to 403(b) Plan	-$500	$0
Taxable Pay	$3,500	$4,000
Minus Estimated Tax Withholding from Pay	-$875	-$1,000
Minus After-Tax Contributions to Other Savings	$0	-$500
Spendable Pay	$2,625	$2,500
BEFORE-TAX ADVANTAGE	$125	**$0**

Additional Benefits

PAID TIME OFF (PTO) BENEFITS - FOR STAFF

Stevens provides eligible staff members with a generous PTO package including the following types of time off:

Vacation
(available following 6 months of employment):

Non Exempt Staff	
10 days	1-5 years of service
15 days	5-10 years of service
20 days	10 or more years of service
Exempt Staff	
20 days	1-24 years of service
25 days	25 or more years of service

* Days are pro-rated on date of hire.

Sick: 12 days per calendar year up to a 72 day maximum

Personal: (available following 30 days of employment):

Non Exempt Staff: 3 days per calendar year

Exempt Staff: 2 days per calendar year

Part-time employees: not eligible

Holidays: 12 holidays per year

Vacation and sick time accruals are pro-rated for eligible part-time staff based on FTE.

For additional details on the time off policy, please visit the Time Off and Leaves section of our website.

EDUCATIONAL ASSISTANCE FOR EMPLOYEES AND DEPENDENTS

There are several tuition assistance programs available to full time faculty, staff and dependents after one year of service.

- Tuition Remission Program - provides a benefit to faculty, staff and dependents which waives tuition costs for courses taken at Stevens.
- Tuition Aid Program - provides a reimbursement benefit to eligible faculty and staff and dependent children of up to $6,000 of tuition costs for courses taken at an institution of higher learning.
- Tuition Exchange Program - a reciprocal scholarship program that provides tuition assistance to dependents of eligible faculty and staff who are accepted and enrolled at participating member institutions.

For full details on our Educational Assistance Programs, please visit our website.

COMMUTER TAX SAVE PROGRAM

Administered by Benefit Resource, Inc.

- Pre-Tax Transit and Parking (park & ride sites) Contribution Maximum - up to $350 per month each (or up to the IRS monthly maximums if they differ from what is noted).
- Contributions can also be withheld on post tax basis to help pay for commuter expenses in excess of the pre-tax monthly maximum.

Log on to Workday to enroll, change or stop your election at any time throughout the year.

To register at benefitresource.com, use employer code **stevens**. Your user ID is your Workday ID with four zeros in front (for example, 0000#####).

Medical Contributions: Biweekly Hourly (26 Periods)*

	$55,000 and Under	$55,001 - $100,000	$100,001 - $150,000	$150,001 - $200,000	Over $200,000
CORE PLAN					
EMPLOYEE ONLY	$93.30	$102.43	$114.43	$128.16	$138.84
EMPLOYEE + SPOUSE	$251.92	$297.23	$332.03	$371.88	$400.65
EMPLOYEE + CHILD(REN)	$202.34	$228.93	$255.74	$286.42	$313.41
EMPLOYEE + FAMILY	$356.00	$443.12	$495.00	$554.40	$599.01
PLUS PLAN					
EMPLOYEE ONLY	$120.80	$135.30	$151.54	$168.31	$170.74
EMPLOYEE + SPOUSE	$329.53	$379.49	$425.03	$471.30	$478.26
EMPLOYEE + CHILD(REN)	$257.83	$288.78	$323.43	$362.24	$369.22
EMPLOYEE + FAMILY	$460.94	$556.26	$623.01	$693.54	$703.95
EPO PLAN					
EMPLOYEE ONLY	$40.12	$44.93	$50.33	$56.36	$63.12
EMPLOYEE + SPOUSE	$94.93	$106.33	$119.09	$133.38	$149.38
EMPLOYEE + CHILD(REN)	$71.60	$80.20	$89.82	$100.60	$112.67
EMPLOYEE + FAMILY	$128.93	$144.40	$161.72	$181.14	$202.86
HDHP PLAN					
EMPLOYEE ONLY	$6.92	$23.46	$27.49	$32.56	$34.73
EMPLOYEE + SPOUSE	$16.98	$54.31	$65.06	$77.04	$82.18
EMPLOYEE + CHILD(REN)	$13.29	$40.97	$46.50	$58.11	$62.00
EMPLOYEE + FAMILY	$22.52	$78.51	$92.08	$104.63	$111.60

Medical Contributions: Semi-Monthly (24 Periods)*

	$55,000 and Under	$55,001 - $100,000	$100,001 - $150,000	$150,001 - $200,000	Over $200,000
CORE PLAN					
EMPLOYEE ONLY	$101.07	$110.97	$123.97	$138.84	$150.41
EMPLOYEE + SPOUSE	$272.91	$322.00	$359.70	$402.87	$434.04
EMPLOYEE + CHILD(REN)	$219.20	$248.01	$277.05	$310.29	$339.53
EMPLOYEE + FAMILY	$385.67	$480.05	$536.25	$600.60	$648.93
PLUS PLAN					
EMPLOYEE ONLY	$130.87	$146.58	$164.17	$182.34	$184.97
EMPLOYEE + SPOUSE	$356.99	$411.11	$460.45	$510.58	$518.12
EMPLOYEE + CHILD(REN)	$279.32	$312.84	$350.38	$392.43	$399.99
EMPLOYEE + FAMILY	$499.35	$602.61	$674.93	$751.33	$762.61
EPO PLAN					
EMPLOYEE ONLY	$43.46	$48.67	$54.52	$61.06	$68.38
EMPLOYEE + SPOUSE	$102.84	$115.19	$129.01	$144.49	$161.83
EMPLOYEE + CHILD(REN)	$77.57	$86.88	$97.31	$108.98	$122.06
EMPLOYEE + FAMILY	$139.67	$156.43	$175.20	$196.23	$219.77
HDHP PLAN					
EMPLOYEE ONLY	$7.50	$25.41	$29.78	$35.27	$37.62
EMPLOYEE + SPOUSE	$18.40	$58.84	$70.48	$83.46	$89.03
EMPLOYEE + CHILD(REN)	$14.40	$44.38	$50.37	$62.95	$67.17
EMPLOYEE + FAMILY	$24.40	$85.05	$99.75	$113.35	$120.90

Contributions may differ due to rounding

Medical Contributions: Semi-Monthly (18 Periods)*

	$55,000 and Under	$55,001 - $100,000	$100,001 - $150,000	$150,001 - $200,000	Over $200,000
CORE PLAN					
EMPLOYEE ONLY	$134.76	$147.96	$165.29	$185.12	$200.55
EMPLOYEE + SPOUSE	$363.88	$429.33	$479.60	$537.16	$578.72
EMPLOYEE + CHILD(REN)	$292.27	$330.68	$369.40	$413.72	$452.71
EMPLOYEE + FAMILY	$514.23	$640.07	$715.00	$800.80	$865.24
PLUS PLAN					
EMPLOYEE ONLY	$174.49	$195.44	$218.89	$243.12	$246.63
EMPLOYEE + SPOUSE	$475.99	$548.15	$613.93	$680.77	$690.83
EMPLOYEE + CHILD(REN)	$372.43	$417.12	$467.17	$523.24	$533.32
EMPLOYEE + FAMILY	$665.80	$803.48	$899.91	$1,001.77	$1,016.81
EPO PLAN					
EMPLOYEE ONLY	$57.95	$64.89	$72.69	$81.41	$91.17
EMPLOYEE + SPOUSE	$137.12	$153.59	$172.01	$192.65	$215.77
EMPLOYEE + CHILD(REN)	$103.43	$115.84	$129.75	$145.31	$162.75
EMPLOYEE + FAMILY	$186.23	$208.57	$233.60	$261.64	$293.03
HDHP PLAN					
EMPLOYEE ONLY	$10.00	$33.88	$39.71	$47.03	$50.16
EMPLOYEE + SPOUSE	$24.53	$78.45	$93.97	$111.28	$118.71
EMPLOYEE + CHILD(REN)	$19.20	$59.17	$67.16	$83.93	$89.56
EMPLOYEE + FAMILY	$32.53	$113.40	$133.00	$151.13	$161.20

Dental Contributions*

	Biweekly Hourly 26 Periods	Semi-Monthly 24 Periods	Semi-Monthly 18 Periods
DHMO PLAN			
EMPLOYEE ONLY	$6.06	$6.57	$8.76
EMPLOYEE + 1 (SPOUSE OR CHILD)	$11.53	$12.49	$16.65
EMPLOYEE + 2 OR MORE	$18.20	$19.72	$26.29
PPO PLAN			
EMPLOYEE ONLY	$29.53	$31.99	$42.65
EMPLOYEE + 1 (SPOUSE OR CHILD)	$46.80	$50.70	$67.60
EMPLOYEE + 2 OR MORE	$78.27	$84.79	$113.05

Vision Contributions*

	Biweekly Hourly 26 Periods	Semi-Monthly 24 Periods	Semi-Monthly 18 Periods
EMPLOYEE ONLY	$3.33	$3.61	$4.81
EMPLOYEE + 1 (SPOUSE OR CHILD)	$5.33	$5.77	$7.69
EMPLOYEE+ CHILDREN	$5.44	$5.90	$7.86
EMPLOYEE+ FAMILY	$8.77	$9.50	$12.67

**Contributions may differ due to rounding*



ABOUT THIS GUIDEBOOK

This document is an outline of the coverage proposed by the carrier(s), based on information provided by Stevens Institute of Technology. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy documents for your reference will be made available upon request. Every effort has been made to ensure the accuracy of this document. In the event of a discrepancy, your actual coverage will be determined by the legal plan documents that govern this plan.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by the Stevens Institute of Technology Human Resources Department.

Contacts

MEDICAL/ PRESCRIPTION DRUG	Aetna	www.aetna.com	888-266-5519
SUPPLEMENTAL HEALTH BENEFITS	Aetna	www.myaetnasupplemental.com	800-607-3366
HEALTH SAVINGS ACCOUNT	Inspira Financial	www.inspirafinancial.com	844-729-3539
DENTAL BENEFITS	Aetna	www.aetna.com	877-238-6200
VISION BENEFITS	VSP	www.vsp.com	800-877-7195
LIFE/ AD&D INSURANCE	New York Life	www.newyorklife.com	888-842-4462
SHORT TERM & LONG TERM DISABILITY	New York Life	www.newyorklife.com	888-842-4462
NY DISABILITY & PAID FAMILY LEAVE (NY EMPLOYEES)	New York Life	www.newyorklife.com	888-842-4462
FLEXIBLE SPENDING ACCOUNTS & COMMUTER TAX SAVE PROGRAM	Benefit Resource, Inc.	www.benefitresource.com	800-473-9595
RETIREMENT SAVINGS	TIAA	www.tiaa.org	800-842-2776
EMPLOYEE ASSISTANCE & WELLNESS SUPPORT PROGRAM	New York Life (GuidanceResources)	guidanceresources.com Web ID: NYLGBS	800-344-9752



STEVENS
INSTITUTE OF TECHNOLOGY
1870

Notices and Important Reminders

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for other benefits under the plan. If you would like more information on WHCRA benefits, contact Stevens Human Resources at 201-216-5190 or benefits@stevens.edu.

Newborns' and Mothers' Health Protection Act

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice of Special Enrollment Rights

This notice is being provided to help you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

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

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact Stevens Human Resources at 201-216-5190 or benefits@stevens.edu.

Hospital/Fixed Indemnity Plan Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance? Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options. To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy? For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments." If you have this policy through your job, or a family member's job, contact the employer.

Medicare Part D

Important Notice from Stevens Institute of Technology About Your Prescription Drug Coverage and Medicare – Creditable Coverage

The Trustees of the Stevens Institute of Technology Health and Welfare Benefit Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Stevens Institute of Technology and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2) Stevens Institute of Technology has determined that the prescription drug coverage offered under the following group health plan(s): The Trustees of the Stevens Institute of Technology Health and Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected. You can keep this coverage if you elect Medicare Part D coverage and the employer's plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may only be able to get this coverage back at the next annual enrollment opportunity or special enrollment event.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with this plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Stevens Institute of Technology changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 10/8/2026

Name of Entity/Sender: Stevens Institute of Technology

Contact: Kristal Attwood-Gonzalez, AVP, Total Rewards and HR Operations, Division of Human Resources

Address: 1 Castle Point on Hudson, Hoboken, NJ 07030

Phone: 201-216-5190 Email: benefits@stevens.edu

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.

GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receiving assistive reproductive services.

Mental Health Parity & Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact Stevens Human Resources at 201-216-5190 or benefits@stevens.edu.

Remember

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Uniformed Services Employment and Re-Employment Rights Act (USERRA)

The Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an employee's military leave of absence. These requirements apply to medical and dental coverage for you and your dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to www.dol.gov/agencies/vets/programs/userra.

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit www.dol.gov/agencies/vets. An interactive online USERRA Advisor can be viewed at www.dol.gov/elaws/userra.htm.



Michelle's Law Notice

Eligibility for Continued Coverage for Dependent Students on Medically Necessary Leave of Absence

The Stevens Institute of Technology Group Health Plan (Plan) *provides dependent coverage for the children of its participants until a child has attained age 26, regardless of the child's status as a student. For children covered under the Plan after attaining age 26, Michelle's Law provides continued coverage for dependent children who are covered as a student but lose their student status because they take a medically necessary leave of absence* from school.

As a result, if your child has attained age 26 and is no longer a student, as defined in the Plan, because he/she is on a medically necessary leave of absence, your ***child*** *may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your* ***child*** *was (1) covered under the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).*

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness *or injury,*
2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. *is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and*
2. *stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.*

If the coverage provided by the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your ***child*** *is eligible for this continued coverage, the child's treating physician must provide a written certification to the Plan stating that your child is suffering from a serious illness or* ***injury*** *and that the leave of absence (or other change in enrollment) is medically necessary.*

Coordination with COBRA Continuation Coverage

If your child is eligible for Michelle's Law's continued coverage and loses coverage under the Plan at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Questions?

If you have any questions regarding the information in this notice or your child's right to Michelle's Law's continued coverage, or if you would like a copy of your Summary Plan Description (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact benefits@stevens.edu.

Notice Regarding Aetna Health Your Way™ (Wellness Program)

Aetna Health Your Way is a voluntary wellness program available to all employees enrolled in the Aetna medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program, you will be asked to complete a voluntary confidential online health survey that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete an annual physical. You are not required to complete the health survey or the annual physical.

However, employees who choose to participate in the wellness program will receive an incentive for completing a health assessment and/or biometric screening on the Aetna Health Your Way platform. Although you are not required to complete the health survey or annual physical, completing these activities will help you earn the wellness incentive.

Additional incentives of up to $100 (including the above incentive) may be available for employees who participate in certain health-related activities or achieve certain health outcomes (like meeting certain thresholds related to the biometric screening). If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a *reasonable accommodation or an alternative standard. You may* request a reasonable accommodation or an alternative standard by contacting Human Resources at benefits@stevens.edu.

The information from your health survey and the results from your annual physical will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program, such as health coaching, weight loss management or smoking cessation.

You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Stevens Institute of Technology may use aggregate information it collects to design a program based on identified health risks in the workplace, Aetna Health Your Way (Wellness Program) will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Human Resources at benefits@stevens.edu.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility -

STATE	ADMINISTRATOR	WEBSITE	PHONE
Alabama	Medicaid	myalhipp.com	855-692-5447
Alaska: The AK Health Insurance Premium Payment Program	Medicaid	myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx	866-251-4861
Arkansas	Medicaid	myarhipp.com	855-MyARHIPP (855-692-7447)
California: Health Insurance Premium Payment (HIPP) Program	Medicaid	dhcs.ca.gov/hipp	916-445-8322 Fax:916-440-5676
Colorado: Health First Colorado	Medicaid	healthfirstcolorado.com	800-221-3943 State Relay 711
Colorado: Child Health Plan Plus (CHP+)	CHIP	colorado.gov/pacific/hcpf/child-health-plan-plus	800-359-1991 State Relay 711
Colorado Health Insurance Buy-In Program (HIBI)	Medicaid	colorado.gov/pacific/hcpf/health-insurance-buy-program	855-692-6442
Florida	Medicaid	flmedicaidtplrecovery.com flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia	Medicaid	medicaid.georgia.gov/health-insurance-premium-payment-program-hipp	678-564-1162 - Press 1
Georgia	CHIPRA	medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162 - Press 2
Illinois	Medicaid	abe.illinois.gov HIPP Email: hfs.boc.hipp@illinois.gov	HIPP Hotline: 217-524-8268
Indiana: Health Insurance Premium Payment Program	Medicaid	www.in.gov/medicaid or www.in.gov/fssa/dfr	Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
Iowa	Medicaid	hhs.iowa.gov/programs/welcome-iowa-medicaid hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 888-346-9562
Iowa: HAWKI	CHIP	hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki	800-257-8563
Kansas	Medicaid	www.kancare.ks.gov	800-792-4884 HIPP Phone: 1-800-967-4660
Kentucky: Integrated Health Insurance Premium Payment Program (KI-HIPP)	Medicaid	chfs.ky.gov/agencies/dms KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov	800-635-2570 855-459-6328
Kentucky	CHIP	KCHIP: kynect.ky.gov	877-524-4718
Louisiana	Medicaid	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid hotline: 888-342-6207 LaHIPP: 855-618-5488
Maine	Medicaid	www.mymaineconnection.gov/benefits/s/?language=en_US Private Health Insurance Premium Webpage: www.maine.gov/dhhs/ofi/applications-forms	800-442-6003 TTY: Maine relay 711 800-977-6740 TTY: Maine relay 711
Massachusetts	Medicaid and CHIP	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY: 711
Minnesota	Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri	Medicaid	www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana	Medicaid	dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HHSHIPPProgram@mt.gov	800-694-3084
Nebraska	Medicaid	www.ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada	Medicaid	dhcfp.nv.gov	800-992-0900

STATE	ADMINISTRATOR	WEBSITE	PHONE
New Hampshire	Medicaid	www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 HIPP program: 1-800-852-3345, ext 15218
New Jersey	Medicaid	www.state.nj.us/humanservices/dmahs/clients/medicaid	800-356-1561
New Jersey	CHIP	www.njfamilycare.org/index.html	CHIP Premium Assistance Phone:609-631-2392 800-701-0710 TTY: 711
New York	Medicaid	www.health.ny.gov/health_care/medicaid	800-541-2831
North Carolina	Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota	Medicaid	www.hhs.nd.gov/healthcare	844-854-4825
Oklahoma	Medicaid and CHIP	www.insureoklahoma.org	888-365-3742
Oregon	Medicaid and CHIP	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania	Medicaid	www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html	800-692-7462
Pennsylvania	CHIP	www.pa.gov/en/agencies/dhs/resources/chip.html	800-986-KIDS (5437)
Rhode Island	Medicaid and CHIP	www.eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina	Medicaid	www.scdhhs.gov	888-549-0820
South Dakota	Medicaid	dss.sd.gov	888-828-0059
Texas	Medicaid	www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah's Premium Partnership for Health Insurance (UPP)	Medicaid	medicaid.utah.gov/upp Email: upp@utah.gov Adult Expansion Website: medicaid.utah.gov/expansion	888-222-2542
Utah Medicaid Buyout Program	Medicaid	Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program	888-222-2542
Utah	CHIP	chip.utah.gov	833-404-4300
Vermont: Health Insurance Premium Payment (HIPP) Program	Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia	Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	800-432-5924
Washington	Medicaid	www.hca.wa.gov	800-562-3022
West Virginia	Medicaid and CHIP	dhhr.wv.gov/bms mywvhipp.com	Medicaid: 304-558-1700 CHIP: 855-MyWVHIPP (855-699-8447)
Wisconsin	Medicaid and CHIP	www.dhs.wisconsin.gov/publications/p1/p10095.pdf	800-362-3002
Wyoming	Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (0MB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by 0MB under the PRA, and displays a currently valid 0MB control number, and the public is not required to respond to a collection of information unless it displays a currently valid 0MB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid 0MB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the 0MB Control Number 1210-0137.

Notice to Individuals Who May Elect COBRA Continuation Coverage

On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law (Pub. L. 104-191). HIPAA section 421 makes changes, described below, to the three areas in the continuation coverage rules applicable to group health plans under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. These three areas related to the disability extension, the definition of qualified beneficiary and the duration of COBRA continuation coverage. These changes are effective beginning January 1, 1997, regard less of when the event occurs that entitles an individual to COBRA continuation coverage.

Disability Extension

Under current law, if an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan is only required to make COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to the COBRA continuation coverage is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation for 29 months, rather than 18 months. Under current law, the individual must be disabled at the time of the termination of employment or reduction in hours of employment. HIPAA makes changes to the current law to provide that, beginning January 1, 1997, the disability extension will also apply if the individual becomes disabled at any time during the first 60 days of COBRA continuation coverage. HI PAA also makes it clear that, if the individual entitled to the disability extension has nondisabled family members who are entitled to COBRA continuation coverage, those nondisabled family members are also entitled to the 29 month disability extension.

Definition of Qualified Beneficiary

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse and dependent children of a covered employee and, in certain cases, the covered employee. Under current law, in order to be a qualified beneficiary an individual must generally be covered under a group health plan on the day before the event that causes a loss of coverage (such as termination of employment, a divorce/legal separation, or death of the covered employee). HIPAA changes this requirement so that a child who is born to the covered employee, or who is placed for adoption with the covered employee, during a period of COBRA continuation is also a qualified beneficiary.

Duration of COBRA continuation coverage

Under the COBRA rules there are situations in which a group health plan may stop making COBRA continuation coverage available earlier than usually permitted. One of those situations is where the qualified beneficiary obtains coverage under another group health plan. Under current law, if the other group health plan limits or excludes coverage for any pre-existing condition of the qualified beneficiary, the plan providing the COBRA continuation coverage cannot stop making the COBRA continuation available merely because of the coverage under the other group health plan. HIPAA limits the circumstances in which plans can apply exclusions for pre-existing conditions. HIPAA makes a coordinating change to the COBRA rules so that if a group health plan limits or excludes benefits for pre-existing conditions but because of the new HIPAA rules those limits or exclusions would not apply to (or would be satisfied by) an individual receiving COBRA continuation coverage, then the plan providing the COBRA continuation coverage can stop making the COBRA continuation available. The HIPAA rules limiting the applicability of exclusions for pre-existing conditions become effective in plan years beginning on or after January 1, 1997 (or later for certain plans maintained pursuant to one or more collective bargaining agreements).

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Stevens Institute of Technology has taken the following steps, to the extent required by law, to comply with the Privacy Regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Stevens Institute of Technology has designated Kristal Attwood-Gonzalez to be the Privacy Officer. She is responsible for the development and implementation of privacy policies and procedures for Stevens Institute of Technology. Individuals may also contact the Privacy Officer for additional information regarding their rights under the Privacy Regulations.

The Privacy Officer is the only member of Stevens Institute of Technology who may be reasonably expected to have access to any protected health information under the Privacy Regulations' requirements. If any additional employees are anticipated to have access to personal health information (PHI), they will be trained accordingly.

All reasonable efforts will be made to avoid disclosure of PHI to any individual who is not the Privacy Officer, or otherwise designated an authorized recipient of PHI. If the Human Resource Department receives PHI, it will be filed in a secure location, separate from other personnel files.

Individuals with complaints regarding the use of PHI by Stevens Institute of Technology or the group health plans it sponsors which are covered by the Privacy regulations may contact the Privacy Officer. The Privacy Officer will address and document any such complaints. If it is determined that the Privacy Regulations were violated, appropriate sanctions will be taken against Stevens Institute of Technology employees who caused the violation. If the complaint involves the Privacy Officer, they will report such complaint to Sheraine Gilliam. If a violation of the Privacy rules occurs, Stevens Institute of Technology will take action to mitigate damages resulting from the violation. In no instance will Stevens Institute of Technology intimidate or retaliate against any individual acting to exercise their rights under the Privacy Regulations.

The identity and authority of any person requesting PHI from Stevens Institute of Technology will, to the extent required by law, be verified prior to disclosure of such PHI.A copy of this policy will be kept on file until at least 6 years from the last day if is in effect.

HIPAA Privacy Reminder Notice

HIPAA requires Stevens Institute of Technology to notify you that a privacy notice is available. Please contact benefits@stevens.edu if you have any questions.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's *household income.12*

1 Indexed annually; see https;//www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

2 An employer-sponsored o~ other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan 1s no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is general/y excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider al/ of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be **able** to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an on line application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered By Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Stevens Institute of Technology		4. Employer Identification Number (EIN) 22-1487354
5. Employer address 1 Castle Point on Hudson		6. Employer phone number 201-216-5190
7. City Hoboken	8. State NJ	9. ZIP code 07030
10. Who can we contact at this job? Kristal Attwood-Gonzalez		
11. Phone number (if different from above)	12. Email address benefits@stevens.edu	

Here is some basic information about health coverage offered by this employer: As your employer, we offer a health plan to:

All employees.

√ Some employees.

Eligible employees are: Full-time employees, regularly scheduled to work 30 hours per week and part-time employees who work an average of 30 hours per week as measured during the standard measurement period.

With respect to dependents

We do not offer coverage

√ *We do offer coverage*

Eligible dependents are: Legal spouses, natural born, step or legally adopted children of employees/spouses who have not attained age 26 & disabled dependent children, if disabled prior to the age of 26.

√ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

***Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are a newly employed mid-year, of if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, healthcare.gov will guide you through the process.

EMPLOYEE RIGHTS AND RESPONSIBILITIES
UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Entitlement
FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service-member during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

***The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

Benefits and Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew employees.**

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor | Wage and Hour Division

WHD Publication 1420 · Revised February 2013

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date – April 2017

STEVENS
INSTITUTE OF TECHNOLOGY
1870

2027
Benefits Guidebook

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding Specific issues or plan provisions, you should contact your Human Resources/Benefits Department.