



*Employee Benefit Plan Enrollment Book
For*



January 1, 2016 – December 31, 2016

Contract Administrators



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How to use this book

Welcome to Minneapolis College of Art and Design's Benefit Book.

The information in this book is designed to be used during enrollment. It contains most of the information that you will need to make your benefit choices. It will introduce your benefits, explain eligibility, show cost associated with each benefit and explain how to enroll.

This book is not intended to be a legal certificate, benefit plan document, or proof of coverage. It is a summary only, and its sole purpose is to help guide you through enrollment. Once you make your elections, you will receive the appropriate benefit certificates and plan documents that explain your benefits in detail.

This enrollment book covers many different plans, some of which are covered under ERISA and have additional Plan Documents and/or Summary Plan Descriptions. The pages in this enrollment book devoted to a summary of the Flex Plan serve as that plan's Summary Plan Documents. The pages devoted to a summary of the Medical Plan also serve as that plan's SPD.

In the event that there is a discrepancy between this book, the Summary Plan Description produced by an Insurance Company or Plan Sponsor, and the Master Plan Document, the Master Plan Document will prevail.

Total Compensation Means More Than Just Salary!

In today's employment arena, one cannot look at salary alone when reviewing employment positions. Our organization understands this and knows how benefits have become a major part of compensation.

Many times benefits received in addition to regular pay, such as medical, dental, life, and disability insurance, workers compensation, 403(b) contributions, etc. can actually be as much as 40% of your total annual compensation.

IMPORTANT:

WHETHER OR NOT YOU ARE ENROLLING FOR COVERAGE, THE COMPLETED ENROLLMENT FORM MUST BE SIGNED AND RETURNED. IF THE FORM IS INCOMPLETE FOR YOURSELF AND ALL DEPENDENTS, IT WILL BE RETURNED TO YOU TO BE COMPLETED.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT HUMAN RESOURCES.

REFERENCE TO THIRD PARTY SITES

This Book may refer to other informational sources or sites that are not under the control of EBSO, Inc. and EBSO, Inc. is not responsible for the contents of any such material. References are provided for convenience only.

CAUTION

This Book is intended to provide accurate information in regard to the subject matter covered. It is provided with the understanding that EBSO, Inc. is not engaged in rendering legal services. Nothing contained in the information in this Book, nor any views expressed at any presentation where this Book is used, should be construed as legal advice pertaining to a specific factual situation. If you need legal advice upon which you can rely, you must seek assistance from your attorney.

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Introduction

EBSO, Inc.'s mission:

To excel in all aspects of benefit plan administration so that our service consistently outshines the competition.

Disclaimer: *This book is a summary of the benefit plans. Each plan has a separate legal plan document that is your primary reference. Should there be any discrepancies between this book and the legal plan document, the legal plan document will prevail.*

Help is Here.



Who to Call

Medical Claims and Plan Information:

HealthPartners
952-883-5000
1-800-883-2177 www.healthpartners.com

Dental Claims and Plan Information:

EBSO, Inc. Group #277
651-695-2500 www.ebsobenefits.com
customerservice@ebsobenefits.com
1-800-486-7664

Dental Preferred Provider Network:

Premier Dental (Classic Network)
1-800-392-3112 www.premier-dental.com

Basic Life, Supplemental Life and Long Term Disability Information:

Guardian Life Insurance
1-888-600-1600 www.guardianlife.com

Supplemental Short-Term Disability Plan Information:

EBSO, Inc. Group #277
651-695-2500 www.ebsobenefits.com
1-800-486-7664

Flexible Benefits Plan (Medical & Dependent Care Reimbursement Accounts):

EBSO, Inc. Group #277
651-695-2500 Fax 651-695-1648
1-800-486-7664 www.ebsobenefits.com

Retirement Plan (403b):

TIAA CREF
1-800-842-2252 www.tiaa-cref.org

Employee Assistance Program (EAP):

HealthPartners
866-326-7194 or
Text us HPEAP to 919-324-5523
www.hpeap.com

Metropass:

612-373-3333 www.metrotransit.org

Parking Benefit Plan (Pre-tax Parking Account):

MCAD HR Department
Intranet.MCAD.edu/sites/default/files20140123_Reimbursement-Form.rev-2014.pdf

EBSO, Inc. Web Access

In this section:

- Overview
- Getting Started is Easy

We give you more brain power.



Overview

Here are some of the items you will have access to with one simple login:

- Information on eligibility, status of dental claims, and printable copies of Explanation of Benefits (EOB's).
- Flexible Spending, Dependent Care & Pre-Tax Parking Account claims and account balances.
- Plan Documents and Benefit Schedules.
- Email the EBSO, Inc. Customer Service Team with questions.
- Online enrollment
- Order ID cards

By using the EBSO, Inc. Internet services, you will be able to reduce time and effort spent in managing personal healthcare information and finances and increase your knowledge of your health benefits.

Getting started is EASY....

1. Go to www.ebsobenefits.com
2. Click on MEMBERS
3. Click on EBSO / SOMI Member Login.
4. In the gray box where it says "Need a username and password", click on the link Proceed to our sign up process, which will take you to EBSO's License Agreement. You must click on "Agree" to proceed to sign up and log in.
5. You will need your date of birth, last name, Member ID# and e-mail address to sign up. Please be sure to include an e-mail address. This is the address that will be used to notify you of new claims available for online viewing and printing.
6. Add link to your 'Favorites'

*You will use the number 277-xx-xxxx, where the final six numbers are the last six digits of your Social Security number.

Once you login, the menu at the left lists the options available to you. "I Need Help" provides online help to assist you.

All the information contained and entered into this site is secure and meets the strict standards of HIPAA.

Medical Plan

Plan Carrier:

HealthPartners

Employee Eligibility:

You are eligible for the health insurance coverage on the first of the month following your date of hire if you are scheduled to work 1,000 hours or more annually. If you are a casual, temporary, or adjunct faculty employee, you are not eligible immediately, but you will become eligible for one year if you averaged 30 hours per week over the previous year.*

Employees moving from eligible to ineligible positions may be entitled to an additional period of coverage during the transition.

Dependent Eligibility:

If you elect health coverage on yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and/or dependent children to age 26.

Plan Rates:

See page 5

Medical Care



Introduction

You Can Help Control The Cost of Benefits.

As a health care consumer, you have the right to question and compare the services you receive from your practitioners, so that you can obtain the most economical, effective and safe treatment available. This important step should be no different than purchasing any other service or commodity.

You can help control costs by using services wisely. Only you can determine when to see a doctor. A phone call may be just as good as a visit. When your doctor gives you a recommendation, it is okay to question the appropriateness and/or cost of their recommendation.

Premium rates are influenced by our claims history, a higher claims history means a higher premium rate.

ABOUT YOUR COVERAGE

The following pages are a brief outline of the medical benefit plan(s). Refer to your HealthPartners Group Certificate for more detailed information.

*MCAD will notify you if you become eligible. Contact Pam Newsome-Prochniak at 612-874-3798 if you have questions.

Plan Rates

Major Medical Plan				
	Total Cost Per Month	MCAD's Contribution Per Month	Employee Cost Per Month	Employee Cost Per Pay Period*
Employee	\$537.96	\$447.96	\$90.00	\$45.00
Employee + 1	\$1,075.92	\$640.24	\$435.68	\$217.84
Family	\$1,613.89	\$935.77	\$660.12	\$330.06

Co-Pay Plan				
	Total Cost Per Month	MCAD's Contribution Per Month	Employee Cost Per Month	Employee Cost Per Pay Period*
Employee	\$575.23	\$435.73	\$139.50	\$69.75
Employee + 1	\$1,150.46	\$655.86	\$494.60	\$247.30
Family	\$1,725.69	\$977.19	\$748.50	\$374.25

*24 pay periods per year

It will be necessary for you to choose either the Major Medical Plan or the Co-Pay Plan. Please refer to www.healthpartners.com for assistance in selecting a clinic, or call Member Services at (952) 883-5000 or 1-800-883-2177. Additional provider and plan information is also available on the Internet at www.healthpartners.com.

Medical Plan – Preferred or Non-Preferred

There are two options under the Major Medical Plan and two under the Co-Pay Plan. The options are either the Preferred or the Non-Preferred Plan.

You are eligible for one of the Preferred plans if you completed the Health and Wellness Program before September 30, 2015 (Frequent Fitness by August 31, 2015). If you have not completed this program, you will only be eligible for the Non-Preferred plans.

The only difference between the Preferred and Non-Preferred plans are the deductible amounts and the office co-pay under the co-pay plan.

Major Medical Plan

Preferred Plan

Completed Health and Wellness Program
\$1,000 Individual Deductible
\$2,000 Family Deductible

Non-Preferred Plan

Incomplete Health and Wellness Program
\$1,250 Individual Deductible
\$2,500 Family Deductible

Co-Pay Plan

Preferred Plan

Completed Health and Wellness Program
\$1,000 Individual Deductible
\$2,000 Family Deductible
\$40 Office Visit & Urgent Care Copay

Non-Preferred Plan

Incomplete Health and Wellness Program
\$1,000 Individual Deductible
\$2,000 Family Deductible
\$60 Office Visit & Urgent Care Copay

HealthPartners – Health and Wellness Program

The Health and Wellness Program was introduced to MCAD employees several years ago. We're committed to helping our employees improve their health. The Health and Wellness Program is a great resource to help you feel great and take an active step toward achieving your health goals

Free access to healthy tools

The first step to Health and Wellness Program Benefits is to discover your health potential with HealthPartners quick, confidential, online health assessment. The second step is to participate in one Health and Wellness Program – at no cost to you! Your health assessment results will help guide you toward a wellness program right for you. Available online or by phone, these wellness programs provide you with the tools you need to make permanent lifestyle changes. You'll find topics ranging from stress management to weight management to smoking cessation and more.

Health and Wellness Program FAQ's

Why does MCAD support the Health and Wellness Program?

We're offering this program because your health is our priority. With the Health and Wellness Program, you can access tools and resources to help you make healthy lifestyle changes. Plus, by completing the Health and Wellness Program requirements, you qualify for one of the lower deductible plans.

Why the emphasis on wellness?

Wellness programs like the Health and Wellness Program help you and fellow employees identify ways to improve your health. Maintaining a healthy lifestyle enriches our lives and lowers healthcare costs for both employees and employers.

Do I have to participate?

You're not required to participate, but we strongly encourage your participation. By participating, you'll qualify for one of the medical plans with a lower deductible or co-pay.

Privacy - Who will see the results of my health assessment?

All health information related to the Health and Wellness Program is confidential. No one within MCAD will ever see employee health information collected as part of the Health and Wellness Program – only HealthPartners specialists who make wellness program recommendations will have access to your personal information.

Will any of my co-workers know if I don't participate?

Your choice to participate or not is confidential. Only your employer and HealthPartners will know.

What if I took my health assessment and/or a program last year, does that count?

No, as our health status can constantly change, we need to continuously take care of ourselves. That's why we believe it's important to take the health assessment and complete a program every year.

Which wellness program will I take?

Based on your health assessment results, your personal Health and Wellness Program web page will display the Health and Wellness Program(s) right for you. Depending on your results, you may get a call from a health coach to help you enroll in the right program for you. There are a variety of Health and Wellness Programs on a wide range of topics. These programs are delivered in several ways including online and phone-based coaching programs. You can access one or more programs at no cost to you with the Health and Wellness Program.

How much time will it take for me to complete the program?

The length of the Health and Wellness Programs vary. Most programs can be completed over 6 to 8 weeks or less. Make sure you understand the program requirements before you enroll in order to leave enough time to complete before the deadline. Then you'll qualify for one of the lower deductible or co-pay plans at enrollment.

How long do I have to complete the program?

The deadline for completing the health assessment will be announced annually. After you take the health assessment, you must enroll in and complete one Health and Wellness Program by the annually communicated deadline.

How will I know what my status is in completing the Health and Wellness Program requirements?

You can track your status online at www.healthpartners.com or call HealthPartners Member Services.

Change Exhibit
For all large employer groups (FI and SI)

This is an overview of changes. For exact coverage terms, consult your plan documents.

Category	Previous benefit		New benefit	
	Effective date	Benefit	Effective date	Benefit
Out-of-Pocket Limits All Plans- Does not apply to Grandfathered plans	Before Jan. 1, 2016:	Varies by plan	Upon renewal on or after Jan. 1, 2016	Self-only annual limitation on cost sharing applies to each individual, regardless if the individual is enrolled in a self-only or family plan. An individual's cost sharing may never exceed the self-only limit on cost sharing. ¹
Out-of-Pocket Limits Non-HSA or HRA Plans- Does not apply to Grandfathered plans	Before Jan. 1, 2016:	The 2015 maximum limit on out-of-pocket expenses was \$6,600 for an individual and \$13,200 for a family. Exact limit varies by plan	Upon renewal on or after Jan. 1, 2016	For in-network benefits, the 2016 maximum out-of-pocket limit can be no more than \$6,850 for an individual and \$13,700 for a family. ¹
Out-of-Pocket Limits HSA and HRA Plans	Before Jan. 1, 2016:	The 2015 maximum limit on out-of-pocket expenses was \$6,450 for an individual and \$12,900 for a family. Exact limit varies by plan	Upon renewal on or after Jan. 1, 2016	For in-network benefits, the 2016 maximum out-of-pocket limit can be no more than \$6,550 for an individual and \$13,100 for a family. ²
Annual Contribution Limit HSA Plans	Before Jan. 1, 2016:	The 2015 HSA annual contribution limit was \$3,350 for an individual and \$6,650 for a family.	Jan. 1, 2016	The 2016 annual contribution limit for a family is \$6,750. There is no change to the limit for individual coverage. ²

References:

1-Final 2016 Notice of Benefit and Payment Parameters (80 FR 10750)

2-IRS 2016 HSA inflation adjustments

Open Access Preferred Major Medical Plan (SBC)



NationalONE Preferred Major Medical Plan

Minneapolis College of Art and
Design

2016

Preferred Plan (\$1000 – 75%) refers to participants who have met the wellness program qualifications.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthpartners.com or by calling 1-800-883-2177.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In-network: \$1,000 Individual, \$2,000 Family Out-of-network: \$2,000 Individual, \$4,000 Family Services marked with * in Common Medical Events are not subject to deductible	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$4,000 Individual, \$8,000 Family Out-of-network: \$8,000 Individual, \$16,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of in-network providers , see www.healthpartners.com/networks or call 1-800-883-2177.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-883-2177 or visit us at www.healthpartners.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-883-2177 to request a copy.

HealthPartners: NationalONE Ded - "\$1000-75% Preferred"

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance virtuwell: No charge for the first three visits and 25% coinsurance thereafter	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance virtuwell: Not covered	_____none_____
	Specialist visit	25% coinsurance	50% coinsurance	_____none_____
	Other practitioner office visit	25% coinsurance	50% coinsurance	_____none_____
	Preventive care/screening/immunization	No charge	50% coinsurance for immunizations, No charge for well child, 50% coinsurance for preventive care, 50% coinsurance for other services	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	_____none_____

HealthPartners: NationalONE Ded - "\$1000-75% Preferred"

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthpartners.com/public/pharmacy/formularies/formulary/preferredrx/index.html .	Generic drugs	Formulary: \$12 copay* at retail, \$24 copay* at mail Non-formulary: \$90 copay* at retail, \$180 copay* at mail	50% coinsurance at retail, mail not covered	31 Day supply retail/93 day supply mail order
	Formulary brand drugs	\$45 copay* at retail, \$90 copay* at mail		
	Non-formulary brand drugs	\$90 copay* at retail, \$180 copay* at mail		
	Specialty drugs	20% coinsurance*	50% coinsurance at retail, mail not covered	\$200 maximum copay per prescription per month.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	25% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	25% coinsurance	25% coinsurance	_____none_____
	Emergency medical transportation	25% coinsurance	25% coinsurance	_____none_____
	Urgent care	25% coinsurance	50% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fee	25% coinsurance	50% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	25% coinsurance	50% coinsurance	_____none_____
	Substance use disorder outpatient services	25% coinsurance	50% coinsurance	_____none_____
	Substance use disorder inpatient services	25% coinsurance	50% coinsurance	_____none_____

HealthPartners: NationalONE Ded - "\$1000-75% Preferred"

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you are pregnant	Prenatal and postnatal care	No charge	Prenatal: No charge Postnatal: 50% coinsurance	_____none_____
	Delivery and all inpatient services	25% coinsurance	50% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	120 visit limit
	Rehabilitation services	25% coinsurance	50% coinsurance	_____none_____
	Habilitation services	25% coinsurance	50% coinsurance	_____none_____
	Skilled nursing care	25% coinsurance	50% coinsurance	120 Days per confinement
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata.
	Hospice service	25% coinsurance	50% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	_____none_____
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-883-2177. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at 1-800-883-2177. You can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For questions about your rights, this notice, or assistance, you can contact your state insurance department at the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-883-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-883-2177.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. Cost sharing or "Patient pays" amounts are based on self-only coverage.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,720
- Patient pays \$2,820

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
Copays	\$20
Coinsurance	\$1,600
Limits or exclusions	\$200
Total	\$2,820

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,360
- Patient pays \$3,040

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,000
Copays	\$1,660
Coinsurance	\$300
Limits or exclusions	\$80
Total	\$3,040

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-883-2177 or visit us at www.healthpartners.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-883-2177 to request a copy.

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00706-CG264-20160101-20151012164934

Open Access Non-Preferred Major Medical Plan (SBC)



NationalONE Non-Preferred Major Medical Plan

Minneapolis College of Art and
Design

2016

Non-Preferred Plan (\$1250 – 75%) refers to participants who have not met the wellness program qualifications.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthpartners.com or by calling 1-800-883-2177.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In-network: \$1,250 Individual, \$2,500 Family Out-of-network: \$2,000 Individual, \$4,000 Family Services marked with * in Common Medical Events are not subject to deductible	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$4,000 Individual, \$8,000 Family Out-of-network: \$8,000 Individual, \$16,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u>?	Yes. For a list of in-network providers , see www.healthpartners.com/networks or call 1-800-883-2177.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u>?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services .

Questions: Call 1-800-883-2177 or visit us at www.healthpartners.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-883-2177 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance virtuwell: No charge for the first three visits and 25% coinsurance thereafter	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance virtuwell: Not covered	_____none_____
	Specialist visit	25% coinsurance	50% coinsurance	_____none_____
	Other practitioner office visit	25% coinsurance	50% coinsurance	_____none_____
	Preventive care/screening/immunization	No charge	50% coinsurance for immunizations, No charge for well child, 50% coinsurance for preventive care, 50% coinsurance for other services	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	_____none_____

HealthPartners: NationalONE Ded - "\$1250-75% Non-Preferred"

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthpartners.com/public/pharmacy/formularies/formulary/preferredrx/index.html .	Generic drugs	Formulary: \$12 copay* at retail, \$24 copay* at mail Non-formulary: \$90 copay* at retail, \$180 copay* at mail	50% coinsurance at retail, mail not covered	31 Day supply retail/93 day supply mail order
	Formulary brand drugs	\$45 copay* at retail, \$90 copay* at mail		
	Non-formulary brand drugs	\$90 copay* at retail, \$180 copay* at mail		
	Specialty drugs	20% coinsurance*	50% coinsurance at retail, mail not covered	\$200 maximum copay per prescription per month.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	25% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	25% coinsurance	25% coinsurance	_____none_____
	Emergency medical transportation	25% coinsurance	25% coinsurance	_____none_____
	Urgent care	25% coinsurance	50% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fee	25% coinsurance	50% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	25% coinsurance	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	25% coinsurance	50% coinsurance	_____none_____
	Substance use disorder outpatient services	25% coinsurance	50% coinsurance	_____none_____
	Substance use disorder inpatient services	25% coinsurance	50% coinsurance	_____none_____

HealthPartners: NationalONE Ded - "\$1250-75% Non-Preferred"

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you are pregnant	Prenatal and postnatal care	No charge	Prenatal: No charge Postnatal: 50% coinsurance	_____none_____
	Delivery and all inpatient services	25% coinsurance	50% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	120 visit limit
	Rehabilitation services	25% coinsurance	50% coinsurance	_____none_____
	Habilitation services	25% coinsurance	50% coinsurance	_____none_____
	Skilled nursing care	25% coinsurance	50% coinsurance	120 Days per confinement
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata.
	Hospice service	25% coinsurance	50% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	_____none_____
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-883-2177. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at 1-800-883-2177. You can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For questions about your rights, this notice, or assistance, you can contact your state insurance department at the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-883-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-883-2177.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. Cost sharing or "Patient pays" amounts are based on self-only coverage.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,570
- Patient pays \$2,970

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,250
Copays	\$20
Coinsurance	\$1,500
Limits or exclusions	\$200
Total	\$2,970

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,210
- Patient pays \$3,190

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,250
Copays	\$1,660
Coinsurance	\$200
Limits or exclusions	\$80
Total	\$3,190

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

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Can I use Coverage Examples to compare plans?

- ✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-883-2177 or visit us at www.healthpartners.com.

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00706-CG265-20160101-20151012164936

Open Access Preferred Co-Pay Plan (SBC)



NationalONE Preferred Co-Pay Plan

Minneapolis College of Art and Design

2016

Preferred Co-Pay Plan (\$1000 – 40) refers to participants who have met the wellness program qualifications.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthpartners.com or by calling 1-800-883-2177.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$1,000 Individual, \$2,000 Family Out-of-network: \$2,000 Individual, \$4,000 Family Services marked with * in Common Medical Events are not subject to deductible	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$4,250 Individual, \$8,500 Family Out-of-network: \$8,000 Individual, \$16,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network providers , see www.healthpartners.com/networks or call 1-800-883-2177.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-883-2177 or visit us at www.healthpartners.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-883-2177 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: \$40 copay* Convenience Care: \$20 copay* virtuwell: No charge for the first three visits and \$20 copay* thereafter	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance virtuwell: Not covered	_____none_____
	Specialist visit	\$40 copay*	50% coinsurance	_____none_____
	Other practitioner office visit	\$40 copay*	50% coinsurance	_____none_____
	Preventive care/screening/immunization	No charge	50% coinsurance for immunizations, No charge for well child, 50% coinsurance for preventive care, 50% coinsurance for other services	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	_____none_____

HealthPartners: NationalONE Ded - "\$1000-40 Preferred "

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthpartners.com/public/pharmacy/formularies/formulary/preferredrx/index.html .	Generic drugs	Formulary: \$12 copay* at retail, \$24 copay* at mail Non-formulary: \$90 copay* at retail, \$180 copay* at mail	50% coinsurance at retail, mail not covered	31 Day supply retail/93 day supply mail order
	Formulary brand drugs	\$45 copay* at retail, \$90 copay* at mail		
	Non-formulary brand drugs	\$90 copay* at retail, \$180 copay* at mail		
	Specialty drugs	20% coinsurance*	50% coinsurance at retail, mail not covered	\$200 maximum copay per prescription per month.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	25% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	\$100 copay*	\$100 copay*	_____none_____
	Emergency medical transportation	25% coinsurance	25% coinsurance	_____none_____
	Urgent care	\$40 copay*	50% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fee	25% coinsurance	50% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40 copay*	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	25% coinsurance	50% coinsurance	_____none_____
	Substance use disorder outpatient services	\$40 copay*	50% coinsurance	_____none_____
	Substance use disorder inpatient services	25% coinsurance	50% coinsurance	_____none_____

HealthPartners: NationalONE Ded - "\$1000-40 Preferred "

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you are pregnant	Prenatal and postnatal care	No charge	Prenatal: No charge Postnatal: 50% coinsurance	_____none_____
	Delivery and all inpatient services	25% coinsurance	50% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	Therapies: \$40 copay* IV: No charge	50% coinsurance	120 visit limit
	Rehabilitation services	\$40 copay*	50% coinsurance	_____none_____
	Habilitation services	\$40 copay*	50% coinsurance	_____none_____
	Skilled nursing care	25% coinsurance	50% coinsurance	120 Days per confinement
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata.
	Hospice service	No charge	50% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	_____none_____
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-883-2177. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at 1-800-883-2177. You can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For questions about your rights, this notice, or assistance, you can contact your state insurance department at the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-883-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-883-2177.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. Cost sharing or "Patient pays" amounts are based on self-only coverage.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,920
- Patient pays \$2,620

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
Copays	\$20
Coinsurance	\$1,400
Limits or exclusions	\$200
Total	\$2,620

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,350
- Patient pays \$3,050

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,000
Copays	\$1,900
Coinsurance	\$70
Limits or exclusions	\$80
Total	\$3,050

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-883-2177 or visit us at www.healthpartners.com.

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00706-CG261-20160101-20151012164925

Open Access Non-Preferred Co-Pay Plan (SBC)



NationalONE Non-Preferred Co-Pay Plan

Minneapolis College of Art and Design

2016

Non-Preferred Co-Pay Plan (\$1000 – 60) refers to participants who have not met the wellness program qualifications.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthpartners.com or by calling 1-800-883-2177.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-network: \$1,000 Individual, \$2,000 Family Out-of-network: \$2,000 Individual, \$4,000 Family Services marked with * in Common Medical Events are not subject to deductible	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network: \$4,250 Individual, \$8,500 Family Out-of-network: \$8,000 Individual, \$16,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of in-network providers , see www.healthpartners.com/networks or call 1-800-883-2177.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: \$60 copay* Convenience Care: \$30 copay* virtuwell: No charge for the first three visits and \$30 copay* thereafter	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance virtuwell: Not covered	_____none_____
	Specialist visit	\$60 copay*	50% coinsurance	_____none_____
	Other practitioner office visit	\$60 copay*	50% coinsurance	_____none_____
	Preventive care/screening/immunization	No charge	50% coinsurance for immunizations, No charge for well child, 50% coinsurance for preventive care, 50% coinsurance for other services	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	_____none_____

HealthPartners: NationalONE Ded - "\$1000-60 Non-Preferred Plan"

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthpartners.com/public/pharmacy/formularies/formulary/preferredrx/index.html .	Generic drugs	Formulary: \$12 copay* at retail, \$24 copay* at mail Non-formulary: \$90 copay* at retail, \$180 copay* at mail	50% coinsurance at retail, mail not covered	31 Day supply retail/93 day supply mail order
	Formulary brand drugs	\$45 copay* at retail, \$90 copay* at mail		
	Non-formulary brand drugs	\$90 copay* at retail, \$180 copay* at mail		
	Specialty drugs	20% coinsurance*	50% coinsurance at retail, mail not covered	\$200 maximum copay per prescription per month.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fees	25% coinsurance	50% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	\$100 copay*	\$100 copay*	_____none_____
	Emergency medical transportation	25% coinsurance	25% coinsurance	_____none_____
	Urgent care	\$60 copay*	50% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	_____none_____
	Physician/surgeon fee	25% coinsurance	50% coinsurance	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$60 copay*	50% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	25% coinsurance	50% coinsurance	_____none_____
	Substance use disorder outpatient services	\$60 copay*	50% coinsurance	_____none_____
	Substance use disorder inpatient services	25% coinsurance	50% coinsurance	_____none_____

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Coverage Period: 01/01/2016 - 12/31/2016

Summary of Coverage: What this Plan Covers & What it Costs

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you are pregnant	Prenatal and postnatal care	No charge	Prenatal: No charge Postnatal: 50% coinsurance	_____none_____
	Delivery and all inpatient services	25% coinsurance	50% coinsurance	_____none_____
If you need help recovering or have other special health needs	Home health care	Therapies: \$60 copay* IV: No charge	50% coinsurance	120 visit limit
	Rehabilitation services	\$60 copay*	50% coinsurance	_____none_____
	Habilitation services	\$60 copay*	50% coinsurance	_____none_____
	Skilled nursing care	25% coinsurance	50% coinsurance	120 Days per confinement
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata.
	Hospice service	No charge	50% coinsurance	_____none_____
If your child needs dental or eye care	Eye exam	No charge	50% coinsurance	_____none_____
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
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Your Rights to Continue Coverage:

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The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

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Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,920
- Patient pays \$2,620

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
Copays	\$20
Coinsurance	\$1,400
Limits or exclusions	\$200
Total	\$2,620

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,230
- Patient pays \$3,170

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,000
Copays	\$2,020
Coinsurance	\$70
Limits or exclusions	\$80
Total	\$3,170

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
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For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

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- ✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

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HealthPartners Value-Added Services

HealthPartners knows that employers and employees want value for their health care investment. But they also recognize that no one wishes to sacrifice choice, quality, or superior care and service. That's why their goal is to deliver health, and not just care. Their plans, valued-added services, and elective products create health care that works for you, giving you the quality health care you demand and the value you want.

Member Services

Member Services responds with the information members want about benefits, providers and care, and helps them resolve any problems quickly. HealthPartners offers Web-based services and special HealthPartners "nurse navigators" to personally assist members with more complex health and coverage concerns. Member Services can be reached at (952) 883-5000 or 1-800-883-2177.

National Network

Through its affiliation with CIGNA HealthCare, HealthPartners offers a national network that members can use if they need care while traveling outside the HealthPartners network area. Members receive assistance finding quality health care providers, and out-of-network coverage, when available, takes advantage of negotiated provider discounts. For more information, contact HealthPartners at 1-800-883-2177 or Member Services at 952-883-5000.

Special Services for Chronically Ill Members

For critically ill members, HealthPartners offers case management services that support physicians, members and their families. Numerous disease management programs have been developed founded on mind-body-spirit approach. HealthPartners has earned national acclaim for its diabetes and heart disease programs. Members Services "nurse navigators" can help members and their families understand complex health and coverage issues. HealthPartners operates an accredited hospice program.

Medical Plan General Rules

Dependent Child

If your dependent(s) reach the maximum age (26) under your plan, you must notify your employer of the change in status within 30 days. Failure to notify your employer within 60 days of the status change will result in loss of COBRA rights for your dependent.

Special Enrollment Rules

Group health plans and health insurance issuers are required to permit certain employees and dependents special enrollment rights. These rights are provided to both employees who were eligible but declined to enroll in the plan when first offered because they were covered under another plan and to individuals upon marriage, birth, adoption or placement for adoption of a new dependent. These special enrollment rights permit these individuals to enroll without having to wait until the plan's next regular enrollment period. The special enrollment rules apply even to plans that do not have an annual open enrollment period.

Loss of Other Coverage

If you declined to enroll yourself or your dependents in this plan solely due to coverage under another group health plan, or other health insurance coverage, you may enroll for coverage under the special enrollment rules in the event you lose the other coverage due to:

- Divorce or legal separation
- Death of spouse or dependent
- Loss of dependent eligibility
- Loss of eligibility for Medicaid, Minnesota Care, CHIP or other government insurance programs
- Termination of employment
- COBRA continuation coverage is exhausted
- Reduction in number of hours of employment including an unpaid leave of absence
- Employer contributions towards such coverage are terminated

Coverage will become effective on the day following the date on which your other coverage would normally terminate. If you experience a change in family status, you must notify Human Resources of your change in family status and submit a completed Status Change Form within 31 days of the event, or within 60 days in the event a child loses eligibility for Medicaid or CHIP or the child obtains eligibility for a state premium assistance subsidiary under this program.

At such time as you or your dependents cease to be covered under this plan, your employer will provide you with a Certificate of Coverage which you may present at the time you become enrolled for coverage under another plan of health coverage.

New Dependents

You may enroll your new dependents, as well as yourself and your eligible spouse, if you previously declined enrollment in this plan, and you acquire a dependent through:

- Birth or adoption of a child or placement for adoption
- Marriage

An employee has 31 days from the date of birth, adoption, or placement for adoption or marriage in which to apply for coverage. If you enroll during the 31 day period, coverage will be effective:

- With respect to a birth, on the date of birth
- With respect to adoption, on the date of adoption or placement for adoption
- With respect to marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received.

Court Order

Your dependents may be added to the plan if a Qualified Medical Child Support Order (QMCSO) is received. Your employer will determine if the Order is qualified. If you previously declined coverage and the court orders your dependent to be covered, your enrollment will be required as well. For more information, please see page 110.

Annual Open Enrollment

The plan will have an annual open enrollment period with a January 1st effective date. At that time, you may enroll yourself or your eligible dependents for coverage under the plan.

Dental Plan

Contract Administrator:

EBSO, Inc.

PPO Preferred Provider Network:

Premier Dental – Classic Network

Provider Information:

Provider information is available on the Internet at www.premier-dental.com or through Customer Service at 1-800-392-3112.

Employee Eligibility:

You are eligible for coverage on the first of the month following your date of hire if you are scheduled to work 1,000 hours or more annually.

Dependent Eligibility:

If you elect coverage on yourself, you may also cover your eligible dependents. Eligible dependents include your spouse and/or dependent children to age 26.

	Your Cost Per Pay Period	Your Cost Per Month
Employee	\$23.85	\$47.70
Employee+1	\$47.95	\$95.90
Family	\$71.45	\$142.90

*24 pay periods per year



Overview

Our dental coverage is designed to provide protection to you and/or your family in the event that you require dental services during the year. The dental plan provides levels of coverage for certain dental expenses ranging from routine services to major services.

Remember, you may also combine the Flexible Spending Account benefit with the dental plan. By incorporating both plans you can design a more comprehensive benefit package which fits your individual needs.

Usual & Customary

Non-Network Dental benefits are paid based upon a Usual and Customary schedule of charges. For example, you may find that a portion of your bill was disallowed because your non-network dentist's fee for that procedure exceeded what is charged by most dentists in your geographic location for a similar procedure. Charges that exceed Usual and Customary are the responsibility of the employee. In-Network Dentists have negotiated their fees with the Premier Dental Network, this means that there will be no Usual & Customary exclusions when using a network provider.

Pre-Treatment Estimates

A covered person may request a pre-determination on any anticipated treatment. You should ask your dentist to describe the proposed treatment and charges on a dental claim form. The form should then be sent to EBSO, Inc. The proposed charges will be reviewed by EBSO, Inc. and an estimate will be sent to your Dentist indicating how much the plan will consider as covered expenses and how much the plan will pay.

A Pre-Treatment Estimate is not a guarantee of payment. Final benefit determination is made upon receipt of claim for actual services rendered, subject to all terms and conditions of this plan.

Schedule of Benefits

First Year Dental - Benefit Summary		
	NETWORK	NON-NETWORK
CALENDAR YEAR DEDUCTIBLE		
<ul style="list-style-type: none"> • Per person • Maximum per family 	None None	\$50 \$150
CALENDAR YEAR MAXIMUM (PER PERSON)	\$1,500	
PREVENTIVE SERVICES	100%	80% (Deductible waived)
<ul style="list-style-type: none"> • Oral Exams and Cleanings – two times per Calendar Year • Fluoride Treatments (Dependent children under age 18) - two times per Calendar Year • Infection Control • Space Maintainers (Dependent children under age 15) • X-Rays <ul style="list-style-type: none"> ▲ bitewing x-rays, two sets per Calendar Year ▲ full mouth set of x-rays including panograph (one in any three year period) ▲ periopical and occlusal x-rays • Sealants (Dependent children under age 15) - once in a three year period 		
BASIC RESTORATIVE	80%	Deductible & 50%
<ul style="list-style-type: none"> • Amalgam (silver), Silicate, Acrylic, or Composite (white) Fillings • Anesthesia • Emergency Palliative Treatment • Extractions • Endodontics • Oral Surgery • General and Local Anesthesia administered with Oral Surgery • Periodontics • Stainless Steel Crowns 		

Where the Plan specifies a Deductible, maximum dollar amount paid, or a maximum number of visits allowed, benefits paid In-Network and Out-of-Network will apply toward each other in determining the maximums allowed under the Plan.

If you or your family members are newly enrolled in the Dental Plan then you are eligible for Preventive and Basic Restorative services only. Upon the second and continuous years on the plan you will be eligible for full dental coverage which includes Preventive, Basic Restorative, Major Services, Prosthodontics and Orthodontics.

NOTE: A Network dentist is a dentist who has signed an agreement with Premier Dental. The dentist has agreed to accept the Premier Dental Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable Deductible and Co-insurance amounts listed in the Dental Benefit Summary and/or Schedule of Benefits. This schedule is just a summary. Please see the plan document for additional details and limitations.

Full Dental - Benefit Summary		
	NETWORK	NON-NETWORK
CALENDAR YEAR DEDUCTIBLE <ul style="list-style-type: none"> • Per person • Maximum per family 	None None	\$50 \$150
CALENDAR YEAR MAXIMUM (PER PERSON)	\$1,500	
PREVENTIVE SERVICES <ul style="list-style-type: none"> • Oral Exams and Cleanings – two times per Calendar Year • Fluoride Treatments (Dependent children under age 18) - two times per Calendar Year • Infection Control • Space Maintainers (Dependent children under age 15) • X-Rays <ul style="list-style-type: none"> ▲ bitewing x-rays, two sets per Calendar Year ▲ full mouth set of x-rays including panograph (one in any three year period) ▲ periopical and occlusal x-rays • Sealants (Dependent children under age 15) - once in a three year period 	100%	80% (Deductible waived)
BASIC RESTORATIVE <ul style="list-style-type: none"> • Amalgam (silver), Silicate, Acrylic, or Composite (white) Fillings • Anesthesia • Emergency Palliative Treatment • Extractions • Endodontics • Oral Surgery • General and Local Anesthesia administered with Oral Surgery • Periodontics • Stainless Steel Crowns 	80%	Deductible & 50%
MAJOR RESTORATIVE <ul style="list-style-type: none"> • Crowns (other than stainless steel) • Gold Fillings • Inlays & Onlays 	60%	Deductible & 50%
PROSTHODONTICS <ul style="list-style-type: none"> • Partial or Complete Dentures • Removable or Fixed Bridgework • Implants including Bone Beam Image and Bone Grafts 	60%	Deductible & 50%

Where the Plan specifies a Deductible, maximum dollar amount paid, or a maximum number of visits allowed, benefits paid In-Network and Out-of-Network will apply toward each other in determining the maximums allowed under the Plan.

NOTE: A Network dentist is a dentist who has signed an agreement with Premier Dental. The dentist has agreed to accept the Premier Dental Maximum Amount Payable as payment in full for covered dental care. You will be responsible for any applicable Deductible and Co-insurance amounts listed in the Dental Benefit Summary and/or Schedule of Benefits. This schedule is just a summary. Please see the plan document for additional details and limitations.

ORTHODONTIA		
	NETWORK	NON-NETWORK
ORTHODONTIC MAXIMUM LIFETIME BENEFIT (PER DEPENDENT CHILD AGE 8 TO 19 YEARS)	\$1,500	
<ul style="list-style-type: none"> • Braces • Fixed or Removable Appliances 	50%	50%

Exclusions
<p>The following is a short list of the Exclusions for this Plan for your convenience. For additional details and a complete list, see the Plan Document.</p> <ul style="list-style-type: none"> • Charges not specifically shown as Covered Expenses in the Schedule of Benefits and/or Benefit Summary • Charges for dental procedures performed other than by a licensed Dentist and his or her employees or agents • Charges for dentistry for cosmetic purposes, including veneers • Charges for replacement of lost, missing, broken or stolen prosthetic or orthodontic appliances • Charges for any service, including material and supplies, not incurred and/or completed while the individual is covered for dental benefits under this Plan. Orthodontics in progress at the time you are effective with this Plan will be covered only if the total dollar amount paid under your prior coverage is less than the Maximum Lifetime Benefit for Orthodontics of this Plan. A service is considered incurred on the date the service is rendered except: <ul style="list-style-type: none"> ◆ Dentures or Fixed Bridges – Service is considered incurred on the date the impression is taken. ◆ Crowns – Service is considered incurred on the date preparation of the tooth begins. ◆ Root Canal Therapy – Service is considered incurred on the date work begins on the tooth and the pulp chamber is opened. • Charges for prosthetic appliances (including but not limited to, bridges and crowns) and the fitting of them, which were ordered while the individual was not covered by this Plan • Charges for dental services related to temporomandibular joint (TMJ) disorders, as shown on the Schedule of Benefits, that are in excess of the Plan's Maximum Benefit and that have not been fully coordinated through a medical plan, if applicable • Charges which would be covered under Workers' Compensation or similar legislation or for conditions resulting while at any occupation for wage or profit <p>This plan Coordinates benefits with other carriers according to the NAIC guidelines.</p>

Life/AD&D Insurance

Plan Carrier:

Guardian Life

Employee Eligibility:

You are eligible for life insurance coverage on the first of the month following your date of hire if you are scheduled to work 1,000 hours or more annually.

Basic Employee Life/AD&D

Plan Rates:

This benefit is 100% paid by your Employer.

Financial Security



Overview

The Minneapolis College of Art and Design provides you with \$30,000 of Group Term Life Insurance through Guardian Life. The \$30,000 Basic Life Insurance Plan also includes an Accidental Death and Dismemberment provision (AD&D). Therefore, should you die through an accident, your beneficiary will receive an additional \$30,000 of life insurance. The AD&D provision also protects you should you lose a limb or sight in both eyes resulting from an accident. (Please see page 50 for more details.)

You also have the option of purchasing additional life insurance coverage on yourself and eligible dependents through Guardian Life. Up to \$20,000 of the additional life insurance you purchase on yourself may be taken on a pre-tax basis. The remainder must be purchased on an after-tax basis. Also, please note, the IRS will not permit employees to purchase dependent life insurance on a pre-tax basis.

An eligible dependent will not include any person who is an eligible employee. No person can be both a covered person and a covered dependent. If you and your spouse are both covered persons, only one will be considered to have any eligible dependents.

If you are under 65, up to \$100,000 of employee Supplemental Life insurance and \$50,000 of spousal Supplemental Life insurance will be guarantee issue if elected when you are first eligible.

Any person age 65 and over must submit proof of good health for any new amount of coverage elected.

Guarantee Issue: Guarantee issue means that the coverage does not have to be approved by the medical underwriting department of the insurance carrier.

In order for the guarantee issue levels listed on the following pages to be available, a minimum 25% of employees must participate in the Employee Supplemental Life Program. Currently, we meet these minimum requirements. Any person who currently has coverage will not lose it.

Newly eligible employees must elect, and in future enrollments maintain, a minimum of \$20,000 in coverage on themselves and a minimum of \$10,000 on their spouse in order to be eligible for the guarantee issue amounts at future benefits annual open enrollments. In subsequent years, maximum increase is limited to \$10,000 employee and \$5,000 spouse at annual open enrollment without evidence of insurability. If you do not enroll for the minimum amount, you will not be able to take supplemental life insurance without completing an “Evidence of Insurability” form and possibly undergoing a health exam, after which you may be denied coverage.

If you have enrolled for the minimum amount prior to this year’s open enrollment period, you can increase your election by \$10,000 (spouse: \$5,000) per year without a health exam. With a health exam, you may enroll for up to a total of \$300,000 in coverage (spouse: \$150,000).

Actively at Work:

If you are not actively at work on the day you would otherwise become insured, your insurance will not take effect until you return to active work. If the day your coverage would normally take effect is not a regular work day for you, your coverage will take effect on that day if you are able to do your regular job.

The following pages are brief descriptions of the Guardian Life insurance benefits provided to you through the college. Please refer to your individual certificates for a more detailed explanation of your coverage.

Basic Life/AD&D Benefit	
Basic Life	\$30,000
AD&D Benefit	\$30,000
Age Reduction	Insurance benefits reduce to 50% at age 70, and terminate at retirement.

The preceding reduction also applies to an employee’s initial insurance amount if his or her insurance starts after he or she reaches age 70.

Employee Basic Accidental Death and Dismemberment Benefits

The Benefit:

Guardian Life (carrier) will pay the benefits described below if an employee suffers an irreversible covered loss due to an accident that occurs while he or she is insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 365 days of the date of the accident.

Covered Losses:

Benefits will be only for losses identified in the following table. The Insurance Amount is shown on the next page.

ACCIDENTAL DEATH AND DISMEMBERMENT

<u>Covered Loss</u>	<u>Benefit</u>
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

For covered multiple losses due to the same accident, the carrier will pay 100% of the Insurance Amount. Insurance Carrier will not pay more than 100% of the Insurance Amount for all losses due to the same accident.

The Loss of:

- (a) a hand or foot means it is completely cut off at or above the wrist or ankle.
- (b) sight means the total and permanent loss of sight.

Supplemental Life Insurance

Plan Carrier:

Guardian Life

Eligibility:

If you are an active employee scheduled to work 1,000 hours or more annually and choose Supplemental Life Insurance on yourself, you may also cover your spouse and/or dependent child(ren) who are 14 or more days old, up to age 25, or 26 if a full-time student. Insurance benefits reduce to 50% at age 70 and terminate at retirement.

Supplemental Life Insurance Rates (Spouse rate is based on employee's age)

	Monthly Rate Per \$10,000	Rate Per Pay Period* Per \$10,000
< 30	\$.85	\$.43
30-34	\$.92	\$.46
35-39	\$1.00	\$.50
40-44	\$1.60	\$.80
45-49	\$2.60	\$1.30
50-54	\$4.50	\$2.25
55-59	\$7.30	\$3.65
60-64	\$11.00	\$5.50
65-69	\$17.00	\$8.50
70-74	\$19.60	\$9.80
75 & over	\$37.20	\$18.60

Dependent Child(ren) Cost

Per Family Unit	Monthly Rate	Rate Per Pay Period*
\$5,000	\$.75	\$.38
\$10,000	\$1.50	\$.75
\$15,000	\$2.25	\$1.13
\$20,000	\$3.00	\$1.50

*24 pay periods per year

Overview

This benefit option gives you the ability to purchase additional life insurance coverage at special reduced rates. If you enroll when first eligible and purchase the minimum requirements, you can increase your election by \$10,000 (spouse \$5,000) per year without a health exam. With a health exam, you may enroll for up to a total of \$300,000 in coverage (spouse \$150,000).

Supplemental Life Insurance	
Employee	Units of \$10,000 to a maximum of \$300,000 (minimum \$20,000). Guarantee issue up to \$100,000 when first eligible for employees under age 65, \$50,000 for ages 65-70 and \$10,000 for age 70 and older.
Dependent Spouse	Units of \$5,000, not to exceed 50% of employee's Supplemental Life amount (minimum \$10,000). Guarantee issue up to \$50,000 for spouse under age 65; \$10,000 for spouse between age 65 and 70. Coverage terminates at age 70. Only available if employee Supplemental Life is purchased.
Dependent Child(ren)	A minimum of \$5,000 up to a maximum of \$20,000. Evidence of insurability is required when amounts are increased after the first election or if more than \$10,000 is elected at any time. Only available if employee Supplemental Life is purchased.

Supplemental Life Special Features and Rules

Please Note: Newly eligible employees must elect, and in future enrollments maintain, a minimum of \$20,000 in coverage on themselves and a minimum of \$10,000 on their spouse in order to be eligible for the annual election option at future open enrollments. In subsequent years, maximum increase is limited to \$10,000 employee and \$5,000 spouse at annual open enrollment without evidence of insurability. If you do not enroll for the minimum amount, you will not be able to take supplemental life insurance without completing an “Evidence of Insurability” form and possibly undergoing a health exam, after which you may be denied coverage. If requesting an increase of more than \$10,000 employee and \$5,000 spouse, evidence of insurability must also be submitted.

For life insurance exceeding the Guarantee Issue amount, coverage goes into effect on the first of the month following approval.

Any person age 65 and over must submit proof of good health for **any new** amount of coverage elected.

Age Reduction:

Your benefit amount will be reduced by 50% upon attainment of age 70. Spousal coverage ends at age 70.

Overview:

You have the option of purchasing additional life insurance coverage on yourself and eligible dependents through Guardian Life. Up to \$20,000 of the additional life insurance you purchase on yourself may be taken on a pre-tax basis. The remainder must be purchased on an after-tax basis. Also, please note, the IRS will not permit employees to purchase dependent life insurance on a pre-tax basis.

An eligible dependent will not include any person who is an eligible employee. No person can be both a covered person and a covered dependent. If you and your spouse are both covered persons, only one will be considered to have any eligible dependents.

Guarantee Issue:

Guarantee issue means that the coverage does not have to be approved by the medical underwriting department of the insurance carrier.

In order for the guarantee issue levels listed on the prior pages to be available, a minimum 25% of employees must participate in the Employee Supplemental Life Program. Currently, we meet these minimum requirements. Any person who currently has coverage will not lose it.

Actively at Work:

If you are not actively at work on the day you or your dependent would otherwise become insured, your insurance will not take effect until you return to active work. If the day your coverage would normally take effect is not a regular work day for you, your coverage will take effect on that day if you are able to do your regular job.

Conversion:

In the event that you terminate your employment, you may continue Basic and/or Supplemental Life coverage for up to 18 months under Minnesota Continuation. Spousal and dependent supplemental coverage may also be continued. At the end of the 18-month continuation period,

you may convert your Basic Life coverage to an individual policy if you desire, and/or you may also portabilize your Supplemental Life coverage as explained below.

Portability:

The Supplemental Life plan is a portable plan which means you can continue the coverage if you leave the Minneapolis College of Art and Design, up to age 70. If you wish to continue the Supplemental Life coverage under the portability option, you must obtain the appropriate form from Guardian Life, complete it, and submit it to Guardian Life within 31 days of your termination date, or the end of your continuation period. At that time, you will receive a bill directly from Guardian Life. Coverage through the portable policy will be for the amount you have in force at the current rate, and you will not be required to provide medical evidence of insurability. Rates will change according to your age as outlined above. The portability option is not available to dependents unless it is also elected by the employee. Portability ceases on attainment of age 70.

What happens if both my spouse and I work here?

An eligible dependent will not include any person who is an eligible employee. No person can be both a covered person and a covered dependent. If you and your spouse are both covered persons, only one will be considered to have any eligible dependents.

What could delay the effective date of the Supplemental Life Coverage?

Spousal insurance will not take effect until your insurance for the same coverage under the policy takes effect.

If an eligible dependent:

- is confined in a hospital;
- is confined in any institution or facility (other than a hospital) or at home or elsewhere, due to an injury or sickness; or
- is disabled either physically or mentally, to the extent of;
 - being unable to perform all of the usual and customary duties and activities (the “normal activities”) of a person of the same age and sex who is in good health; and/or
 - not being able to engage in any work or occupation for wages or profit,

on the day insurance would otherwise take effect, it will not take effect until either such confinement ends and/or is no longer medically necessary or until the full resumption of all normal activities and/or return to active work.

These exceptions do not apply to a child born while the covered person’s insurance is in effect, or to a child who is your first eligible dependent provided you apply for dependent insurance no later than 31 days after the dependent becomes eligible.

NOTE: The dependent life coverage offered in this booklet is provided as an additional benefit and, per IRS regulations, may be purchased only on an after-tax basis. Information pertaining to this coverage is included in this booklet for enrollment purposes only.

Other Life Options

In addition to the Supplemental Life insurance through Guardian Life, you may also purchase individual term life Insurance through TIAA-CREF on yourself or your spouse. Visit TIAA-CREF for more information and application instructions at www.tiaa-cref.org/lifeinsurance.

Disability Plans

Supplemental Short-Term Disability Administrative Provider:

EBSO, Inc., for Minneapolis College of Art and Design Self-Funded Disability Plan

Contract Administrator:

EBSO, Inc.

Long-Term Disability Carrier:

Guardian Life Insurance

Eligibility:

You are eligible for both Supplemental Short-Term Disability and Long-Term Disability coverage on the first of the month following your date of hire if you are scheduled to work 1,000 hours or more annually.

Supplement Short-Term Disability Costs:

See page 55

Long-Term Disability Costs:

See page 56

Income Protection



Overview

Why have Disability coverage?

Disability coverage provides you with income protection against disabilities and illnesses that prevent you from working. The risk of disability is greater than most people realize.

Disability Statistics:

It happens more often than you'd imagine.

- **In just the past hour, almost 3,000 Americans became disabled.** That's 49 every minute.¹
- Over 51 million Americans – 18% of the population – are classified as disabled.²
- Every 1 second another disabling injury occurs in the US. Every four minutes the injury is fatal.¹
- Almost one-third of Americans entering the work force today (3 in 10) will become disabled before they retire.³
- Nearly 7 million workers currently receive Social Security Disability benefits. Almost half are under age 50.⁴

1. National Safety Council, Injury Facts 2008 Ed.
2. US Census Bureau, Nov 2008.
3. Social Security Administration, Fact Sheet Jan 31, 2007
4. "Illness and Injury as Contributors to Bankruptcy," Health Affairs, Feb 2, 2005.

Statistically, there is a small chance you will become disabled at some point during your working career. However, when it does happen, the financial consequences can be very serious. Your Medical Plan will probably cover hospital and medical expenses, but what about your paycheck? If you are disabled and unable to work, where will you get the money for living expenses?

The need for disability coverage is clear, and our company provides short and long term coverage in the event you do become disabled.

Tax Treatment of Disability Benefits

If the company pays the entire cost of this benefit without contribution by you, or you contributed on a "BEFORE TAX BASIS", your benefits would be subject to payroll tax at the time of disability.

If you pay your premiums "AFTER TAX," benefits will be tax free.

Supplemental Short-Term Disability Schedule of Benefits

Waiting Period: Benefits are payable after the 14th day of disability due to an accident or an illness.

Full Benefit Amount: Up to 60% of your earnings to a maximum of \$600 per week*. This benefit, when coordinated with other sick or disability pay, may not exceed 100% of your regular full salary.

Benefit Duration: Benefits will be payable on the 15th day due to accidental injury or illness. Benefits are payable until you are no longer disabled or through 180 days (includes 14 day waiting period), whichever occurs first.

Your Cost Per Month: \$8.00

Your Cost Per Pay Period:** \$4.00

* There will be a partial benefit paid to any participant who is unable to work full-time due to an accident or illness. The benefit will be prorated and integrated with the Basic Short-Term Disability Benefit.

** 24 pay periods per year.

Long-Term Disability Schedule of Benefits

Definition of Disability: During the first 24 months of a period of disability (including the qualifying period), an injury, or sickness, or pregnancy requires that you be under the regular care and attendance of a doctor, and prevents you from performing at least one of the material duties of your regular occupation; and after 24 months of disability, if an injury, sickness, or pregnancy prevents you from performing at least one of the material duties of each gainful occupation for which your education, training, and experience qualifies you.

Waiting Period: Benefits are payable for long-term disability after 180 days of disability.

Full Benefit Amount: 60% of monthly earnings to a maximum of \$10,000 per month*. Benefits may be offset by amounts received from Social Security, workers' compensation and other government or employer sponsored plans.

Benefit Period: Benefits payable on the following schedule or until no longer disabled, whichever is less.

3/12 Pre-Existing Limitation: Includes a 3/12 pre-existing limitation. A pre-existing condition is an injury or sickness, whether diagnosed or misdiagnosed, and any symptoms thereof, for which, in the 3 month look back period, you receive advice or treatment from a doctor; undergo diagnostic procedures other than routine screening, are prescribed or taking prescription drugs or receive other medical care or treatment including consultation with a doctor. Benefits for a pre-existing benefit are not payable until you have been covered for 12 months in a row under this plan.

<u>Age on Date Disability Starts</u>	<u>Maximum Payment Period</u>
Less than 60	To age 67
60	5.00 years
61	4.00 years
62	3.50 years
63	3.00 years
64	2.50 years
65	2.00 years
66	1.75 years
67	1.50 years
68	1.25 years
69 and over	1.00 year

Cost Per Month:

In order to prevent disability payments from being taxed, you will pay the premiums yourself on an after-tax basis and then the College will give you back the equivalent premium by crediting your check. This will be a taxable credit. We determine both your premium and College credit by multiplying your gross monthly wage by .0029.

* There is a partial benefit under this policy which is payable should you become unable to work full-time due to an accident or illness.

Flexible Benefits Plan

Contract Administrator:

EBSO, Inc.

Employee Eligibility:

You are eligible to participate in the Flexible Benefits Plan on the first of the month following your date of hire if you are scheduled to work 1,000 hours or more annually.

A benefit to fit your needs.

No Federal Tax

No State Tax

No Social Security Tax

Lower your taxable income!

Your Annual Election:

Flexible Spending Account (FSA)
\$2,550

Monthly \$212.50

Dependent Care Account (DCA)
\$5,000

Monthly \$416.67

**We put the pieces together
for you.**



Overview

This section is the Summary Plan Description for the Flexible Benefit Plan. The Flex Plan is a separate plan from the plans described in this enrollment booklet.

What is a Flexible Benefits Plan?

Section 125 of the Internal Revenue Code allows employees to make premium contributions on a pre-tax basis. Consequently, employees save approximately 30%+ by avoiding state, federal and social security tax on these benefits. Contributions to medical, dental and a Flexible Benefits Plan, which could include a Flexible Spending Account or a Dependent Care Account, are eligible. Because your choices in these plans can accommodate your personal needs, these plans are considered "flexible". A flexible benefit plan wraps all of the choices into one plan of benefits for your convenience.

What are the components of a Flexible Benefits Plan?

There are three main parts to the Flexible Benefits Plan. The I.R.S. regulates each type of plan so each plan has its own set of rules.

The first part is the opportunity to have your contributions to medical, dental and some other benefits taken on a pre-tax basis. This part is called the **Pre-tax Premium Plan**. The rules of this plan are governed by Section 125 of the Internal Revenue Code.

The second plan is a **Dependent Care Reimbursement Account (DCA)**. Daycare expenses for children under age 13 or for children or adults incapable of self-care are reimbursable if the expenses allow you to work. Rules for this plan are found in Section 129 of the Internal Revenue Code.

The third part is a **Medical/Dental Reimbursement Plan**. It also is called a Flexible Spending Account (FSA). Rules for this plan are found in Section 105 and 106 of the Internal Revenue Code. Each employee can elect to set aside an amount out of their paycheck dollars for medical, dental, vision and some other expenses (examples on the following page) that are not reimbursed from any other source.

Some Important Notes

1. You must make your pre-tax election **prior** to the beginning of the Plan Year. Once you have made a pre-tax election, you cannot change your election for the duration of the Plan Year, except in the event of a change in family status that affects your eligibility for benefits. All changes must correspond and be consistent with the event. Events qualifying as a status change are:
 - Marriage, divorce, legal separation, or annulment
 - Addition of family dependent for federal income tax purposes (for example, birth, adoption, loss of child's employment)
 - Death of spouse or dependent
 - Loss of sole dependent child (for example, last eligible child no longer qualifies as a dependent for federal income tax purposes, or last eligible child reaches age 26 and no longer qualifies for health care coverage under the plan)
 - Your layoff
 - Order, Decree, or Judgment requiring coverage for a dependent, or requiring spouse, former spouse, or other individual to provide coverage for the child
 - You, your spouse, or dependent become entitled to, or lose eligibility for, Medicare or Medicaid
 - Employee's, spouse's, or dependent's commencement or return from FMLA leave
 - HIPAA and CHIPRA Special Enrollment events
 - Change of employment status for you or your spouse from full-time to part-time or vice versa, hourly to salaried or vice versa
 - Loss or gain of spouse's or dependent's employment
 - Unpaid leave of absence by you or your spouse
 - Open enrollment for your spouse's employer
 - Discontinuation of all health care coverage by spouse's employer
 - Dependent satisfies or ceases to satisfy eligibility requirement under employer's plan
 - Change in residence or worksite of employee, spouse or dependent
 - Significant cost change imposed by a dependent care provider who is not a relative of the employee
 - Change in Daycare provider and associated costs
 - Enrolling in a qualified health plan through the Health Insurance Marketplace during its annual open enrollment period
 - Change in full-time employee's status to an average of less than 30 hours of service per week if the employee enrolls in another plan that provides minimum essential coverage, which begins at least on the "first day of the second month" after the original coverage is revoked

If you experience a change in family status, you must notify Human Resources of your change in family status and submit a completed Status Change Form within 31 days of the event, or within 60 days in the event a child loses eligibility for Medicaid or CHIP or the child obtains eligibility for a state premium assistance subsidiary under this program. The Contract Administrator will determine if the event qualifies as a change in family status and if a change in election is consistent with the change in family status.

2. To be eligible for reimbursement from your account, services and expenses must be incurred during the plan year. You must be a plan participant at the time the services are incurred. Claims for services or expenses incurred during the Plan Year may be submitted

to the Plan during the course of the Plan Year and for a run-out period of 90 days following the end of the Plan Year. Funds remaining in your account at the end of the run-out period will be forfeited.

3. If your employment terminates, you may elect to continue to participate in the Plan's Flexible Spending Account, according to COBRA regulations, by submitting an after-tax payment to the Plan equal to the amount of your election. You cease to be a plan participant after your employment terminates. Expenses incurred after your termination date will not be considered eligible expenses unless you have elected COBRA.
4. If you elect to continue your life, medical, or dental insurance coverage on an individual basis after termination of employment, you may do so. However, premiums for such insurance may not be paid through this plan on a BEFORE TAX basis. Benefits may be extended according to COBRA or State Continuation regulations.
5. **“Use It or Lose It Rule”**
The money you set aside in any of the Flexible Spending Accounts is not transferable to another expense account, nor will it be returned to you in the event that you have overestimated your expenses. In the event that there is money left in your account at the end of the 90 day run-out period for the plan year, it will be forfeited.

Claim Filing Process

EBSO, Inc.'s claim filing process allows for access in the plan account(s) by any of the following methods:

1. **Flex Benefits Debit Card Purchase:** Members can use the Flex Benefits Debit Card, at the point of purchase, toward qualified purchases. Receipts must still be sent in following the purchase for “post” authorization by EBSO, Inc.
2. **Online Claim Filing:** Members can file claims online via our participant portal website. Members can scan and upload receipts at the point of filing the claim online. There is also the option to mail, fax or email the receipts.
3. **Paper Claim Filing:** Members can also file claims using the paper form(s) available on the website under the “Forms” tab, and attach required receipts according to IRS rules. Forms are also available in the Human Resource department.
4. **Automatic Monthly Reimbursement for Orthodontia and Daycare Expenses**
When you or your eligible dependent incurs an orthodontia expense, and you have established a payment plan with your orthodontist or contracted monthly payment plan with your Daycare Provider, you may receive a monthly reimbursement automatically, every month for Orthodontia or per pay period for Dependent Care, without filing a claim each month. To do this, you must submit an initial Flexible Benefit Claim Form along with your Orthodontia or Daycare Financial Agreement. You will not need to submit a claim form each month. ***You will be reimbursed only for the services incurred during the current month and within the current plan year.***

Special Rules involving Orthodontia

Orthodontic treatment typically spans several years. Individuals are often charged an initial, up-front payment and then make monthly payments over the course of the treatment contract. The portion of expense paid up front for orthodontia work is eligible for reimbursement immediately, provided the employee has actually made the payment in advance. The remainder of any contract balance not paid initially is divided over the remaining months of treatment to determine how much will be reimbursed monthly. This amount usually mirrors the monthly payment specified in the contract. Care should be exercised in determining how much money to set aside if monthly payments are required. **Set aside only an amount equal to the initial and monthly amounts you will be required to pay in this plan year when making your election.**

Dependent Care Account (DCA)

Dependent Care Account:

A Dependent Care Account lets you set aside on a pre-tax (free of federal income taxes, state income taxes and social security taxes) basis, dollars from your paycheck to cover eligible dependent care expenses. Expenses you pay for the care of your legal dependents are eligible for reimbursement from this account. The expenses must be incurred to allow you to work or look for work.

Points of Interest

- **DID YOU KNOW...**a Dependent Care Account lets you pay for eligible expenses if you or your spouse attends school full-time or if either of you is looking for work.
- Generally, if your family's adjusted gross income is more than \$24,000 annually, you will probably save more in taxes using a Dependent Care Account than using the federal tax credit

Dependent Care Account Requirements:

If, in order to maintain employment, you are paying for child care or dependent care services, you may be reimbursed through the Dependent Care Account for these expenses.

Child care or dependent care services will qualify for reimbursement under the plan if they meet these requirements:

1. If you are married, the services must be provided to enable both you and your spouse to be employed, unless one spouse is a full-time student at an educational institution and the other is employed full-time. In the case of a student spouse, benefits are limited to \$200 per month if one child is being cared for or \$400 for more than one child. If you are a single parent and the child receiving daycare actually lives with you (you have physical custody), you may also elect to participate in the Dependent Care Account.
2. The amount to be reimbursed must not be greater than your income, or your spouse's, whichever is lower.
3. The child must be under 13 years old or, if older, mentally or physically incapable of caring for him or herself.
4. The services may be provided inside or outside your home, but not by someone who is your dependent for income tax purposes, such as an older child, your spouse, or a grandparent who lives with you.

5. If child care is provided at a daycare center, the center must comply with all the rules and regulations issued by the state.
6. You may also use the Dependent Care Account to pay for expenses for the care of a mentally or physically incapacitated dependent or spouse, if such care is necessary to enable you to work.
7. Fees charged for kindergarten or overnight camp are not eligible for reimbursement.
8. **The maximum amount of dependent care expenses that may be paid on a pre-tax basis is \$5,000 per plan year (or a pro-rated amount of \$416.66 per month). The total benefit election for an employee and a spouse who is participating in a Dependent Care Account through their employer, may not exceed \$5,000 combined, per plan year.**

Dependent care expenses may be reimbursable through your employer's Dependent Care Account, or you may be able to file for a credit on your yearly individual income taxes. The following information on the income tax credit is provided to you for comparison purposes.

IRS CHILD AND DEPENDENT CARE CREDIT

The tax act increases the amount of eligible child and dependent care expenses (see Table 1 below). The maximum child and dependent care credit allowed for eligible expenses increased from 30% to 35%. The credit decreases 1% for EACH \$2,000 (or fraction thereof) that the taxpayer's adjusted gross income EXCEEDS \$15,000, and bottoms out at a minimum of 20% (see table 2 below).

Table 1 – Eligible Child & Dependent Care Expenses	
Number of Qualifying Children	MAXIMUM Eligible Expenses
1	\$3,000
2 or More	\$6,000

Table 2 – Child & Dependent Care Credit Percentage	
If the adjusted gross income is...	Multiply the eligible expenses by...
\$0 - \$15,000	.35
\$15,001 - \$17,000	.34
\$17,001 - \$19,000	.33
\$19,001 - \$21,000	.32
\$21,001 - \$23,000	.31
\$23,001 - \$25,000	.30
\$25,001 - \$27,000	.29
\$27,001 - \$29,000	.28
\$29,001 - \$31,000	.27
\$31,001 - \$33,000	.26
\$33,001 - \$35,000	.25
\$35,001 - \$37,000	.24
\$37,001 - \$39,000	.23
\$39,001 - \$41,000	.22
\$41,001 - \$43,000	.21
\$43,001 & UP	.20

For a list of frequently asked questions about the dependent care credit under Code Section 21 and dependent care assistance plans under Code Section 129, please consult the IRS website. The site also contains links to additional references, such as Publication 503 (Child and Dependent Care Expenses), Tax Topic 602 (Child and Dependent Care Credits), Form 2441 and its instructions, and form W-10 (Dependent Care Provider's Identification and Certification). www.irs.gov

Dependent care expenses paid on a pre-tax basis through the Dependent Care Account are not eligible for the dependent care credit on your taxes. In the event that there are pre-tax and after-tax dependent care expenses, the after-tax expenses may be applied to the IRS credit if the combined pre-tax and after-tax amounts are less than \$3,000 (or \$6,000 if more than one child).

Since the actual tax savings is based upon joint family income, the advantage of one plan over the other will vary based upon individual family circumstances.

No Change to Dependent Care Assistance Plan Election Maximum

The amount that may be elected under an employer sponsored Dependent Care Assistance Plan **has not** been increased. The maximum election under a Dependent Care Assistance Plan for a plan year is \$5,000 for married individuals filing a joint return, or \$2,500 for married individuals filing separately.

ENROLLMENT

Should you enroll in the Dependent Care Account, you must determine the monthly reimbursement very carefully. Dollars allocated to this account may be reimbursed for this expense only.

FORFEITURE

- 1. This money is not transferable to another expense account;**
- 2. Nor may it be returned to you in the event that you have overestimated your dependent care expenses. In the event that there is money left in your account at the end of the year, it will be forfeited.**

Therefore, take vacation or holiday time into account when determining your monthly expense. It is probably not a bad idea to underestimate this expense during your first year in this program. Excess expenses may be used for the dependent care credit on your income taxes within certain limits.

Flexible Spending Account (FSA)

The Flexible Spending Account is a benefit that covers many types of medical-care services that might not be included in certain medical and dental insurance plans. When you use this benefit, these expenses are paid with BEFORE-TAX dollars.

THIS MONEY IS NOT TRANSFERABLE TO ANOTHER EXPENSE ACCOUNT, NOR WILL IT BE RETURNED TO YOU IN THE EVENT THAT YOU HAVE OVERESTIMATED YOUR MEDICAL AND/OR DENTAL EXPENSES. IN THE EVENT THAT THERE IS MONEY LEFT IN YOUR ACCOUNT AT THE END OF THE PLAN YEAR, IT WILL BE FORFEITED.

Claims for services incurred during the plan year must be submitted during the course of the plan year and before the end of the plan's claim run-out period, which ends 90 days after the end of the plan year. Funds remaining in your account at the end of the run-out period will be forfeited.

Generally, medical-care and dental expenses which qualify as medical deductions under IRS rules will qualify for a tax-free reimbursement under this plan. Some examples are listed on the next page.

The Internal Revenue Service (IRS) determines which expenses can be reimbursed through the Flexible Spending Account. Generally, medical and dental expenses that the IRS considers tax deductible are eligible for reimbursement. For further information, refer to IRS Publication 502.

Health Savings Accounts (HSA) and Flexible Spending Accounts (FSA)

If you choose to participate in the FSA, it will be available to you, your spouse and your dependents. This means that you, your spouse and your dependents may not contribute to a Health Savings Account (HSA), due to IRS rules.

Distributions from Health FSAs for Reservists

The *Heroes Earnings Assistance and Tax Relief Act of 2008* (also called the *Heroes or Heart Act*) amends the cafeteria plan rules to allow distributions of all or part of health FSA account balances for reservists called to active duty of 180 days or more. Distributions can be made at any time from the date of the Reservist's call to active duty through the last date on which reimbursements may be made for the plan year (through the end of the Plan's claim run-out period). This provision of the Act will provide a way for flex plans to help reservists avoid unwanted forfeitures under the "use it or lose it" rules. This provision of the law applies to distributions made on or after June 18, 2008.

Reservists please complete a regular Flex paper claim form and:

- attach a copy of your military notice to active duty (at least 180 days)
- you will be reimbursed up to your current medical flexible spending account balance.
- your reimbursement will be taxable income to you.

Flex Plan Year Guidelines

Plan Year	Plan Year Maximum	2 ½ month Extension End Date to Incur Expenses *	After End of Plan Year Last Date to Submit Claims	OTC Medicines Physician prescription IS required
1/1/2015 – 12/31/2015	Flex: \$2,550 DC: \$5,000	N/A	3/31/2016	X

Flexible Spending Account (FSA) Eligible Benefits

To be eligible for reimbursement under the FSA plan, they must not be reimbursed by any insurance plan.

***Note:** OTC medications require a prescription – see following pages for more details.

Maximum election amount: \$2,550

Insurance

Eligible

- Deductible and co-payments for medical, dental and vision plans.
- Coinsurance
- Amounts not reimbursed

Ineligible

- All premiums for insurance
- Expenses reimbursed by other insurance

Drugs and Medications

Eligible*

- Prescription drugs for a specific medical treatment
- Drugs for medical care available over the counter with a prescription
- Birth Control drugs
- Insulin

Ineligible

- Prescription and over the counter drugs for cosmetic purposes

Vision Care

Eligible

- Optometrist or ophthalmologist fees
- Eyeglasses
- Contact lenses and cleaning solutions
- Prescription Sunglasses
- Lasik Eye Surgery
- Radial Keratotomy

Ineligible

- Lens replacement insurance
- Warranties
- Protection Plans

Dental/Orthodontic Care

Eligible

- Dental Care
- Artificial teeth / dentures
- Fluoridation of home water supply advised by dentist
- Braces, orthodontic services incurred within plan year*

Ineligible

- Teeth Bleaching
- Tooth bonding that is not medically necessary

**Special rules apply to Orthodontia contracts. Expenses Can only be paid if incurred within the plan year. Most contracts span several years.*

Treatments/Therapies

Eligible

- Weight loss programs prescribed to treat a medical condition
- X-ray treatments
- Smoking Cessation
- Treatment for drug or alcohol dependency
- Acupuncture
- Vaccinations
- Physical therapy

Ineligible

- Physical treatments unrelated to specific health problems or diagnosis

Fees/Services

Eligible

- Physicians Fees
- Routine exams
- Obstetrical expenses
- Hospital services
- Nursing services for a specific condition
- Cost of a nurse's room and board and nurse's services
- Surgical or diagnostic services
- Legal Sterilization
- Cosmetic surgeries or treatment that treat deformity caused by, an accident or trauma or disease, an abnormality from birth
- Services of chiropractors or osteopaths
- Anesthesiologist fees
- Dermatologist fees
- Gynecologist fees

Ineligible

- Cosmetic surgeries or procedures that improve patient's appearance but do not meaningfully promote the proper function of the body or prevent or treat an illness or disease
- Payments to domestic help, companion, babysitter, chauffeur, etc. who primarily render services of a non-medical nature.
- Nursemaids or practical nurses who render general care for healthy infants
- Payments for child care (eligible under the Dependent Care FSA)

Medical Equipment

Eligible

- Wheelchair (includes cost of operating and maintaining)
- Crutches (purchased or rented)
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition
- Artificial Limbs
- Support hose (if medically necessary)
- Wigs (where necessary for mental health of individual who loses hair because of disease)
- Testing equipment, i.e. blood sugar monitors.

Ineligible

- Wigs, when not medically necessary for mental health
- Vacuum cleaner purchased by an individual with dust allergy

Psychiatric Care

Eligible

- Services of psycho-therapists, psychiatrists and psychologists
- Legal fees directly related to commitment of a mentally ill person

Ineligible

- Psychoanalysis undertaken to satisfy curriculum requirements of a student
- Marriage counseling

Assistance for the

Disabled

Eligible

- Cost of guide for a blind person
- Cost of note-taker for a deaf child in school
- Cost of Braille books and magazines in excess of cost of regular editions
- Seeing eye dog (cost of buying, training and maintaining)
- Hearing-trained cat or other animal to assist deaf person (cost of buying, training and maintaining)
- Household visual alert system for deaf person
- Excess costs of specifically equipping automobile for a disabled person over the cost of ordinary automobile; device for lifting a disabled person into automobile

Miscellaneous Charges

Eligible

- Sales tax associated with an eligible expense
- Hearing aids, batteries for operation of hearing aids, hearing aid repairs
- Bandages/Dressings
- Expenses connected with donating an organ
- Cost of computer storage of medical records
- Cost of special diet, but only if it is medically necessary and only to the extent that costs exceed that of a normal diet
- Transportation expenses primarily for, and essential to, medical care including car mileage, bus, taxi, train, plane fares, ambulance services, parking fees and tolls
- Lodging expenses (not provided in a hospital or similar institution) not to exceed \$50 per night per individual while away from home if the lodging is primarily for and essential to medical care provided by a doctor.

Ineligible

- Expenses of divorce when doctor or psychiatrist recommends divorce
- Cost of toiletries, cosmetics and sundry items
- Cost of specialized foods taken as a substitute for regular diet, when the special diet is not medically necessary or cost is not in excess of a normal diet
- Maternity clothes
- Diaper service
- Distilled water purchased to avoid drinking fluoridated city water supply

Over-the-Counter (OTC) Expenses

Dual-Purpose OTC Drugs and Medicine Prescriptions

You must have a prescription from a licensed health care provider in order to receive reimbursement under an FSA for the following types of OTC drugs and medicines. The Prescription must list the specific OTC drugs or medicine as you are purchasing and must be submitted to the FSA plan along with the prescription and documentation of the product and cost to be reimbursed from your account.

Type/Class of Drug or Product	Examples
Allergy and Sinus Medication	Actifed ★ Allerest ★ Benadryl ★ Chlor-Trimetron ★ Claritin ★ Contac ★ Lortadine ★ Nasalcrom ★ Sudafed ★ Tavist ★ Zyrtec OTC
Analgesics/Antipyretics (Pain Relievers)	Aspirin ★ Advil ★ Alleve ★ Ibuprofen ★ Naproxen ★ Tylenol ★ Midol ★ Pamprin ★ Premsyn PMS
Anti-Diarrheal and Laxatives	Ex-Lax ★ Immodium AD ★ Kaopectate Miralax ★ Pepto-Bismol
Anti-Gas and Acid Controllers	AXID AR ★ Gas-X ★ Maalox ★ Mylanta ★ Tums ★ Pepsid AC ★ Prilosec OTC ★ Roloids ★ Tagamet HB ★ Zantac 75 ★ Nexium
Anti-Itch Lotions and Creams	Bactine ★ Benadryl ★ Caldecort ★ Caladryl ★ Calamine ★ Cortaid ★ Gold Bond Medicated Cream ★ Hydrocortisone ★ Lanacort ★ Lamisil AT ★ Lotramin AF
Anti-Parasitic Treatments	Nix ★ Rid
Antibiotics (topical)	Bacitracin ★ Neosporin ★ Triple antibiotic ointment
Antifungal	Lamisil AT ★ Lotrimin AF ★ Micatin
Antihistamines	Actidil ★ Actifed ★ Allerest ★ Benadryl ★ Claritin ★ Chlor-Trimetron Contact ★ Drixoral ★ Sudafed ★ Tavist ★ Triaminic
Asthma Medicines	Bronitin Mist ★ Bronkaid ★ Bronkolixer ★ Primatene
Baby Ointments/Creams	Aquaphor ★ Balmax ★ Desitin
Cold, Flu, Decongestant and Sinus Remedies	Actidil ★ Actifed ★ Advil Cold and Sinus ★ Afrin ★ Alka Seltzer Cold and Flu ★ Afrinol ★ Alleve Cold and Sinus ★ Children's Advil Cold ★ Contac ★ Dayquil ★ Dimetane ★ Dristan Long-Lasting ★ Drixoral ★ Neo-Synephrine 12-Hour ★ Nyquil ★ Orrivin ★ Pediacare ★ Sudafed ★ Tavist-D ★ Thera-flu ★ Triaminic ★ Tylenol Cold and Flu ★ Cough Drops ★ Nasal Sprays
Cold Sore/Fever Blister	Abreva Cream ★ Gly-Oxide ★ Herpecin
Cough Suppressants or Expectorants	Robitussin ★ Vicks 44 ★ Chloraspectic ★ Mucinex ★ Cough Drops ★ Throat Lozenges
Dehydration	Pedialyte
Dental/Denture Care	Orajel ★ Anbesol ★ Poligrip
Digestive Aids/Lactose Intolerance	DairyCare ★ Dairy Relief ★ Lactaid ★ Lacteeze ★ Lactrase
Feminine , Anti-Fungal/Anti-Itch	Femstat 3 ★ Gyne-lotrimin ★ Miconazole ★ Mycelex ★ Monistat ★ Vagistat
Hemorrhoidal Preparations	Preparation H ★ Hemorrhoid ★ Tronolane ★ Tucks Pads
Insulin	
Motion Sickness	Dramamine ★ Motion Eaze ★ Bonine
Pre-natal Vitamins	
Sleep Aids & Sedatives	
Teething/Toothaches	Anbesol ★ Orajel
Topical Steroids	Hydrocortisone
Wart Removal	Compound W ★ Dr. Scholl's Clear Away ★ Wart-Off

Eligible Over-the-Counter (OTC) Expenses include materials and supplies that alleviate or treat injuries or illnesses for you and your dependents. You do not need a Letter of Medical Necessity (LMN) or a prescription from a medical provider in order to receive reimbursement for the materials and supplies listed below. This is a representative list of eligible expenses but is not all inclusive.

Note: The IRS requires a prescription or Letter of Medical Necessity from a licensed Health Care Provider in order to receive reimbursement for OTC drugs and medicines. **You will no longer be able to purchase these items with your Flex Benefits Debit Card.**

Type/Class of Drug or Product	Examples
Contraceptive/Family Planning	Ovulation predictor kits ★ Pregnancy tests ★ Spermicides ★ Condoms
Ear Care	Ear drops ★ Ear wax removal
Eye Care	Contact lens solutions ★ Eye drops ★ Reading glasses ★ Eye patches
First Aid/Medical Supplies	Antiseptics ★ Witch Hazel ★ Peroxide ★ Bandages ★ First aid kits (must be a “reasonable” price) ★ Cold/Hot packs for injuries ★ Joint supports (ankle, elbow, knee, wrist) ★ Rubbing alcohol ★ Ace wraps ★ Splints ★ Thermometers ★ Liquid adhesives
Foot Care	Arch and insole supports ★ Callous removers ★ Athlete’s Foot products (see antifungal) ★ Bunion, blister and corn treatments
Home Diagnostic Tests or Kits	Blood pressure (monitor and related equipment) ★ Cholesterol ★ Diabetic equipment and supplies ★ Colorectal screenings ★ HIV test ★ Disposable Enema

Excluded OTC Products (non-eligible expenses)

Type/Class of Drug or Product	Examples
Cosmetic Products	Face soaps ▲ Creams ▲ Make-up ▲ Perfumes ▲ Hair removal
Dental Products	Dental floss ▲ Toothpaste ▲ Toothbrushes ▲ Teeth whitening kits ▲ Mouthwash
Ear Care	Ear plugs
Herbal Supplements	
Toiletries	Deodorant ▲ Shampoo ▲ Body sprays ▲ Soaps Moisturizers ▲ Chapstick

For more information on eligible FSA over the counter drugs, medicines and supplies, refer to The IRS - Publication 17, Publication 502 and Affordable Care Act: Over the Counter Medicines and drugs.

Flexible Spending Account Worksheet

Use this worksheet to estimate the out-of-pocket expenses you (and your eligible dependents) expect to incur during the plan year that will not be reimbursed from another source. Remember to be conservative in your estimate because any unused balance in your Flexible Spending Account is forfeited at the end of the Plan Year.

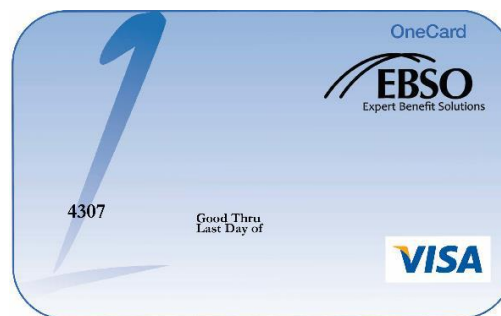
Estimate Your UNREIMBURSED Costs For:	
Medical:	
Medical Deductibles	\$ _____
Co-Insurance payments	\$ _____
Routine exams (physicals, etc.)	\$ _____
Medical Office co-payments (\$15 per visit, for example)	\$ _____
Prescription Drug co-payments	\$ _____
Over the counter drugs and medicines (with a prescription after 12/31/2010)	\$ _____
Hearing aids and exams	\$ _____
Vision Care (eye exams, contact lenses, prescription eyewear)	\$ _____
Medically required equipment (wheelchair, prosthetic devices)	\$ _____
Chiropractor	\$ _____
Emergency Room charges	\$ _____
Dental:	
Dental Deductibles	\$ _____
Co-Insurance payments	\$ _____
Orthodontia (braces, retainers)	\$ _____
Other dental expenses not covered by insurance	\$ _____
_____	\$ _____
_____	\$ _____
Other expenses	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
TOTAL OUT OF POCKET HEALTH CARE EXPENSES	\$ _____
<i>(indicate this amount on your Enrollment Form)</i>	

Note: To determine the impact on each paycheck, divide your total expenses by the number of pay periods remaining in the plan.

$$\text{\$ } \underline{\hspace{2cm}} \div \underline{\hspace{2cm}} = \text{\$ } \underline{\hspace{2cm}} / \text{paycheck}$$

Flex Benefits Debit Card

When you enroll in the Flexible Spending Account you will automatically receive the Flex Benefits Debit Card at no cost to you! Conveniently pay your eligible FSA or DCA (if the provider accepts VISA) expenses incurred by you and your dependents by swiping your card at the point-of-service. Purchases you make using the Flex Benefits Debit Card are funded by the money in your FSA and DCA. If you are currently enrolled in the FSA and/or DCA and wish to re-enroll in the new plan, your current Flex Benefit Debit Card will automatically be re-loaded with the amount you elect for the upcoming plan year. If you are new to the plan, the card will be mailed directly to your home address



How it Works

The Flex Benefits Debit Card is accepted at child care providers (if they accept VISA), healthcare merchants as well as non-healthcare merchants who have implemented an inventory information approval system (IIAS). Qualified merchants include physician and dental offices, hospitals, mail order prescription vendors, hearing and vision care providers and dependent care providers. The card can also be used at discount stores, grocery stores and pharmacies, provided the merchant has implemented an IIAS.

It is important you keep all itemized receipts and Explanation of Benefits (EOB's) in the event information is requested by EBSO, Inc. to comply with IRS regulations. If documentation is required you will receive a letter from EBSO, Inc. requesting documentation of the expense. To document the expense, send in a copy of the itemized cash register receipt, co-payment receipt, itemized statement from your provider, or prescription drug receipt. **The letter will be sent to your email address if available.** You will have 15 days to send in your documentation. It is best for participants to wait for the letter or email, attach a copy of the documentation to the letter or email copy and return it to EBSO.

- If EBSO does not receive documentation within 15-days of the first letter, a reminder letter will be sent. There will be a second 15-day grace period for claim documentation to be submitted from the date the reminder letter is sent (a total of 30 days). If we do not receive your claim documentation within **30-days** of the date the expense is incurred your Flex Benefits Debit Card will be temporarily deactivated until the outstanding expense(s) are substantiated. Once expenses are documented, your Flex Benefits Debit Card will be reactivated. Again, if your purchases are from a retailer with an Inventory Information Approval System (IIAS), you will not receive a letter from EBSO requesting documentation. We still encourage members to keep their receipts as a record of their Flex purchases.
- Many systems have Spam filters in place that will prevent our letters from reaching you. To avoid having your Flex Benefits Debit Card deactivated because you have not received the letters and have not documented your expenses, please add the following addresses to your Junk Mail or Spam to permit receipt of these requests.
-customerservice@ebsobenefits.com
-customerservice@ebsobenefits.LH1OD.com

Frequently Asked Questions

What is the debit card?

The debit card from EBSO is a Visa® that gives you an easy, automatic way to pay for qualified health care expenses. The debit card lets you electronically access pretax contributions you set aside in your flexible spending account (FSA).

How does the debit card work?

It works like a Visa®, with the value of your account contributions stored on it. When you incur qualified eligible expenses at a business that accepts Visa®, simply use your debit card. The amount of your qualified purchases will be deducted – automatically – from your account and the dollars will be electronically transferred to the provider/merchant for immediate payment.

Is that all I have to do?

No. You must also remember to save all of your itemized documentation.

Why do I need to save my receipts?

It's important that you save all itemized receipts. The IRS requires that all FSA reimbursements be substantiated. The debit card is designed to pay the merchant immediately without any supporting documentation from you. To remain compliant with the IRS regulations, EBSO may need to request a copy of your itemized receipt to validate that the expense was eligible for reimbursement from your FSA. If a receipt cannot be provided to substantiate an expense, the transaction will be classified as an overpayment/denied claim and your card privileges may be suspended. Please save all your itemized receipts.

What happens if there is an overpayment?

EBSO will request that the funds be returned to the Flexible Spending Account in which the overpayment occurred. Participants can contact the Customer Service Department at EBSO to inquire about reimbursing an overpayment or offsetting the overpayment with other eligible claims.

Is the debit card just like other Visa® cards?

The debit card is a special Visa®, but only for qualified expenses. There are no monthly bills and no finance charges.

If asked, should I select "Debit" or "Credit?"

The debit card is actually a stored value card. But since there is no "stored value" selection available, you'll select "Credit." You do not need a PIN number and you cannot get cash with the debit card. You will need to sign the receipt.

BE SURE TO SAVE YOUR ITEMIZED DOCUMENTATION!

Are there places the debit card won't be accepted?

Yes. Examples include department stores, discount stores and grocery stores that don't have an IIAS

(Inventory Information Approval System) implemented, hardware stores, restaurants, bookstores, gas stations and home improvement stores. Please see below regarding OTC items for an explanation of IIAS.

What are some reasons my debit card might not work at the point of service?

- Your card has not been activated.
- You have insufficient funds remaining in your FSA account to cover the expense.
- You have an outstanding request to substantiate a previous purchase that has exceeded the 30 day timeframe to provide documentation. Your card may be temporarily on hold until substantiation is received.
- The merchant is encountering problems.
- The non-healthcare merchant does not have the IAS implemented.

How many debit cards will I receive?

You'll receive one debit card in the employee's name.

Do I need a new debit card each year?

While it is important to spend all of the funds in your account each year, you should also hang onto your card for the next plan year. As long as you elect to participate in your FSA plan each year, your debit card will be loaded with your new annual election amount at the start of each plan year. Your debit card will have an expiration date on it and a new card will be provided when that date is coming due.

What if I lose my debit card or need another one?

You can request a replacement through your plan administrator, EBSO.

What dollar amount is on my debit card?

The dollar value on your card will be the amount you elected to contribute to your health care FSA during your benefits enrollment period. It's from that total dollar amount that eligible expenses will be deducted as you use your card or submit manual claims.

Can I use the debit card if I receive a statement with a Patient Due Balance for a medical service?

Yes. As long as you have money in your account for the balance due, simply write the debit card number on your statement and send it back to the provider. The expense must be incurred during the plan year for which you are using the funds. Prior plan year expenses are considered an overpayment and the funds will need to be returned to the plan.

What do I need to know about paying for prescription drugs?

The debit card is programmed to pay for prescription drugs at pharmacies, department stores, discount stores and grocery stores that have pharmacies.

Can I use the debit card for over-the-counter (OTC) medications?

No, per IRS Healthcare Reform, as of 1/1/2011 OTC medications can no longer be purchased with your debit card. These expenses now require a doctor's prescription to be eligible for reimbursement from your FSA. You can pay for OTC medications with another form of payment and submit an electronic claim online or complete a paper claim form and send along with a copy of your prescription to EBSO for reimbursement.

Can I use the debit card for eligible OTC supplies?

Yes. In order for the OTC items to be purchased with your card, the merchant must have an IIAS (Inventory Information Approval System) in place. This system allows you to use your card for eligible OTC expenses and automatically substantiates the expense at the point of sale. Your card will be declined at merchants who do not have this system implemented. You may still pay for these items by another means and submit an electronic claim online or complete a paper claim and submit to EBSO for reimbursement. OTC items deemed not FSA eligible by the IIAS system will be declined and you will not be able to purchase these items with your card.

How do I know how much is in my account?

You can visit the FSA Web site at www.ebsobenefits.com to view your account activity and current balance. Or, you can call EBSO at the phone number on the back of your card to obtain your current balance. It's a good idea to know your account balance before you make a purchase with your debit card.

What if I have an expense that is more than the amount left in my account?

By checking your account balance often -- either online or by calling EBSO at the phone number on the back of your card -- you will have a good idea of how much is available. When incurring an expense that is greater than what is remaining in your account, you can split the cost at the register. For example, tell the clerk you wish to use your debit card for the exact amount left in your account and then pay for the remaining balance separately. Alternatively, you may submit the qualified transaction manually via a claim with the appropriate documentation to EBSO.

Can I use my debit card to pay for my deductible and/or out-of-pocket amounts under my medical or dental plan?

Yes, as long as you have a supporting Explanation of Benefits from the medical or dental carrier that illustrates your out-of-pocket balance amounts.

Can I use my debit card to pay for my office and prescription drug copays?

Yes, each time you use your flex convenience card for one of the following "defined copayments" you will not be required to submit documentation of the expense. The Card will recognize the exact dollar amount listed below in conjunction with the vendor or provider type that this is an approved expense under the Flexible Benefit Plan.

Office and Urgent Care Copayment	\$40.00, \$60.00
Convenience Care Clinic Copayment	\$20.00, \$30.00
Prescription Drug Copayment	\$12.00, \$24.00, \$45.00, \$90.00, \$180.00
Emergency Room Copayment	\$100.00

Filing Claims

Reimbursement Method

If your provider does not accept Visa® when you incur an expense that is eligible for payment, you must submit a FSA or DCA Claim Form to EBSO, Inc. You can do so electronically (see instructions below) or using a paper form found in your Human Resource department. You must include written documentation (itemized bill or itemized cash register receipt, co-pay receipt, or prescription receipt) with the completed form, showing that the claims have been incurred, and the amount of such expense(s). We are also able to process claims using a copy of your insurance company's Explanation of Benefits (EOB) which shows you what your responsibility is. Balance due statements will not be accepted as adequate documentation of your expense(s). Daycare reimbursement cannot be made in advance of your payroll reduction for the benefit year to date.

Reimbursement Methods and Claims Processing Timelines

You have two options for payment, check by mail or direct deposit. The direct deposit method is recommended for a faster reimbursement. A Credit Authorization Form must be completed once at the beginning of your plan year for direct deposit.

All claims are generally processed within 10 working days of receipt of your claim. Reimbursements for claims are issued twice per week.

FILE FLEXIBLE BENEFIT CLAIMS ONLINE

How Do I Access This Information?

Sign Up: You will need your date of birth, last name, Member ID# and e-mail address to sign up. Go to www.ebsobenefits.com, click on MEMBERS and click on EBSO, Inc. / SOMI Member Login. In the gray box where it says "Need a username and password", click on the link Proceed to our sign up process, which will take you to EBSO, Inc.'s License Agreement. You must click on "Agree" to proceed to sign up and log in. Please be sure to include an e-mail address. This is the address that will be used to notify you of new claims available for online viewing and printing.

Create Your Username and Password.

Use a name and password that only you will know. Also indicate a "hint" question and answer so that your password can be provided should you forget it in the future.

Sign In and Use the System.

Once the sign up process is completed, you will have access to check your claims and eligibility online 24 hours a day, 7 days a week. Click on the link labeled "EBSO, Inc. / SOMI Member Login" and fill in your username and password to access your Flex information. You will be able to view your Flex claims, balances, and file claims online.

HOW TO FILE A CLAIM ONLINE

1. Click the **File Claims** tab.
2. Click the **File a Claim** button next to the plan you wish to file a claim for.

NOTE! To view the history of all claims you've filed for a plan, click on "View History".

3. **Enter your claim information** and **submit** the claim. Make sure you have valid receipt(s) for your expenses, as you will need to send these in.

Note regarding Dependent Care claims: A qualified dependent is required for Dependent Care claims. You may add your dependent(s) from the Dependent Care Claim Entry screen if necessary.

4. You may upload your receipt for the claim you are filing. Must be in a PDF, GIF or JPG format and cannot exceed 2 MB.
5. If you have more than one claim you'd like to file, you may choose to **Add a New Claim** from your claims basket.
6. Once all claims are entered, you must agree to the **Terms & Conditions** (click on appropriate box) and submit the claim(s) by clicking **Submit**.
7. If you have uploaded your receipt (s), you are not required to mail, fax or email your claim. The Confirmation page verifies that all claims have been submitted successfully. You may then print the Confirmation page for your records. If you have not uploaded your receipt (s) you need to print the confirmation page and fax, mail or email it along with your receipts to the contact listed on the page.

Claim Forms

You may obtain a Flexible Benefit Claim Form from your Human Resource Department, or you may print a form from EBSO, Inc.'s web site: www.ebsobenefits.com.

VIEW YOUR ACCOUNT INFORMATION

My Account: You can view up-to-date account information at any time.

- Choose **Account Balance** to check the balances of any account. You can also check the claims history of any account by clicking the **Claims History** link.
- Select **Profile** to review your personal and dependent information that's on file in the system. You may also **add dependents** under the profile option.

- Select **Payment History** to see a detail of the claims that have been paid. You can click **View Detail** for more information about any claim.

Plans: Your Pre-tax plan information is available at any time. To view this information, log on and click on the **Plans** tab.

Forms: You can download Pre-tax forms at any time. Log on and click on the **Forms** tab, and select the form you would like to download.

The forms are in pdf format, requiring Adobe Acrobat Reader. You may download a free version of acrobat reader from the Adobe website:

<http://www.adobe.com/products/acrobat/readermain.html>.

Appealing a Claim

If your Claim is denied in whole or in part, you may appeal to the Plan Administrator or its agent, the Contract Administrator, for a review of the denied Claim. Your appeal must be made in writing within 180 days of the Plan Administrator's initial notice of adverse benefit determination. If you do not appeal on time, you will lose your right to appeal, and consequently, your right to file suit under ERISA. Exhausting your Plan's internal administrative appeal rights is generally a prerequisite to bringing a suit under ERISA.

Your written appeal should state the reasons that you feel your Claim should not have been denied. It should include any additional facts and/or documents that you feel support your Claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information relevant to your appeal. The Plan Administrator or its agent, the Contract Administrator, will review all written comments you submit with your appeal.

Review of Appeal

The Plan Administrator or its agent, the Contract Administrator, will review and decide your appeal within a reasonable time, not longer than 60 days after it is submitted, and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial Claim denial and will not be that individual's subordinate. The Plan Administrator or its agent, the Contract Administrator, may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial Claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your Claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provision on which the denial is based;
3. A statement of your right to review (on request and at no charge) relevant documents and other information;
4. If the Plan Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
5. A statement of your right to bring suit under ERISA §502(a).

Potential savings with pre-tax program participation

Mary is an MCAD faculty member who earns \$45,000 per year. She is married with a two-year old daughter. She claims three deductions on her payroll withholding. Mary's enrollment choices are as follows:

- She elects family coverage with HealthPartners Open Access Major Medical Plan, at a cost to her of \$7,921.44 annually (12 months).
- She enrolls in the Supplemental Short Term Disability Plan (SSTD), at a cost of \$96.00 annually.
- She puts \$2,400.00 annually in a Dependent Care Account (DCA) to cover her daughter's daycare costs.
- She puts \$750.00 in a Flexible Spending Account (FSA) to cover the anticipated deductible.
- She is saving \$1,300.00 annually in the TIAA-CREF, Tax-Deferred Supplemental Retirement Annuity (SRA).

If Mary were to pay for all of these benefits on an after-tax basis, her annual take-home pay would look like this:

\$45,000.00	Gross Pay
-2,542.56	SS/Medicare
-3,334.56	Federal Withholding
<u>-1,560.00</u>	State Withholding
\$37,562.88	Net Pay
-7,921.44	Health Premium
-1,300.00	Supplemental Retirement Annuity
-2,400.00	Dependent Care Expense
-750.00	Medical Expense
<u>-96.00</u>	Supplemental Short-Term Disability
\$25,095.44	Net Take-Home Pay

Because the College allows Mary to take these benefits on a pre-tax basis, her annual take-home pay actually looks like this:

\$45,000.00	Gross Pay
-7,921.44	Health Premium
-1,300.00	Supplemental Retirement Annuity
-2,400.00	Dependent Care Expense
-750.00	Medical Expense
<u>-96.00</u>	Supplemental Short-Term Disability
\$32,532.56	Net Pay
-2,016.48	SS/Medicare
-1,741.44	Federal Withholding
<u>-1,008.00</u>	State Withholding
\$27,766.64	Net Take-Home Pay
\$2,671.20	Additional Take-Home Pay

Because of Flexible Benefits, Mary has an additional \$2,671.20 in take-home pay each year.

Joe is a full-time MCAD employee who earns \$16.50 per hour. He is single and has no dependents. Joe claims no withholding deductibles. Joe's enrollment choices are as follows:

- He elects single coverage with HealthPartners Open Access Co-Pay Plan, at a cost to him of \$1,674.00 annually (12 months).
- He does not enroll for supplemental life insurance, because no one is dependent upon his income.
- He knows it would be difficult to cover his personal expenses should he be unable to work due to a disability, so he enrolls in the Supplemental Short Term Disability Plan (SSTD), at a cost of \$96.00 annually
- He knows he will need a new pair of glasses this year which will cost approximately \$130.00, so he puts \$130.00 annually into his Flexible Spending Account (FSA).
- In the hope of being financially independent at retirement, he puts \$650.00 annually into a TIAA-CREF, Tax-Deferred Supplemental Retirement Annuity (SRA).

If Joe were to pay for all of these benefits on an after-tax basis, his annual take-home pay would look like this:

\$30,030.00	Gross Pay
-1,304.01	SS/Medicare
-3,764.54	Federal Withholding
-1,586.00	State Withholding
\$23,375.45	Net Pay
-1,674.00	Health Premium
-650.00	Supplemental Retirement Annuity
-130.00	Medical Expense
-96.00	Supplemental Short-Term Disability
\$20,825.45	Net Take-Home Pay

Because the College allows Joe to take these benefits on a pre-tax basis, his annual take-home pay actually looks like this:

\$30,030.00	Gross Pay
-1,674.00	Health Premium
-650.00	Supplemental Retirement Annuity
-130.00	Medical Expense
-96.00	Supplemental Short-Term Disability
\$27,480.00	Net Pay
-1,607.00	SS/Medicare
-3,526.22	Federal Withholding
-1,466.00	State Withholding
\$20,880.78	Net Take-Home Pay
\$55.33	Additional Take-Home Pay

Because of Flexible Benefits, Joe's take-home pay is increased by \$55.33 annually.

Retirement Plan

Overview

Minneapolis College of Art and Design provides you with the option of purchasing Supplemental Tax-Deferred Annuities. You may elect investment options through TIAA-CREF.

The Supplemental Tax-Deferred Annuity Plan is designed to help employees who want to help themselves prepare for retirement.

Why is this a good way to prepare for retirement?

Retirement savings plans enable you to invest pre-tax dollars to earn a tax-free investment yield until retirement.

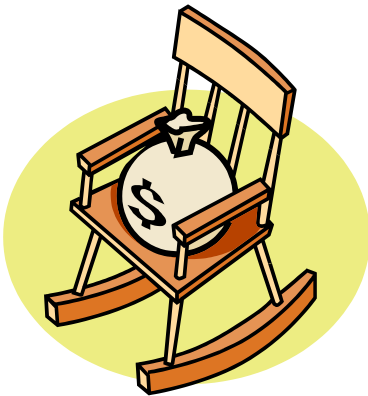
Why is it important to start early?

You benefit when you start saving early and let interest compound. The earlier you begin to save for retirement the better. But even if you are older, it's not too late to start saving. The advantages of tax-deferred growth in a 403(b) plan can still help you accumulate the money you'll need for retirement.

What does salary deferral mean?

This is the employee's optional contribution that is made with "pre-tax" dollars.

Retirement ...



Supplemental Tax-Deferred Annuity Plan

TIAA-CREF allows you to choose among multiple investment options. (Periodically, there may be additions and/or deletions to these investment options.)

EQUITIES

CREF Equity Index Account
CREF Global Equities Account
CREF Growth Account
CREF Stock Account
TIAA Access Account – TIAA-CREF Equity Index Fund
TIAA Access Account – TIAA-CREF International Equity Fund
TIAA Access Account – TIAA-CREF Large-Cap Growth Fund
TIAA Access Account – TIAA-CREF Large-Cap Value Fund
TIAA Access Account – TIAA-CREF Mid-Cap Growth Fund
TIAA Access Account – TIAA-CREF Mid-Cap Value Fund
TIAA Access Account – TIAA-CREF Real Estate Sec Fund
TIAA Access Account – TIAA-CREF Small-Cap Blend Index Fund
TIAA Access Account – TIAA-CREF Small-Cap Equity fund
TIAA Access Account – TIAA-CREF Social Choice Equity Fund

REAL ESTATE

TIAA Real Estate Account

FIXED INCOME

CREF Bond Market Account
CREF Inflation-Linked Bond Account
TIAA Access Account – TIAA-CREF Bond Fund
TIAA Access Account – TIAA-CREF Inflation-Linked Bond Fund

MONEY MARKET

CREF Money Market Account
TIAA Access Account – TIAA-CREF Money Market Fund

GUARANTEED

TIAA Traditional Account

MULTI-ASSET

CREF Social Choice Account
TIAA-CREF Lifecycle Fund Accounts (5 year increments from 2010 – 2060)
TIAA Access Account – TIAA-CREF Lifecycle Retirement Income Fund

TIAA-CREF has a number of investment choices, loan provisions, lump sum withdrawal features, and a multiple of payment options at retirement.

For more details regarding investment options, please read the plan prospectuses at www.tiaa-cref.org.

Defined Contribution Retirement Plan

Eligible employees who participate in MCAD's defined contribution retirement plan may choose among many investment options offered by TIAA-CREF. (Periodically, there may be additions and/or deletions to these investment options.)

For more details regarding investment options, please read the plan prospectuses at www.tiaa-cref.org.

EQUITIES

CREF Equity Index Account
CREF Global Equities Account
CREF Growth Account
CREF Stock Account
TIAA Access Account – TIAA-CREF Equity Index Fund
TIAA Access Account – TIAA-CREF Growth & Income Fund
TIAA Access Account – TIAA-CREF International Equity Fund
TIAA Access Account – TIAA-CREF Large-Cap Growth Fund
TIAA Access Account – TIAA-CREF Large-Cap Value Fund
TIAA Access Account – TIAA-CREF Mid-Cap Growth Fund
TIAA Access Account – TIAA-CREF Mid-Cap Value Fund
TIAA Access Account – TIAA-CREF Real Estate Sec Fund
TIAA Access Account – TIAA-CREF Small-Cap Blend Index Fund
TIAA Access Account – TIAA-CREF Small-Cap Equity fund
TIAA Access Account – TIAA-CREF Social Choice Equity Fund

REAL ESTATE

TIAA Real Estate Account

FIXED INCOME

CREF Bond Market Account
CREF Inflation-Linked Bond Account
TIAA Access Account – TIAA-CREF Bond Fund
TIAA Access Account – TIAA-CREF Inflation-Linked Bond Fund

MONEY MARKET

CREF Money Market Account
TIAA Access Account – TIAA-CREF Money Market Fund

GUARANTEED

TIAA Traditional Account

MULTI-ASSET

CREF Social Choice Account
TIAA-CREF Lifecycle Fund Accounts (5 year increments from 2010 – 2060)
TIAA Access Account – TIAA-CREF Lifecycle Retirement Income Fund

Employee Assistance Program (EAP)

Provider:

HealthPartners

Eligibility:

You and anyone in your immediate family household are eligible to use this service immediately upon hire if you are scheduled to work 1,000 hours or more annually.

Phone: 866-326-7194

Text: US HPEAP and your concerns to 919-324-5523

Website: www.hpeap.com

Password: mcad

Your Cost:

There is no cost to you for this benefit.



Overview

When you or your family need us, call anytime – literally – we’re here 24/7.

We can help with:

- Finances
- Senior Living
- Grief and Loss
- Stress/Depression
- Legal Issues
- Parenting and Childcare
- Relationships
- Senior Living
- Stress/Depression
- Substance Abuse
- Work/Life Balance
- And more!

Face-to-face counseling available – up to 6 visits for free.

Available for personal, relationship and emotional concerns.

HealthPartners Employee Assistance Program (EAP) Features

Employee services

Unlimited access to solution-focused counseling by phone: Masters-level counselors are available 24/7 to provide confidential help to employees and their families for personal, family, work-related, substance abuse and emotional issues. Support for multiple languages is available.

Face-to-face, solution-focused counseling: Employees and their dependents can meet face-to-face up with a licensed counselor up to three (3) times for help with emotional, personal and family concerns. EAP face-to-face network is integrated with HealthPartners behavioral health providers to ensure continuity of care.

Health plan integration: When appropriate employees will be transferred to the Personal Assistance Line for help finding a covered behavioral health provider or other appropriate health plan resources.

Work-life consultation, resource and referral: Employees have access 24/7 to work-life experts for help with a broad range of concerns including child care, elder care, education, adoption and transportation needs. They can also help with finding resources like pet care, car mechanics and other daily needs.

Legal consultation: Phone consultation with an advice attorney and one ½ hour face-to-face consultation with a practice attorney per legal issue. And 25 percent discount if the attorney you meet with is retained.

Financial consultation: Phone consultation with a financial specialist on a variety of financial issues.

Multi-lingual website: Available in 15 languages, Online legal and financial center, discount shopping program, tax preparation software, access to counselors and work-life experts via texting/instant messaging.

Online caregiving community: Convenient way for caregivers to keep caregiving needs/support organized.

Online learning: Monthly webinars archived by date, 98 interactive online training courses with certificates of completion, over 300 streaming audio and video files, and articles, action plans, assessment tools and quick tips. Over 4000 articles and tip sheets

iPhone app: iFindCare app – search for child and eldercare resources.

Employee Assistance Program (EAP)

Support for your life

Whether you or your family need help with your personal life or are having issues at work, HealthPartners Employee Assistance Program (EAP) is here for you. Call 24/7 for help from a counselor finding child care, dealing with a loss, finding community resources and more.

Help by phone

EAP counselors are ready to give you the type of support you need. Just call and they'll listen to your concerns, give you guidance and help you find solutions that are right for you. Here are just a few things they can help you with:

- Marital issues
- Balancing work and family
- Financial concerns
- Mental and emotional health
- Parenting
- Job stress
- Legal issues
- Substance abuse
- Personal relationships
- Child care and elder care
- Grief and loss
- Divorce
- Finding community resources

Help online

Get help 24/7 with our wide range of online resources. You'll find:

- More than 4,000 articles and tip sheets
- Self-assessment tools
- Child care and elder care resource searches
- Legal information and forms
- More than 60 financial calculators
- Monthly webinars
- Savings Center
- Relocation Center
- And more!

Can't find what you're looking for? Text or instant message an EAP counselor or work-life consultant anytime, day or night.

Help with an app

Experience help on-the-go with the iFindCare app for your iPhone. Use it to search for child and elder care resources wherever you are. Just visit the app store to download it today.

Help face-to-face

If you want to talk to a counselor in person, just call us and we'll connect you with an EAP professional. You can meet with a counselor for up to three visits per issue.

You're privacy is important

Everything you do with HealthPartners EAP is confidential. No information is shared with your employer or health plan and will only be released with your permission or when required by law.

HealthPartners EAP is here for you anytime, day or night. Just call **866-326-7194**, TTY 866-228-2809, text US HPEAP and your concern to **919-324-5523** or go online at **hpeap.com**. **Password:**

Other Programs

Metropass Program

Employee Eligibility

You are eligible to participate in the Metropass Program on the first of the month following your date of hire if you are benefits eligible. Metro Transit requires that MCAD have at least five employees enrolled in the program for it to be offered by MCAD.

Plan Rates

Metropass is currently \$76 per month. Rates may change. MCAD will subsidize \$35 a month of this cost; the cost to the employee is \$41 per month. This cost will be deducted on a pre-tax basis from the first and second payroll check of each month, saving you approximately 30% by avoiding state, federal and social security tax on this benefit.

About Metropass

Metropass is a plan offered by Metro Transit. When you purchase a Metropass, you are purchasing a personalized unlimited use, unlimited route, bus and light rail pass. The pass is not transferable; it will contain your picture.

Enrollment

You can enroll in the Metropass Program at any time. If enrollment is received by the 15th of the month, your Metropass will be effective the 1st of the following month.

Cancellation of Enrollment

Your enrollment will be cancelled upon written request. You will need to notify Human Resources by the 15th of the month for your deduction to end the first of the next month.

Lost or Stolen Cards

Lost or stolen cards must be reported to Human Resources immediately. There is a \$20 fee to replace the card the first time, \$40 the second time. MCAD and/or Metro Transit reserve the right to revoke or deactivate your card if you do not comply with the program guidelines.

Guaranteed Ride Home Program

Metropass participants are eligible for the Guaranteed Ride Home Program, offered through Metro Transit. Enrollment can be done at metrotransit.org/guaranteed-ride-home.aspx.

Other Bus Passes

Discounted Stored Value Cards are available for purchase in the Art Cellar.



Parking Benefit Plan (Pre-tax Parking Account)

Employee Eligibility: Regular employees scheduled to work at least 1,000 hours are eligible to participate the first of the month following the date of hire. Casual or temporary employees and adjunct faculty are not eligible to participate.

About Your Plan

If you participate in this plan, you can receive reimbursement for parking in the MCAD parking lot with your pre-tax dollars (pre-tax payroll deductions). In 2016, you can elect up to \$45 per month of pre-tax reimbursements.

MCAD charges .25 cents (plus tax) per hour of parking, 7:00 a.m. to 9:00 p.m., Monday through Friday; and .15 cents (plus tax) per hour of parking, all other times. In 2016 MCAD will charge for parking on following dates: January 1st – January 14th, January 24th – May 10th and September 6th – December 31st. There is no charge for parking during the summer months.

Because we do not charge for parking in the summer, we will not take any deductions for parking in the months of June, July, and August.

How are the costs of benefits covered under the plan?

Plan benefits are paid for through reductions to your compensation on a pre-tax basis; you designate the monthly amount on the attached enrollment form. Your enrollment form must be received in Human Resources by the 15th of the month to be effective the first of the following month. You can receive reimbursement for parking only if you have contributions in your account.

How do I receive reimbursement for my parking costs?

Receipts for the purchase of pre-paid parking debit cards are submitted to Human Resources on the Pre-tax Parking Account Reimbursement form. The date on the receipt must be after the date you were enrolled in the program. Reimbursement will be paid from the available funds in your account. You cannot receive reimbursement if there are no funds remaining in your account.

Any month that you receive a reimbursement for parking expenses cannot be counted as a bicycle commuting month for purposes of the Bicycle Commuting Reimbursement Benefit.

May I cancel or change my election?

Unless you revoke your election in writing, your initial election will remain in force. If you wish to change your election, you must do so by the 15th of the month prior to the month in which you want the change to happen. The change will be effective the first of the next month. You may change the amount deducted from your check or stop your deduction. To make a change, complete the change section on the attached form and submit it to Human Resources.

Use it or lose it rule

The money you set aside in your account is not transferable to another account, nor will it be returned to you if you have overestimated your expenses. If you terminate your employment, you have three months to make claims. The date on any receipt submitted for reimbursement must be prior to your termination date.

Qualified Bicycle Commuting Reimbursement Program

Employee Eligibility

You are eligible to participate in the Qualified Bicycle Commuting Reimbursement Program on the first of the month following your date of hire if you are benefits eligible.

Description of the benefit: MCAD will reimburse you for reasonable expenses incurred to purchase a bicycle and for bicycle improvements, bicycle repair, and bicycle storage. This reimbursement will not be taxable, provided that you comply with all the requirements.

- The maximum reimbursement for a calendar year is the lesser of
 - Your total bicycle expense for the calendar year, or
 - \$20 multiplied by the number of bicycle commuting months in the calendar year.
- A bicycle commuting month is a month that you regularly used your bicycle for a substantial portion of the travel between your residence and MCAD.
- A substantial portion of the travel means no less than 50% of your monthly commute.
- Only the months of your active employment can be bicycle commuting months. Any month during which you are not required to come to MCAD's campus is not a bicycle commuting month.
- Any month that you receive a reimbursement for parking expenses under the Pre-Tax Parking Account, use a Metropass, or pay for a reserved parking space, cannot be counted as a bicycle commuting month.

Each calendar year is looked at separately for purposes of reimbursement. Expenses must be incurred in the same year that you earn reimbursement. Expenses can occur at any time during the year. You don't have to submit reimbursement forms on a monthly basis – you may turn in a single reimbursement request after the end of the year.

Requirements: To obtain the benefit, you must submit requests for reimbursement no later than March 15 of the year following the calendar year in which you incur the expenses. Your reimbursement amount will be based on the number of bicycle commuting months you had in the year you made the purchase. Your request is complete only if you include the claim form with your signature, receipts for your eligible expenses, and a bicycle commuting log (calendar with bicycle commuting days circled). You will receive reimbursement by check. Please allow two weeks for processing.



Important Legislation and Government Notices

Important Information for you:

It is crucial that you read the following pages, as they contain extremely valuable information about your responsibility and your rights under the various laws as they apply to your benefit plans.

COBRA – Consolidated Omnibus Budget Reconciliation Act

This law governs continuation of medical insurance coverage.

Special Enrollment Provision

This provision is a brief explanation of reasons certain employees and dependents may qualify for special enrollment rights.

USERRA – Uniformed Services Employment and Reemployment Rights Act

This law governs how employees are to be protected for employment and benefits due to absence while serving in the U.S. Armed Forces.

HIPAA – Health Insurance Portability and Accountability Act

This law governs such things as health insurance portability, privacy rules, women's health and cancer rights and medical child support orders.

CHIPRA – Children's Health Insurance Program Reauthorization Act

CHIPRA creates two new Special Enrollment Rights for children: (1) termination of Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility or (2) obtaining eligibility for a state premium assistance subsidy under these programs.

CHIPRA Annual Notice

This Notice informs employees of their potential rights to receive premium assistance under a State's Medicaid or CHIP program.

Newborns' and Mother's Health Protection Act of 1996

This law governs hospital length of stay in connection with childbirth for the mother or newborn child.

Mastectomy Provision (Women's Health & Cancer Rights Act of 1998)

This law governs group health plans providing medical and surgical benefits for mastectomy.

QMSCO – Qualified Medical Child Support Orders

This law governs providing health coverage to Dependents of a Covered Employee or Retired Employee in connection with the Covered Employee or Retired Employee's separation or divorce from his or her spouse

ERISA – Employee Retirement Income Security Act

This law governs your rights under federally regulated plans such as self-funded health and dental, flexible benefits, and retirement plans.

COBRA Continuation

CONTINUATION OF GROUP HEALTH COVERAGE FOR QUALIFIED PERSONS

The Federal, Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that your group plan allow a Qualified Beneficiary (as defined below) to continue group health coverage after it would otherwise end. For this purpose, the term "group health coverage" includes any medical, dental, vision care and prescription drug coverage that is included in the group health plan. The Medical Flexible Spending Account (FSA) is also included.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Qualified Beneficiary - A Covered Employee or Dependents of a Covered Employee who were Covered Persons on the date preceding the date on which the Qualifying Event occurred, and a child born to or placed for adoption with the Covered Employee during the period of COBRA coverage.

Qualifying Event - Any one of the following, which, but for this Coverage Continuation Option, would result in the loss of coverage under this Plan:

- the death of the Covered Employee;
- the termination of the Covered Employee (other than by the Employee's gross misconduct);
- reduction in a Covered Employee's hours of employment to an ineligible status;
- the divorce or legal separation of the Covered Employee from the Employee's spouse;
- the Covered Employee's becoming entitled to Medicare Coverage; or
- the cessation of Covered Dependent child coverage by operation of Plan provision.

With regard to retirees, regardless of the date of retirement, the Employer's filing for financial protection under chapter 11 on or after July 1, 1986, if such financial difficulty would cause the retiree to lose coverage, will constitute a COBRA qualifying event.

Notification - Qualified Beneficiaries must notify Employer within 60 days of their Qualifying Event, in the event of divorce, legal separation or Dependent child becoming ineligible.

Employer must notify Qualified Beneficiaries of Coverage Continuation rights in the event of Employee's death, termination, and reduction in hours or Medicare entitlement. Notice mailed to Qualified Beneficiary's last known address will be considered adequate. Notice to spouse is treated as notification to all other Qualified Beneficiaries residing with spouse at the time notice is made. Notification must be made to Qualified Beneficiaries within 14 days of Employer's notice of the occurrence of Qualifying Event.

Election and Election Period - Coverage Continuation may be elected during the period beginning on the date coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

- sixty (60) days after coverage ends due to a Qualifying Event;
- sixty (60) days after the Qualified Beneficiary receives notice of Coverage Continuation rights.

If Coverage Continuation is elected by one Qualified Beneficiary, it will be deemed to be an election for all other beneficiaries who would otherwise lose coverage. However, each individual who would otherwise lose coverage is entitled to make an individual election, which would allow one to elect continued coverage even if others in the same family have declined.

Trade Act of 2002 – If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Effective Date of Coverage - Coverage Continuation, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event and Qualified Beneficiary will be retroactively charged for coverage accordingly.

Level of Benefits - Continuation Coverage hereunder will be equivalent to coverage provided to a similarly situated person to whom a Qualifying Event has not occurred. If coverage is modified with respect to similarly situated employees, the same modification shall apply to Qualified Beneficiaries.

Cost of Coverage Continuation - The cost of coverage will not exceed 102% of the cost of coverage, during the same period, for a similarly situated beneficiary to whom a Qualifying Event has not occurred or, in the event of Disability, 150% of the cost of coverage for months 19 through 29. Notwithstanding the above paragraph, premiums are due monthly on or before the first day of each month for which the Qualified Beneficiary is to receive Coverage Continuation. Retroactive premiums must be paid by the Qualified Beneficiary to the Plan within 45 days of the election of Coverage Continuation hereunder, or the Qualified Beneficiary will be ineligible for Coverage Continuation. Payment is considered made on the date on which it is sent to the Plan. If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A 'reasonable period of time' is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Termination of Coverage Continuation - Coverage under this provision will terminate on the occurrence of the earlier of:

- the end of eighteen (18) months if the Qualifying Event is employment termination or reduction of hours to a non-eligible status;
- the end of thirty six (36) months if the Qualifying Event is ineligibility as a dependent;
- the end of thirty-six (36) months if the Qualifying Event is death of the employee, divorce or legal separation;
- the end of twenty-nine (29) months for a Qualified Beneficiary whose total disability commenced no later than 60 days following the Employee's termination or reduction in hours. The disability that extends the continuation coverage must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided within 18 months of the employee's termination or reduction of hours in employment, and the affected individual must inform the Employer of the determination of disability within 60 days of the date of the notice.
- the termination of all Employer provided group health plans;
- the failure to make timely premium payments under the Plan (coverage may be terminated if the beneficiary is more than 30 days delinquent in paying his/her premium);
- the Qualified Beneficiary becomes covered under any other group health plan as a result of employment, re-employment or re-marriage;
- the Qualified Beneficiary becomes entitled to Medicare benefits.

Conversion - For fully insured plans, covered person(s) may convert to an individual policy without evidence of insurability, at a premium rate established by the insurance carrier. Self insured plans may or may not offer a conversion option. Please refer to the appropriate coverage contracts for specific details.

Special Enrollment Provisions (HIPAA and CHIPRA)

An eligible Employee or Dependent who waives coverage under the Plan at the time of initial Eligibility (and states in writing at that time that coverage was waived because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage under this Plan shall be a Special Enrollee provided such person:

- (1) was under a COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation provision and the coverage under such provision was exhausted; or
- (2) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or loss of Dependent status); or
- (3) lost eligibility for coverage through an HMO, or other arrangement, in the individual market, that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual); or
- (4) lost eligibility for coverage through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual), and no other benefit package option is available to the individual; or
- (5) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. The Special Enrollment Period continues in the event a claim is incurred or exceeds the lifetime limit until at least 30 days after the earliest date a claim is denied due to the operation of the lifetime limit; or
- (6) when a plan no longer offers any benefits to a class of similarly situated individuals; or
- (7) employer contributions toward such coverage were terminated; or
- (8) was covered under Medicaid or a Children's Health Insurance Program Plan (CHIP) and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage; or
- (9) becomes eligible for premium assistance to purchase coverage under this Plan under the applicable state Medicaid or CHIP Plan.

Individuals who lose other coverage due to nonpayment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder.

An eligible Employee or Dependent who waives coverage under this Plan at the time of initial Eligibility and seeks to enroll in this Plan as a result of the acquisition of a new Dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the eligible Employee or Dependent enrolls within thirty-one (31) days of the acquisition of the new Dependent. Coverage will be effective in the event of marriage, the first day of the first calendar month following the date the completed request for enrollment is received by the Plan; or in the event of birth, adoption or placement for adoption, the date of such birth, adoption or placement for adoption.

Coverage for other classes of Special Enrollee shall be effective not later than the first day of the first calendar month following the date the completed request for enrollment is received by the Plan if the eligible Employee or Dependent enrolls within thirty-one (31) days of an event described in (1), (2), (3), (4), (5), (6) and (7); or an Employee or Dependent enrolls within sixty (60) days of an event described in (8) or (9) above.

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)**.

Because you live in Minnesota, you may be eligible for assistance paying your employer health plan premiums. The following is current as of July 31, 2015. Contact the number below for further information on eligibility.

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/id_006254
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Minnesota Continuation Rules

State Law requires insured group health plans, issued in Minnesota, to offer qualified beneficiaries additional continuation privileges. These continuation rules do not apply to the Medical Flexible Spending Account (FSA).

- A. Surviving Spouses and Dependents or Divorcees and their Dependents that were covered prior to the employees death or divorce, may continue Medical Insurance until:
 - (1) The date the Qualified Beneficiary becomes covered under another group plan; or
 - (2) The date the Qualified Beneficiary would have lost coverage had the employee lived or there had not been a divorce.

A person who elects continuation can be required to pay the entire cost for the continued coverage. At the employer's option, a 2% surcharge can be attached to each monthly premium to help defray the employer's administrative expenses.

Special payment rules for Surviving Spouses and Dependents:

- (1) After the employer has sent notification of the right to continue coverage, the continuee has 90 days in which to make the first payment.
 - (2) The employer must send notice in writing at least 30 days before terminating coverage for non-payment of premium.
 - (3) Insured plans must allow conversion to an individual policy.
- B. Coverage may be continued indefinitely for the handicapped child of an employee, notwithstanding age limits for dependent children.
 - C. Totally Disabled Employees must be allowed to continue group medical coverage as long as they remain totally disabled.

State definition of total disability:

- (1) The inability of an injured or ill employee to engage in or perform the duties of the employee's regular occupation or employment within the first two years of such disability; and
- (2) After the first two years of such disability, the inability of the employee to engage in any paid employment or work for which the employee may, by education and training, including rehabilitative training, be or reasonably become qualified.

The employer may charge only 100% of premium.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

This provides benefits in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. If an employee or dependent loses coverage during the employee's absence from work due to military service, the employee or dependent will regain coverage immediately if the employee

returns to work. However, a waiting period must be served if it would have otherwise applied had the employee not been on military leave of absence.

What is USERRA? The Uniformed Services Employment and Reemployment Rights Act of 1994 provides employees who are absent from work by reason of service in the U.S. Uniformed Services (basically the Armed Forces and the U.S. Public Health Service) with certain rights regarding employment, reemployment, health plan coverage and tax-qualified retirement plan coverage.

When was USERRA effective? USERRA is effective as to all reemployments requested or initiated on or after December 12, 1994.

What employers are covered (and what employers are exempt)? Any person, institution, organization or other entity that pays salaries or wages (or otherwise has control over employment opportunities) is an "employer" and is covered under USERRA. Notably, USERRA provides no exemptions for specific types of organizations (such as tax-exempt employers or "small" employers).

What employees are protected? All private sector and public sector employees (except for certain temporary employees), regardless of whether employed on a full-time or part-time basis. Only temporary employees (employed in positions not reasonably expected to continue indefinitely) are not provided USERRA rights. However, only returning employees who receive honorable discharges retain their USERRA rights.

What military, reserve or other service is covered? USERRA "Uniformed Service" includes service in the Army, Navy, Marines, Air Force, Coast Guard, Army National Guard, Air National Guard and "commissioned service" in the United States Public Health Service. USERRA also covers service other than active duty, including the performance of duties, on a voluntary or involuntary basis, regarding all types of military service or training, full-time National Guard duty and all time necessary for examination to determine fitness for duty.

What reemployment rights do former employees have under USERRA? A returning employee who meets certain USERRA requirements has the right (depending on the length of Uniformed Service and his or her ability to perform the job) to return to the position that the employee would have attained if he or she had not left to perform Uniformed Service, to a position of like seniority, status and pay, or to their prior position. If a returning employee is unable to perform the duties of such a position, an employer may be required to make reasonable accommodation under the Americans with Disability Act (to allow the employee to return to work to such position or an alternative position).

How long does an employee returning from USERRA leave have to report for reemployment (or submit an application)? If an employee was absent due to Uniformed Service for less than 31 days, the employee generally has until the first regularly scheduled work period on the first full calendar day following completion of the Uniformed Service and eight hours after a period allowing for safe travel to the employee's residence (to report for reemployment).

If an employee was absent due to Uniformed Service for a period longer than 30 days, but less than 181 days, the employee generally has fourteen (14) days from the end of Uniformed Service (to submit an application for reemployment).

If an employee was absent due to Uniformed Service for longer than 180 days, the employee generally has ninety (90) days from the end of Uniformed Service (to submit an application for reemployment).

What are a former employee's specific rights to health plan benefits during Uniformed Service? If a former employee (and/or former employee's dependents) maintain coverage under a health plan in connection with the employee's employment, and the employee is absent by reason of Uniformed Service, the employee/former employee may elect to continue coverage under the plan for up to 24 months (or, if less, the period ending on the day after the former employee's failure to return to, or apply for return to, employment within the applicable USERRA timeframe. Such former employees may be required to pay up to 102% of the applicable full premium under the plan. If the Uniformed Service involved continues for less than 31 days, only the employee's normal share of the applicable premium may be charged.

What are a returning employee's specific rights to health plan benefits? USERRA guarantees the covered employee's reinstatement in the employer's group (or other) health plan, without meeting eligibility or coverage requirements (or other limitations). For employees whose health coverage was terminated because of Uniformed Service, immediate reinstatement (without application of coverage waiting period) is required. USERRA prohibition against reinstatement limitations extends to both affected employees and dependents. The sole exception to the prohibition against application of health plan eligibility and coverage requirements is for employee disabilities that the United States Veterans Administration determines are "service related".

What employer health plans are subject to USERRA's reinstatement requirements? All medical service agreements, including self-administered self-insured plans and those self-insured plans using a third party administrator and administrative service agreement, membership contracts, subscription contracts or other arrangements by which employee health services are provided or employee health expenses are reimbursed. USERRA's application is not limited to "group health plans" as defined under COBRA. No exceptions are provided for health plans of "small" employers or other "special" employers.

What are the pension rights of a returning employee? An employer generally must: (1) credit all years of service while the employee is on leave for Uniformed Service; and (2) fund the plan for all such years of service. The employer must make employer contributions to any "defined contribution" plan for the employee's benefit (for all periods during which the employee remains on leave for Uniformed Service). With respect to elective deferrals or elective employee contributions, the employer must make the applicable matching contributions if the returning employee makes the permitted plan deferrals or contributions within the "catch-up" period provided under USERRA.

How must Uniformed Service be treated for purposes of vesting? A former employee who is reemployed shall be treated as not having incurred any plan "break-in-service" by reason of Uniformed Service. Further, all such Uniformed Service shall be recognized and counted for purposes of vesting and other service-based plan requirements.

How long does a returning employee have to make make-up 403(b) elective deferrals or elective contributions? Make-up contributions must be completed between the actual date of reemployment and the end of the period that is equal to three times the applicable period of Uniformed Service (up to a maximum of five years).

Do returning employees have a right to claim a share of plan forfeitures or allocations of plan earnings? No, except to the extent the plan otherwise provides specifically for an allocation of forfeitures or earnings to inactive/separated participants and beneficiaries).

How must an employer calculate its liability to a plan for service of a returning employee under the Act? In calculating plan contribution liabilities (or the returning employee's available elective deferrals or employee contributions), the employer must compute the employee's compensation for the period of Uniformed Service at either: (1) the actual rate of pay the employee would have received for the specific period of covered leave (if the employee had remained employed); or (2) on the basis of the employee's average rate of compensation for the twelve month period immediately preceding the covered leave (for any employee whose rate of pay changes/ or is not reasonably certain). If the period of employment preceding covered leave is less than twelve months, the employer's computation must use the prior compensation for that entire prior period.

Health Insurance Portability and Accountability Act (HIPAA)

CREDITABLE COVERAGE

Important Notice of Your Right To Documentation Of Health Coverage

Changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for pre-existing medical conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll.

Certification of Prior Health Coverage

You have a right to receive a certificate showing you or your dependents' prior health coverage. If you enroll in this plan, and have a pre-existing condition, which is excluded under the plan, you may be entitled to reduce the period of the pre-existing condition exclusion by providing a certificate of coverage. The period during which the Pre-Existing Conditions Limitation applies will be reduced by the number of months during which you were previously enrolled for coverage under most group health plans, an individual health policy or most government health programs (Creditable Coverage), provided there has been no break in coverage which exceeds 63 days. In order to receive credit for prior coverage, you will be required to provide Certification to the plan of such prior coverage. The Certification must include documentation of the duration of coverage under the prior health plan (including COBRA coverage) or other coverage and any waiting/affiliation periods used under the prior coverage.

If you have questions about the law or certification of coverage, check with your employer or benefits administrator about the requirements for obtaining a certificate of prior coverage.

If you buy health insurance coverage other than through an employer group health plan, a certificate of your prior coverage may help you obtain coverage without a pre-existing condition exclusion. Contact your State insurance department for further information if you purchase private insurance coverage.

At such time as you or your dependents cease to be covered under this plan, HealthPartners will provide you with a Certificate of Coverage, which you may present at the time you become enrolled for coverage under another plan of health coverage.

Effective January 1, 2014, your employer group health plan will not exclude Pre-existing conditions from coverage under the plan. Refer to your Summary Plan Description for additional information.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by your Group Health Plan to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact, your Human Resource Department.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on September 23, 2013.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available *by including in the Member Handbook*.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

- **Payment and Health Care Operations**
We have the right to use and disclose your PHI for all activities that are included within the definitions of “payment” and “health care operations” as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.
- **Payment**
We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations

We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- **Required by Law**
We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- **Public Health Activities**
 We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Health Oversight Activities**
 We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.
- **Abuse or Neglect**
 We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.
- **Legal Proceedings**
 We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.
- **Law Enforcement**
 Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.
- **Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations**
 We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.
- **Research**
 We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.
- **To Prevent a Serious Threat to Health or Safety**
 Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- ***Military Activity and National Security, Protective Services***
Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.
- ***Inmates***
If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.
- ***Workers' Compensation***
We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- ***Emergency Situations***
We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.
- ***Fundraising Activities***
We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Group Health Plan Disclosures***
We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.
- ***Underwriting Purposes***
We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.
- ***Others Involved in Your Health Care***
Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

Sale of PHI

We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing

We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes

We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services***
We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.
- ***Disclosures to You***
We are required to disclose to you most of your PHI in a “designated record set” when you request access to this information. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

- ***Business Associates***
We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

- **Other Covered Entities**

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- **Plan Sponsor**

We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- **Right to Request a Restriction**

You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- **Right to Request Confidential Communications**

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate

your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice as soon as you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for *all* your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- ***Right to Inspect and Copy***

You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- ***Right to Amend***

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the

designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- ***Right of an Accounting***

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- ***Right to a Copy of This Notice***

You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

MCAD Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (“Notice”) applies to Protected Health Information (defined below) associated with Group Health Plans (defined below) provided by Minneapolis College of Art and Design (“MCAD”) to its employees, its employees’ dependents and, as applicable, retired employees. This Notice describes how MCAD may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

This notice is being provided to you because MCAD is the Plan Administrator of the MCAD Flexible Benefit Plan, and because the Health Spending Account program under the Flexible Benefit Health Plan is a “Group Health Plan” as defined by HIPAA. However, please be aware that MCAD will have access to your Protected Health Information under the Health Spending Account program only in very rare circumstances, since claims for benefits under that program are generally administered by EBSO, Inc.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plans with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all participants then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting MCAD at the telephone number or address below.

DEFINITIONS

Group Health Plan means, for purposes of this Notice, the Flexible Benefit Plan Health Spending Account coverage.

Protected Health Information (“PHI”) means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – We may use and disclose your PHI as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Group Health Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to your Group Health Plan.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan.

Other Uses and Disclosures – We may make certain other uses and disclosures of your PHI without your authorization.

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.

- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of Protected Health Information, as described above, we will restrict our uses or disclosure of your Protected Health Information in accordance with the more stringent standard.

RIGHTS THAT YOU HAVE

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Access request forms are available from MCAD at the address below. We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request. Amendment request forms are available from us at the address below.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain of our uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. In addition, you may also call Pamela Newsome-Prochniak at 612-874-3798, to discuss your complaint or ask questions.

You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services – Office of Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue SW, Room 509F HHH Building, Washington, D.C. 20201, within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact MCAD by writing to: Minneapolis College of Art and Design, Attn: Pamela Newsome-Prochniak, 2501 Stevens Avenue South, Minneapolis, Minnesota 55404.

EFFECTIVE DATE

This Notice is effective April 14, 2004.

STP:128859.1/50156-15/srk

Newborns' And Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's attending physician, after consultation 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 physician obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mastectomy Provision (Women's Health And Cancer Rights Act of 1998)

Federal law requires group health plans providing medical and surgical benefits for mastectomy to provide the following coverage to a plan participant who elects breast reconstruction in connection with such mastectomy: 1) reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce symmetrical appearance; and 3) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductible and coinsurance provisions as may be deemed appropriate and that are consistent with those established for other benefits provided under the plan or coverage. Plans not already providing this type of coverage must do so beginning with the first plan renewal after the enactment date shown above. Refer to your Summary Plan Description for further information.

Qualified Medical Child Support Order (QMSCO)

In August, 1993, a new federal law went into effect which requires all employee benefit plans to recognize Qualified Medical Child Support Orders for the purpose of providing health coverage to Dependents of a Covered Employee or Retired Employee in connection with the Covered Employee or Retired Employee's separation or divorce from his or her spouse. In order for this plan to recognize a Qualified Medical Child Support Order, it must satisfy the following criteria:

1. It must be a judgment, decree or other court order relating to health benefits coverage for a Dependent Child of a Covered Employee or Covered Retired Employee; and,
2. The order must specify:
 - a. the name and address of the Employee or Retired Employee;
 - b. the name and mailing address of each Dependent Child covered by the order;
 - c. a reasonable description of the type of coverage afforded by the plan;
 - d. the beginning period for which the order applies; and
 - e. the name and address of each Alternate Payee, which means the spouse, former spouse, legal guardian of the Dependent Child or the child of an Employee or Retired Employee.

Upon receipt of a medical child support order, the Administrative Manager shall promptly notify the Employee or Retired Employee and Alternate Payee. The Trustees shall determine whether an order received meets the criteria and promptly notify the Employee and each Alternate Payee. In the event of a dispute regarding any medical child support order furnished to the Trust, the Employee or Alternate Payee shall promptly notify the Trust Office in writing.

Coverage shall commence upon either the date specified in the order or the date the Employee or Retired Employee becomes eligible for coverage, if later.

Any order, which requires this plan to provide any type of benefit or increased benefits not otherwise provided by this plan or coverage for any period of time the Employee or Retired Employee is not covered under this plan, other than under COBRA, will not be recognized as a Qualified Medical Child Support Order.

Employee Retirement Income Security Act (ERISA)

This notice applies to the Medical Reimbursement Plan, the Medical Plan, the Dental Plan, the Supplemental Short-Term Disability Plan, the Long-Term Disability Plan, the Group Life Insurance Plan, and the Defined Contribution Retirement Plan. As a participant in these plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information about Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

ERISA provides that all plan participants shall be entitled to:

- Continue health care coverage for a plan participant, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan and the rules governing COBRA continuation coverage rights.
- Elimination of exclusionary periods of coverage for pre-existing conditions under this group health plan, if an employee or dependent has Creditable Coverage from another plan. The employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If a plan participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the plan participant up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

The court will decide who should pay the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your Questions

If you have any questions about your plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Contract Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

General Plan Information

Name of the Plan: Minneapolis College of Art and Design Medical Plan

Plan Sponsor: Minneapolis College of Art and Design
2501 Stevens Avenue
Minneapolis, MN 55404

Plan Sponsor Tax ID Number: 41-1607453

Plan Identification Number: 503

Type of Plan: Group Health

Type of Administration: Insurance

Plan Administrator: Minneapolis College of Art and Design
2501 Stevens Avenue
Minneapolis, MN 55404
612-874-3798

Agent for Service of Legal Process: For benefits under HealthPartners Group Certificate:
HealthPartners Insurance Company
Member Services Department
8170 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309
952-883-5000

For all other matters related to the Plan:
Plan Administrator

Named Fiduciary: For benefits under HealthPartners Group Certificate:
HealthPartners Insurance Company

For all other matters related to the Plan:
Plan Administrator

Eligible Classes: Regular employees scheduled to work at least 1,000 hours per year are eligible. Casual, temporary, and adjunct faculty are not eligible upon hire, but if they complete an average of 30 hours per week during a measurement period, they can earn eligibility for the following one year period. Employees moving from eligible to ineligible positions may be entitled to an additional period of coverage during the transition. If the employee becomes eligible and enrolls, spouse and children up to age 26 are eligible to enroll.

Network Providers: NationalONE Network

Amendment or Termination of Plan: MCAD's Board of Trustees can amend or terminate the Plan at any time. You will receive notice of significant Changes sixty days before they become effective. Expenses incurred before amendment or termination will be covered according to the Plan terms in effect at the time the expense was incurred.

Contributions: Employer and Employee, See MCAD Employee Benefit Enrollment Book for amount.

Funding: This Plan is fully insured

Plan Year: January 1 – December 31

Employment Waiting Period: Coverage begins first of month following date of hire.

Contact for Continuation of Coverage Notices: EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, MN 55116-1912
651-695-2500 or toll free 800-486-7664

Name of Plan: Minneapolis College of Art and Design Dental Benefit Plan

Plan Sponsor/Plan Administrator: Minneapolis College of Art and Design
2501 Stevens Avenue
Minneapolis, MN 55404
612-874-3798

Group Number: 277

Plan Sponsor Tax ID Number: 41-1607453

ERISA Plan Number: 501

Effective Date: January 1, 2013 (as restated)

Plan Year End: December 31

Type of Plan: Group Dental Coverage

Contact Administrator: EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, MN 55116-1912
651-695-2500 or toll free 800-486-7664

Agent for Service of Legal Process: Minneapolis College of Art and Design
2501 Stevens Avenue
Minneapolis, MN 55404
612-874-3798

Contribution Basis: This Plan provides Contributory coverage for Employees and Dependents.

Eligible Classes: Regular employees scheduled to work at least 1,000 hours per year are eligible. Casual, temporary, and adjunct faculty are not eligible. If employee enrolls, spouse and children up to age 26 are eligible to enroll.

Name of Plan: Minneapolis College of Art and Design
Flexible Benefit Plan

Plan Sponsor/Plan Administrator: Minneapolis College of Art and Design
2501 Stevens Avenue
Minneapolis, MN 55404
612-874-3798

Group Number: 277

Plan Sponsor Tax ID Number: 41-1607453

ERISA Plan Number: 599

Plan Year: January 1, 2016 - December 31, 2016

Type of Plan: Flexible Benefit Plan, which includes a Health
Flexible Spending Plan

Contact Administrator: EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, MN 55116-1912
651-695-2500 or toll free 800-486-7664

Agent for Service of Legal Process: Minneapolis College of Art and Design
2501 Stevens Avenue
Minneapolis, MN 55404
612-874-3798

Eligible Classes: Regular employees scheduled to work at least 1,000 hours per year are eligible. Casual, temporary, and adjunct faculty are not eligible. If employee enrolls, spouse and children up to age 26 are eligible to enroll.

Method of Funding

Plan benefits are provided directly from the general assets of the Plan Sponsor. The Plan Sponsor is responsible for the financing and administration of the plan.

The employer may require that covered persons contribute toward the cost of providing plan benefits. The amount of such contributions will be determined by the employer and may be changed by the employer from time to time. The employer will deduct such contributions on a regular basis from the wages or salary of employees who receive coverage under the plan.

Discrepancies

This booklet describes the basic features of the plan, how it operates, and how you can get the maximum advantage from the plan. The booklet is only a summary of the plan. If there is a conflict between this booklet and the legal Plan Documents, the Plan Documents will prevail.

Amendment, Termination, and Administration of the Plan

The Plan Sponsor reserves total rights and power to alter and amend or terminate the plan, at any time within its discretion by adoption of a written amendment containing the new terms of the plan. The Plan Sponsor has full discretion to determine eligibility of benefits and to construe plan terms and conditions.

If the plan is terminated, amended, or benefits are eliminated, the rights of covered persons are limited to covered expenses incurred before termination, amendment or elimination.