Employee Benefit Enrollment Guide
For

MCAD

January 1, 2019 – December 31, 2019

Contract Administrators

EBSO

2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 ▯ 1-800-486-7664
www.ebsobenefits.com

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Introduction

MCAD aims to provide the best benefits package possible for our staff. Every year, MCAD assess the current benefits package in order to ensure that it remains competitive with other similar organizations while also keeping benefits affordable. This section details many of the benefits employees may enjoy while working for MCAD. For more information, please refer to the full Benefits Summary available from the Office of Human Resources and on the MCAD Intranet. Should there be any discrepancy between this summary and the full Benefits Summary, please refer to the latter and the included carrier Summary of Benefits.

Benefits highlights:

Below is a summary of the benefits provided by MCAD. Please see the full Benefits Summary for more detailed information on each of the benefits:

- Health Insurance: Employer subsidized (rates on page 2)
- Dental Insurance: Employee elective (rates on page 2)
- Long-Term Disability : Employer paid
- Supplemental Short-Term Disability: Employee elective
- Supplemental Life Insurance: Employee elective
- Medical Flexible Spending Account (FSA)
- Dependent Care Account (DCS)
- Transit Benefits
    - Metro Pass Program
    - Pretax Parking Account
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- Retirement Benefits:
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    - Supplemental Retirement Account
- Paid Time Off Benefits
    - Vacation
    - Sick
    - Holiday
- Employee Assistance Plan (EAP)

Who to Call

In all cases, please start with contacting your Human Resources office.

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
1-800-486-7664 customerservice@ebsobenefits.com

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.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

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

*MCAD will notify you if you become eligible. Contact Patty Helin at 612-874-3504 or patty_helin@mcad.edu if you have questions.

ABOUT YOUR COVERAGE

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.

The following page is a brief outline of the medical benefit plans and the SBC's are included in the back of this booklet. Refer to your HealthPartners Group Certificate for more detailed information.

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 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 107.

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.

Major Medical Plan

HealthPartners Summary of Coverage 2019	$1000-75% Preferred	$1250-75% Non-Preferred
Deductible		
In-Network	$1,000 / $2,000	$1,250 / $2,500
Out-of-Network	$2,000 / $4,000	$2,000 / $4,000
Out-of-Pocket Maximum		
In-Network	$4,000 / $,8000	$4,000 / $8,000
Out-of-Network	$8,000 / $16,000	$8,000 / $16,000
Office Visit - Primary Care	25% coinsurance	25% coinsurance
Virtuwell	No charge for the 1st 3 visits, 25% coinsurance thereafter	No charge for the 1st 3 visits, 25% coinsurance thereafter
Convenience Care	25% coinsurance	25% coinsurance
Office Visit - Specialists	25% coinsurance	25% coinsurance
Preventive Screening	No charge	No charge
Diagnostic Test	25% coinsurance	25% coinsurance
Imaging	25% coinsurance	25% coinsurance
Prescriptions		
Retail 31 day supply (Generic/Formulary/Non-Formulary)	$12 / $45 / $90	$12 / $45 / $90
Mail 93 day supply (Generic/Formulary/Non-Formulary)	$24 / $90 / $180	$24 / $90 / $180
Specialty Drugs ($200 max copay/RX/Mo.)	20% coinsurance	20% coinsurance
Out-patient Services (Facility & Physician)	25% coinsurance	25% coinsurance
Emergency Room	25% coinsurance	25% coinsurance
Urgent Care	25% coinsurance	25% coinsurance
Ambulance	25% coinsurance	25% coinsurance
In-Patient Hospital Services (Facility & Physician)	25% coinsurance	25% coinsurance
Mental/Behavioral Health Inpatient Services	25% coinsurance	25% coinsurance
Mental/Behavioral Health Outpatient Services	25% coinsurance	25% coinsurance
Substance Abuse Inpatient Services	25% coinsurance	25% coinsurance
Substance Abuse Outpatient Services	25% coinsurance	25% coinsurance
Prenatal and Postnatal Care	No Charge	No Charge
Delivery and all inpatient services	25% coinsurance	25% coinsurance
Other Special Health Needs	25% coinsurance	25% coinsurance

Medical Plan Rates

Major Medical Plan				
	Total Cost Per Month	**MCAD's Contribution Per Month**	**Employee Cost Per Month**	**Employee Cost Per Pay Period***
Employee	$640.17	$540.43	$99.74	$49.87
Employee + 1	$1,280.35	$768.21	$512.14	$256.07
Family	$1,920.54	$1,143.68	$776.86	$388.43

Co-pay Plan

HealthPartners Summary of Coverage 2019	$1000-$40 Preferred	$1000-$60 Non-Preferred
Deductible		
In-Network	$1,000 / $2,000	$1,000 / $2,000
Out-of-Network	$2,000 / $4,000	$2,000 / $4,000
Out-of-Pocket Maximum		
In-Network	$4,250 / $8,500	$4,250 / $8,500
Out-of-Network	$8,000 / $16,000	$8,000 / $16,000
Office Visit - Primary Care	$40 copay	$60 copay
Virtuwell	No charge for the 1st 3 visits, $20 copay thereafter	No charge for the 1st 3 visits, $30 copay thereafter
Convenience Care	$20 copay	$30 copay
Office Visit - Specialists	$40 copay	$60 copay
Preventive Screening	No charge	No charge
Diagnostic Test	No charge	No charge
Imaging	25% coinsurance	25% coinsurance
Prescriptions		
Retail 31 day supply (Generic/Formulary/Non-Formulary)	$12 / $45 / $90	$12 / $45 / $90
Mail 93 day supply (Generic/Formulary/Non-Formulary)	$24 / $90 / $180	$24 / $90 / $180
Specialty Drugs ($200 max copay/RX/Mo.)	20% coinsurance	20% coinsurance
Out-patient Services (Facility & Physician)	25% coinsurance	25% coinsurance
Emergency Room	$100 copay	$100 copay
Urgent Care	$40 copay	$60 copay
Ambulance	25% coinsurance	25% coinsurance
In-Patient Hospital Services (Facility & Physician)	25% coinsurance	25% coinsurance
Mental/Behavioral Health Inpatient Services	25% coinsurance	25% coinsurance
Mental/Behavioral Health Outpatient Services	$40 copay	$60 copay
Substance Abuse Inpatient Services	25% coinsurance	25% coinsurance
Substance Abuse Outpatient Services	$40 copay	$60 copay
Prenatal and Postnatal Care	No Charge	No Charge
Delivery and all inpatient services	25% coinsurance	25% coinsurance
Other Special Health Needs	$40 copay unless otherwise noted	$60 copay unless otherwise noted

Medical Plan Rates

Co-Pay Plan				
	Total Cost Per Month	**MCAD's Contribution Per Month**	**Employee Cost Per Month**	**Employee Cost Per Pay Period***
Employee	$672.41	$509.41	$163.00	$81.50
Employee + 1	$1,344.83	$771.93	$572.90	$286.45
Family	$2,017.26	$1,150.85	$866.41	$433.21

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.

Plan Rules & Highlights

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.

First Year Dental Plan

Summary of Benefits		
	NETWORK	**NON-NETWORK**
CALENDAR YEAR DEDUCTIBLE • Per person • Maximum per family	 None None	 $50 $150
CALENDAR YEAR MAXIMUM (PER PERSON)	$1,500	
PREVENTIVE SERVICES • 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 ▲ 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 • 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%

Dental Plan Rates

	Your Cost Per Pay Period	**Your Cost Per Month**
Employee	$27.14	$54.28
Employee+1	$54.76	$109.52
Family	$81.69	$163.38

*24 pay periods per year

Second Year Dental Plan

Summary of Benefits		
	NETWORK	**NON-NETWORK**
CALENDAR YEAR DEDUCTIBLE • Per person • Maximum per family	 None None	 $50 $150
CALENDAR YEAR MAXIMUM (PER PERSON)	$1,500	
PREVENTIVE SERVICES • 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 ▲ 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 • 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 • Crowns (other than stainless steel) • Gold Fillings • Inlays & Onlays	60%	Deductible & 50%
PROSTHODONTICS • Partial or Complete Dentures • Removable or Fixed Bridgework • Implants including Bone Beam Image and Bone Grafts	60%	Deductible & 50%

Dental Plan Rates

	Your Cost Per Pay Period	**Your Cost Per Month**
Employee	$27.14	$54.28
Employee+1	$54.76	$109.52
Family	$81.69	$163.38

*24 pay periods per year

Life/AD&D Insurance

Plan Carrier: Guardian Life Insurance

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.

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.

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.

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.

Supplemental Life Insurance

Plan Carrier: Guardian Life Insurance

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 Option	
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.

Rates paid by Employee

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

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.

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.

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.

Age on Date Disability Starts	Maximum Payment Period
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.

Your Annual Election:
Flexible Spending Account (FSA) $2,700 (Monthly $225.00)
Dependent Care Account (DCA) $5,000 (Monthly $416.67)

What is a Flexible Benefits Plan?
Section 125 of the IRS code allows employees to convert taxable pay to tax free for qualified expenses.

The three components of a Flexible Benefits Plan:

1. **Pre-tax Premium Plan** The opportunity to have your contributions to medical, dental and some other benefits can be taken on a pre-tax basis.
2. **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.
3. **Medical/Dental Reimbursement Plan**. Also called a Flexible Spending Account (FSA). Employees 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.

Change of Eligibility for Qualifying Events

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.

"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.

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.**

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.

The debit card cannot distinguish service dates between the current and the next plan year. This means you are not able to use the debit card for expenses incurred in the 2018 plan year after January 1, 2019. After this date, you will need to submit a paper claim for 2018 reimbursement or file your claim online.

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.

Filing Claims

How Do I Access This Information?

Sign Up: You will need your date of birth, last name, Member ID# or Social Security Number and e-mail address to sign up. Go to www.ebsobenefits.com, click on MEMBERS and click on EBSO Member Login. If you have previously signed in, enter your username and password you have already created, then click Submit.

If you are a new user, you "Need a username and password", click on the link Register Account, which will take you to EBSO, Inc.'s License Agreement. You must click on "Agree" to proceed to sign up and log in. Please refer to your ID card. You will need your Member ID/SSN#, Member First Name, Member Last Name and Group Number. Phone number is optional.

Then click next and create your username and password. Also indicate a "hint" question and answer so that your password can be provided should you forget it in the future. Add link to your 'Favorites'.

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.

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 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 Do I 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.

Retirement Plan

Supplemental Tax-Deferred Annuity Plan

TIAA allows you to choose among multiple investment options. (Periodically, there may be additions and/or deletions to these investment options.) For current fund choices and information, go to www.tiaa.com.

EQUITIES FUNDS	**REAL ESTATE FUND**
FIXED INCOME FUND	**MONEY MARKET FUND**
GUARANTEED FUND	**MULTI-ASSET FUND**

TIAA 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.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. (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.org.

EQUITIES FUND	**REAL ESTATE FUND**
FIXED INCOME FUND	**MONEY MARKET FUND**
GUARANTEED FUND	**MULTI-ASSET 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.

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 $83 per month. Rates may change. MCAD will subsidize $35 a month of this cost; the cost to the employee is $48 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 $5.00 fee to replace the card for the first and 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.

Other Transportation/Parking Resources

MCAD offers additional transportation and parking resources.
Please review the intranet transportation website: Faculty and Staff Transportation Information for more information about:

- Van/Carpool
- Low Emitting Vehicle
- Electric Vehicle Parking

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 2019, 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.

Date MCAD will typically charge for parking:

- Spring Semester: January 1* – last day of classes in May
  *parking free for one week after classes begin in January
- Fall Semester: Tuesday after Labor Day – December 31

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, 2018. Contact the number below for further information on eligibility.

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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 12/31/2019)

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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 previous 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 Administrate 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 Autumn Amadou-Blegen at 612- 612.874.3798 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: Autumn Amadou-Blegen, 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, 2019 - December 31, 2019
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.

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage fox information on how to get a copy of your policy or plan document.)
- **Bold Blue** text indicates a term defined in this Glossary.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expenses," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing
When a **provider** bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's chare is $100 and the **allowed amount** is $70, the provider may bill you for the remaining $30. A **preferred provider** may ***not*** balance bill you for covered services.

Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service. You pay co-insurance ***plus*** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include, oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an **emergency medical condition**.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services
Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or **plan**.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium.**

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in that last stage of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider
A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

Out-of-Pocket Limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinate or helps a patient access a range of health care services.

Provider
A physician (M.D. – medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licenses, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, or prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.