



BENEFIT-ELIGIBLE EMPLOYEES
INFORMATION GUIDE

2013



Benefit Programs:

Medical Insurance

Dental Insurance

Vision Insurance

Flex Spending Account (Medical Care & Dependent Care Reimbursement)

Life Insurance

Long-term Disability Insurance

January 1, 2013 - December 31, 2013

Welcome

Welcome to Hamline University employee benefits program. We are very happy to provide you with a copy of the *2013 Information Guide*. Its purpose is to assist you in understanding and selecting the benefits that meet your individual needs.

We are pleased to offer a competitive and comprehensive benefits program for all eligible employees. Our program includes, medical, dental, vision, life, and long term disability insurance coverage, along with a retirement plan, flexible spending and Health Savings Account options, tuition waiver and employee assistance program. In addition to these options, Hamline provides traditional leave benefits (vacation, sick, holiday) to all eligible employees.

Coverage or participation is not automatic. You must complete the enrollment process. Health benefits are effective for the calendar year (January 1 – December 31). You have the opportunity to change your health benefit selections once per year during the Open Enrollment period or immediately during a life event (such as marriage, divorce, birth/adoption of a child). *If you are a union employee, you may have certain benefits that are part of your collective bargaining agreement. We encourage you to refer to your labor agreement for guidance.*

The Human Resources Department is available to assist you with any questions you may have. Please do not hesitate to contact us at 651-523-2815 or visit us in the lower level of Old Main, room 12.

You can also visit the Human Resources Department website at <http://www.hamline.edu/hr>

This is not a contract of employment, and nothing stated herein implies or guarantees any special term of employment or entitlement of benefits, and the material contained in this packet supersedes and replaces all prior Flexible Benefits Program informational materials issued. For specific details please consult the Summary Plan Description for each benefit.

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GENERAL INFORMATION

The Information Guide contains information that will be helpful in your benefit selection decisions. We encourage you to read the Guide carefully.

NEW EMPLOYEES OR THOSE NEWLY ELIGIBLE FOR BENEFITS

New employees **must** complete the benefits enrollment process within **30 days** of your benefits eligibility date. Please return the **Benefits Election/Waiver form**, the **HealthPartners enrollment form** (if enrolling for medical or dental coverage), the **Avesis enrollment form**, (if enrolling for vision), and **Lincoln Financial enrollment form** (life and disability enrollment). Return completed paper forms to the Human Resources office, mail stop C1904, or deliver to Old Main room 12.

BENEFIT ENROLLMENT FORMS

Enrollment forms can be found on the Benefits section of the Human Resources website at <http://www.hamline.edu/hr> . On the left navigation margin, click on **Benefits Forms** link.

BENEFIT CHOICE SELECTION COVERAGE

Your benefit selection choices are effective the first day of the month following (or concurrent with) your benefit eligibility date. Your choices are in place for the calendar year (January 1 – December 31). Changes are allowed only **once** per calendar year during the Open Enrollment period. However, if you experience a life event (marriage, divorce, birth or adoption of a child, or changes to your spouse's employment which affects health coverage), you may be able to change your benefit elections within 30 days of the event.

ANNUAL OPEN ENROLLMENT

Hamline uses an on-line process for its Annual Open Enrollment period (held in November). During the Open Enrollment period you will have the opportunity to make changes to current medical, dental, and vision plan choices for the next calendar year. Your changes will be made through the "Employee Services" section of Hamline's Pipeline system. Changes allowed during the Open Enrollment process include:

- Health (Medical, Dental, and Vision) plan choice change.
- Additions to or cancellation of coverage for yourself and family members.

If coverage is elected, medical, dental, and vision plan premiums are **automatically deducted** from your pay on a **pre-tax** basis, unless you inform Human Resources otherwise, and your current coverage (or waiver of coverage) will stay the same from one calendar year to the next, unless a change is made during the Annual Open Enrollment period.

The Annual Open Enrollment period is also your opportunity to enroll for the pre-tax flexible spending accounts for the next year.

Annual Open Enrollment (continued)

- Medical Reimbursement Account.
- Dependent Care Reimbursement Account.

The flexible spending accounts **require annual renewal**. A payroll deduction will **not** continue to the next calendar year, you must go through the open enrollment process and indicate a contribution/deduction amount.

The Annual Open Enrollment period is also your opportunity to enroll in or make changes to your MetLaw, legal plan for the next year.

ONLINE OPEN ENROLLMENT

Hamline uses an online open enrollment process. All open enrollment changes are processed online, through the “Employee Services” section of Hamline’s Pipeline system, between the dates designated as the open enrollment period. Any employee who doesn’t have access to a computer at Hamline should contact Human Resources for assistance.

During the online open enrollment, you may also need to complete a HealthPartners or Avesis form:

- If you are newly enrolling in either the medical or dental plan, complete the HealthPartners **Medical/Dental Enrollment Form**.
- If you are newly enrolling in the vision plan or if you are adding/dropping dependents, you will need to complete the **Avesis Enrollment Form**.
- If you’re already enrolled in Hamline’s plan, but want to make a change, such as changing from one medical plan to the other, canceling coverage, or adding/removing dependents from your current coverage, complete the HealthPartner’s **Change Form**.

ONLINE ACCESS TO BENEFITS INFORMATION

You can view your current benefit elections and payroll deductions online through **Pipeline**:

- Go to www.hamline.edu
- Click on Logins, then Pipeline Login
- Enter your ID and PIN; click on Login
- Click on “**Employee Services**”
- Click on “**Benefits & Deductions**” to view payroll deduction information for your benefits.
- During the dates designated as the open enrollment period, you can click on “**Open Enrollment**” under “Employee Services” to enroll in the flex spending program or make changes to your medical, dental, and vision plan for the next calendar year.

ABOUT HAMLIN'S BENEFIT PROGRAM

Hamline has a Flexible Benefits Program that allows you to tailor some of your benefits to suit your individual needs. Sometimes referred to as a "cafeteria plan" because it allows you to choose among more than one benefit, it also allows you to convert part of your current taxable pay into non-taxable benefits.

BENEFITS PROVIDED UNDER THE PLAN

The types of benefits available to you under the Plan are summarized and include:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Medical Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Health Savings Account (HSA)

ADDITIONAL INSURANCE BENEFITS

Insurance benefits available outside of the Flexible Benefits Program include:

- Life insurance
- Accidental death and dismemberment insurance (AD&D)
- Long-term disability insurance (LTD)

These benefits are not a part of the Flexible Benefits Program (i.e., cannot be paid for with pre-tax dollars). Summary information is provided at the end of this guide.

HOW A FLEXIBLE BENEFITS PROGRAM AFFECTS TAXES

The Flexible Benefits Program has been designed so that you may take advantage of tax laws. Your compensation is provided in the form of salary, which is taxable, and in the form of benefits, which may or may not be taxable. If you use some of your salary for benefit-related items such as child care, medical, dental, or vision expenses, including co-pays and deductibles, you may restructure your compensation package so that these items become part of your benefits which will not be taxed.

You should be aware that any health or dental expenses paid on a pre-tax basis **cannot** be deducted on your income tax return, because you have already saved by paying for them with pre-tax dollars. However, unless your health, dental, or vision expense exceeds 7.5% of your adjusted gross income, you are not permitted to take the deduction anyway.

The Social Security benefits which you receive upon retirement, or in the case of a disability, are based on your wages and the amount of Social Security taxes that have been paid on those wages. If you are participating in the Flexible Benefits Program, you are reducing your salary, thus paying less Social Security taxes. Consequently, you may experience a very slight reduction in Social Security benefits, if any, at

How A Flexible Benefits Program Affects Taxes (continued)

retirement or in the event of a disability. This reduction will depend on a number of factors such as your age, how close you are to retirement, the amount of the reduction, etc. You may want to confer with your financial advisor or with the Social Security Administration for further information regarding the program and impact to social security benefits.

CONDITIONS FOR PARTICIPATION

To participate in the Flexible Benefits Program **you must agree** to observe all plan rules and federal regulations for participation summarized at the end of this guide. For a more detailed description of the rules, a Summary Plan Description is also available.

MEDICAL PLANS

HEALTHPARTNERS MEDICAL PLANS

The HealthPartners Open Access Plans allow members to see any provider in the HealthPartners network. You do not need to specify a primary clinic choice when you join, and no referrals are required in the network.

HEALTHPARTNERS ONLINE RESOURCES

A listing of providers in the Open Access Network is available online at www.healthpartners.com. You can also get information by calling HealthPartners Member Services at (952) 883-5000 or 1-800-883-2177.

HealthPartners members will find many online tools and resources available at www.healthpartners.com. Refill prescriptions, view your benefits, compare cost and quality of providers, and view or print out your claims history.

In addition, you can find health improvement and wellness programs, such as weight control, stop smoking, disease management, stress management, and fitness programs. Also on line, members can find out how to receive discounts on health club memberships, exercise equipment and wellness services.

IN-NETWORK AND OUT-OF-NETWORK CARE

The health plans allow you to choose in-network or out-of-network care on a per-medical-incident basis for maximum flexibility in choosing the medical care that is best for you. However, when you choose a provider outside of the HealthPartners network, services will be covered at a lower level, or may not be covered at all; refer to the summary of coverage for in-network and out-of-network benefits. A listing of providers in the Open Access Network is available online at www.healthpartners.com.

NATIONAL PROVIDER NETWORK

Through an alliance with CIGNA HealthCare, HealthPartners members have access to a national network of doctors and hospitals at the same benefit level as other in-network providers. These providers are included in the listing of providers in the Open Access Network available online at www.healthpartners.com.

WELLNESS PROGRAM

Wellness programs are becoming a regular part of organizations' commitments to help employees achieve healthy lifestyles—they are here to stay. Currently the program consists of two components: an **on-line health assessment** and a **wellness program**. Hamline reserves the right to make changes to the wellness program at any time.

COORDINATING YOUR MEDICAL INSURANCE WITH THE FLEXIBLE SPENDING ACCOUNT OPTION

If you anticipate that you'll have certain out-of-pocket expenses under the medical plan (such as office co-pays, prescription co-pays, deductibles, eyeglasses and contact lenses, etc.), remember that you can use the Flexible Spending Account (described on page 22) to pay for these expenses on a pre-tax basis. Note: Expenses are limited to dental and vision if you have a Health Savings Account (HSA). Depending on your tax situation (the amount of your taxable income, the number of tax exemptions you can claim), you can **save approximately 25-40%** off the cost of your eligible expenses by paying for them with pre-tax dollars. The annual limit on contributions to the Flexible Spending Account is **\$2,500**.

The premium for your medical coverage is automatically deducted pre-tax from your paycheck, again saving you money on these costs.

SUMMARY OF BENEFITS AND COST OF COVERAGE

Refer to the following pages for a summary of benefits and costs offered under each medical plan. For exact terms and conditions of the plans, consult the HealthPartners Group Membership Contract, or call Member Services at (952) 883-5000. After you enroll in a plan, and at the start of each plan year, HealthPartners will send you a copy of the Group Membership Contract.

CHOOSING A MEDICAL PLAN

When choosing a medical plan, take into consideration:

- Your monthly premium.
- Your predictable medical expenses, or what types of medical services you are likely to use, and your share of the cost under the medical plan.
- The plan's **out-of-pocket maximum**, is the total amount you would have to pay in the calendar year. Expenses above the annual out-of-pocket maximum are covered 100% by the medical plan.

<p>Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families</p>

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid and CHIP
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414

OREGON – Medicaid and CHIP	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-877-314-5678	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

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

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

OMB Control Number 1210-0137 (expires 09/30/2013)

MEDICAL PLAN OPTIONS

Hamline offers three medical insurance plans through HealthPartners. All three plans offer in-network coverage using the **HealthPartners Open Access** network of providers, or out-of-network benefits if you wish to use a provider that is not within the HealthPartners system. Refer to the Summary of Coverage on the following pages for more information.

Employees have a choice in electing coverage as follows:

- Employee
- Employee + One
- Family

PLAN A: LOWER PREMIUM, HIGHER DEDUCTIBLE WITH HEALTH SAVINGS ACCOUNT (HSA)

Plan A is paired with a health savings account (HSA) through US Bank. The HSA can only be offered with a health plan that meets the Federal requirements of a qualified high-deductible medical plan. When you enroll in Plan A, you are responsible for **all** costs associated with non-preventive care up to the annual deductible amount, including prescription drug costs. The plan covers in-network preventive care at 100%, so these services are not subject to the deductible. After your costs reach the deductible amount, the plan pays for 100% of covered expenses for the remainder of the calendar year.

PLAN B: MODERATE PREMIUM, MODERATE DEDUCTIBLE

For in-network benefits, Plan B has a moderate deductible. Coverage after the deductible is at 75%. The plan covers in-network preventive care at 100%, so these services are not subject to the deductible. In addition, each family member may receive up to three free virtual visits, online with virtwuell, in addition to three (3) doctor's office or urgent care visits per year where the physician's services are covered at 100%. This does not include charges that may be associated with lab or other tests that may be ordered by your doctor during the three visits.

PLAN C: HIGH PREMIUM, LOWER DEDUCTIBLE

Hospital services are covered at 80% after an annual deductible. The plan covers in-network preventive care at 100%, so these services are not subject to the co-pay or the deductible. Office visits are subject to a co-pay.

2013 Summary of Medical Plans, HealthPartners

2013 Medical Plans Hamline University	Plan A Lower Premium / Health Savings Account		Plan B Moderate Premium / Moderate Deductible		Plan C High Premium / Lower Deductible	
<u>In-network Benefits</u> These benefits apply if you use HealthPartners providers, listed online at www.healthpartners.com . Choose the OPEN ACCESS network option.	<u>In-network Benefits</u>		<u>In-network Benefits</u>		<u>In-network Benefits</u>	
	JourneyWell Completed	Non-Journey Well	JourneyWell Completed	Non-Journey Well	JourneyWell Completed	Non-Journey Well
<u>Deductible – per calendar year</u>	\$2500 per person / \$5000 per family	\$2750 per person / \$5500 per family	\$750 per person / \$2250 per family	\$1000 per person / \$2750 per family	\$300 per person / \$600 per family	
<u>Out-of-pocket maximum</u> Coverage is 100% after your costs reach this annual maximum amount.	\$2500 per person / \$5000 per family	\$2750 per person / \$5500 per family	\$3250 per person / \$6000 per family	\$3250 per person / \$6000 per family	\$2000 per person / \$4000 per family	
<u>Preventive health care:</u> Routine care, physicals, eye exams, well child exams.	100% coverage		100% coverage		100% coverage	
<u>Office visits / illness or injury</u> Includes non-routine tests and services, urgent care, chiropractic, mental health, physical therapy.	100% coverage, after deductible		three free physician visits per person, per year, then 75% coverage, after deductible		\$35 co-pay	\$55 co-pay
<u>Hospital services</u> In-patient or out-patient services.	100% coverage, after deductible		75% coverage, after deductible		80% coverage, after deductible	
<u>Prescription drugs (formulary)</u> Drugs on the HealthPartners formulary.	100% coverage, after deductible		\$11 co-pay generic \$45 co-pay brand name Specialty Drugs: You pay 20% up to \$200 max per script		\$11 co-pay generic \$45 co-pay brand name Specialty Drugs: You pay 20% up to \$200 max per script	
<u>Emergency Care</u>	100% coverage, after deductible		75% coverage, after deductible		\$75 co-pay	
<u>Lifetime maximum benefit</u>	Unlimited		Unlimited		Unlimited	
<u>Out-of-network Benefits</u> These benefits apply when you use providers <u>not</u> listed as part of the HealthPartners network.	<u>Out-of-network Benefits</u>		<u>Out-of-network Benefits</u>		<u>Out-of-network Benefits</u>	
Preventive health care:	75% coverage, after deductible		50% coverage, after deductible		No coverage	
Office visits, hospital:	75% coverage, after deductible		50% coverage, after deductible		55% coverage, after deductible	
Deductible (calendar year):	\$4800 per person / \$9600 family		\$2500 per person / \$7000 family		\$500 per person / \$1000 family	
Out-of-pocket maximum (annual):	\$10,200 per person / \$19,400 family		\$6000 per person		\$3500 per person / \$5000 family	
Lifetime maximum benefit:	\$1,000,000		\$1,000,000		\$1,000,000	

2013 Medical Insurance Rates & Cost Sharing

MEDICAL PLANS	Plan A Lower Premium / Health Savings Account	Plan B Moderate Premium / Moderate Deductible	Plan C High Premium / Lower Deductible
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JourneyWell Completed Cost Sharing Model

FULL-TIME JourneyWell Participant Rates:	Employee		Employee+One		Family		Employee		Employee+One		Family		Employee		Employee+One		Family	
	Employee cost:	\$24.97	5%	\$393.33	35%	\$456.26	35%	\$27.17	5%	\$488.99	40%	\$567.23	40%	\$146.70	22%	\$780.15	52%	\$904.97
Hamline cost:	\$474.50	95%	\$730.46	65%	\$847.34	65%	\$516.16	95%	\$733.48	60%	\$850.84	60%	\$520.10	78%	\$720.13	48%	\$835.36	48%
Total monthly premium:	\$499.47		\$1,123.79		\$1,303.60		\$543.33		\$1,222.47		\$1,418.07		\$666.80		\$1,500.28		\$1,740.33	
PART-TIME JourneyWell Participant Rates:	Employee		Employee+One		Family		Employee		Employee+One		Family		Employee		Employee+One		Family	
	Employee cost:	\$224.76	45%	\$752.94	67%	\$847.34	65%	\$298.83	55%	\$855.73	70%	\$992.65	70%	\$466.76	70%	\$975.18	65%	\$1,305.25
Hamline cost:	\$274.71	55%	\$370.85	33%	\$456.26	35%	\$244.50	45%	\$366.74	30%	\$425.42	30%	\$200.04	30%	\$525.10	35%	\$435.08	25%
Total monthly premium:	\$499.47		\$1,123.79		\$1,303.60		\$543.33		\$1,222.47		\$1,418.07		\$666.80		\$1,500.28		\$1,740.33	

Non-JourneyWell Completed Cost Sharing Model

FULL-TIME Non-JourneyWell Participant Rates:	Employee		Employee+One		Family		Employee		Employee+One		Family		Employee		Employee+One		Family	
	Employee cost:	\$84.91	17%	\$427.04	38%	\$495.37	38%	\$92.37	17%	\$525.66	43%	\$609.77	43%	\$166.70	25%	\$825.15	55%	\$957.18
Hamline cost:	\$414.56	83%	\$696.75	62%	\$808.23	62%	\$450.96	83%	\$696.81	57%	\$808.30	57%	\$500.10	75%	\$675.13	45%	\$783.15	45%
Total monthly premium:	\$499.47		\$1,123.79		\$1,303.60		\$543.33		\$1,222.47		\$1,418.07		\$666.80		\$1,500.28		\$1,740.33	
PART-TIME Non-JourneyWell Participant Rates:	Employee		Employee+One		Family		Employee		Employee+One		Family		Employee		Employee+One		Family	
	Employee cost:	\$239.75	48%	\$786.65	70%	\$886.45	68%	\$315.13	58%	\$892.40	73%	\$1,035.19	73%	\$486.76	73%	\$1,020.19	68%	\$1,357.46
Hamline cost:	\$259.72	52%	\$337.14	30%	\$417.15	32%	\$228.20	42%	\$330.07	27%	\$382.88	27%	\$180.04	27%	\$480.09	32%	\$382.87	22%
Total monthly premium:	\$499.47		\$1,123.79		\$1,303.60		\$543.33		\$1,222.47		\$1,418.07		\$666.80		\$1,500.28		\$1,740.33	

HOW THE HEALTH SAVINGS ACCOUNT WORKS (HSA)

Enrollment in Medical Plan A qualifies you to enroll in a Health Savings Account, commonly referred to as an “HSA”. You can make tax-free contributions to the HSA, similar to an individual retirement account, except that the balance can be withdrawn tax-free to pay for eligible current and future health care expenses. Unused funds roll over from year to year (there is no “use-it-or-lose-it” provision) and the account balance remains with you if you leave the organization or retire.

You’re eligible to contribute money to an HSA if you meet all of the following requirements:

- You’ve selected Plan A as your medical insurance plan option, and, you’re not covered by any other health plan that does not meet the federal requirements of an HSA medical plan option.
- You’re not currently enrolled in Medicare or TRICARE.
- You have not received medical benefits through the Department of Veterans Affairs during the preceding three months.
- You cannot be claimed as a dependent on someone else’s tax return.

You can use your HSA money to:

- Pay for qualified medical, dental, vision and certain over-the-counter drug expenses, as defined in IRS Section 502 (available online at www.irs.gov/pub/irs-pdf/p502.pdf).
- Pay for COBRA, Medicare or long-term care insurance premiums, as well as for medical premiums during periods of unemployment.
- Supplement your income, but money withdrawn and used towards something other than a qualified medical expense is taxable and, if you’re under age 65, subject to a 20% penalty.
- Build a nest egg by saving your HSA dollars for the future. Your HSA balance rolls over from year to year, and can be invested so that it will grow over time, giving you more dollars to spend on future health care expenses.

CONTRIBUTIONS

You can contribute to an HSA pre-tax through payroll deduction. Your maximum HSA contribution depends on the level of medical coverage you elect. For 2013 the maximum is \$3,250 for Employee coverage and \$6,450 for family coverage. If you’re age 55 or older in 2013 you may make an additional “catch-up” contribution of \$1000.

HOW THE HEALTH SAVINGS ACCOUNT (HSA) WORKS (continued)

You can change your HSA contribution amount during the year-HSA contributions are **not** subject to the same “Change in Family Status” rules as the flex spending account, on a monthly basis. Complete a new Benefit Election/Waiver form and return to the Human Resources department.

YOUR RESPONSIBILITIES

As the HSA accountholder, you are responsible for ensuring that distributions are used for qualified medical expenses. Records of medical expenses should be maintained as evidence that distributions have been made for these purposes. **Qualified medical expenses may only be reimbursed, tax-free, if the expenses are incurred after the date your HSA account was established.**

You’re also responsible for ensuring that your annual HSA contributions do not exceed IRS limits.

TAX REPORTING

Tax reporting is required for the HSA. IRS form 8889 **must** be completed with your tax return each year to report total deposits and withdrawals from your account (you do not have to itemize to complete this form).

COORDINATING WITH THE FLEX SPENDING ACCOUNT

Be aware that your use of the flex spending account option will be **limited** to dental and vision expenses. Although you can submit vision and dental expenses to your HSA for reimbursement, you may choose to maximize your tax benefits by using the flex account for vision and dental. Spouses covered under Hamline’s Plan A medical plan option, would **not** be eligible to enroll in their employer’s medical flex spending account while covered by Hamline’s plan, unless their employer offers a “limited use flex plan” for dental and vision only.

DOMESTIC PARTNER COVERAGE

If you cover a domestic partner under the Plan A medical plan option, remember that the HSA (a separate entity from the medical plan) is a tax advantaged account. This means that under federal rules it can only be used for family members who are tax dependents, or a spouse. Partners are eligible to open their own, separate HSA account at the financial institution of their choice, and fund it to the maximum allowed, which is driven by the level of coverage.

US BANK – ACCOUNT ADMINISTRATION

Hamline has chosen US Bank to handle its HSA administration services. After you elect to contribute to the HSA, an account will be opened for you, and contributions made through payroll deduction. Contributions will be deposited to your account at the end of each month. US Bank will send you a **Welcome Kit** that contains complete information about how to activate and use your HSA. To activate the account, you’ll need to sign an account agreement, either electronically or by returning a paper form to US Bank.

Account services include:

- Use of debit card to pay for qualified medical expenses, where the money comes directly out of your account when used; second card available for no additional fee;
- Online access to view balance, transaction history and other account details;

HOW THE HEALTH SAVINGS ACCOUNT (HSA) WORKS (continued)

- Electronic monthly statements (paper statements available for a fee);
- Year-end tax reporting information mailed to your home;
- Customer Service support available Monday through Friday, 8am to 7pm Central Time. Contact the Health Savings Solution Center at (877) 470-1771.

If your average monthly balance is less than \$2500, a **monthly maintenance fee of \$3.25** will be charged to your account. Other fees may apply, such as overdraft or account termination fees. The balance of your HSA will initially be invested in an FDIC-insured, interest bearing deposit account with US Bank.

When your account balance exceeds \$2500, you will also have the option to invest dollars over that amount into the mutual fund options, with no additional fee.

DENTAL INSURANCE COVERAGE

Hamline offers dental insurance through HealthPartners. You may choose in-network coverage using the HealthPartners Open Access Dental Network, or out-of-network coverage (using a dentist of your choice).

New Enrollees: On the Benefits Election/Waiver form, indicate your choice of either Employee or family coverage, and complete a HealthPartners Enrollment Form.

Changes to Coverage: If you are currently enrolled in the Hamline dental plan, and want to cancel coverage or add/remove family members, please complete a HealthPartners Change Form. The annual open enrollment period is an opportunity for you to make changes to your coverage. During the plan year you can only make changes in the event of a Change in Family Status (see Rules for Participation).

Forms: All forms are available on the Human Resources benefits web page of Hamline's web site, at www.hamline.edu/hr. Or, contact the HR office at 651-523-2210.

WAIVING DENTAL COVERAGE: If you choose to waive dental coverage, simply indicate this on the Election/Waiver form. If you choose to waive coverage through Hamline's dental plans, you will not be able to enroll until the next open enrollment, unless you experience a Change in Family Status during the Plan Year (see Rules for Participation).

COORDINATING YOUR DENTAL INSURANCE WITH THE FLEXIBLE SPENDING ACCOUNT OPTION

If you anticipate that you'll have certain out-of-pocket expenses under the dental plan (such as co-pays, deductibles, etc.), remember that you can use the Flexible Spending Account (described on page 20) to pay for these expenses on a pre-tax basis. Depending on your tax situation (the amount of your taxable income, the number of tax exemptions you can claim), you can **save approximately 25-40%** off the cost of your eligible expenses by paying for them with pre-tax dollars. The annual limit on contributions to the Flexible Spending Account is **\$2,500**.

The premium for your dental coverage is automatically deducted pre-tax from your paycheck, again saving you money on these costs.

SUMMARY OF BENEFITS AND COST OF COVERAGE

Refer to the following pages for a summary of benefits offered under each plan and the cost. For exact terms and conditions of the plans, consult the HealthPartners Group Membership Contract, or call Member Services at (952) 883-5000.

2013 Hamline University Summary of Dental Plan HealthPartners Open Access Network (PX184)	In-Network Coverage Using HealthPartners Open Access Network	Out-of-Network Coverage
<p><u>Diagnostic & Preventive Services:</u> Teeth cleaning & exams (twice each calendar year), x-rays, sealants, fluoride treatments</p> <p><u>Fillings:</u> Amalgam & anterior composite</p> <p><u>Endodontics:</u> Root canal therapy</p> <p><u>Periodontics:</u> Gum disease</p> <p><u>Oral Surgery:</u></p> <p><u>Major Restorative:</u> Crowns / prosthetics</p> <p><u>Orthodontics:</u> Dependent children under age 19</p> <p><u>Calendar Year Deductible:</u></p> <p><u>Calendar Year Maximum Benefit:</u></p>	<p>100%</p> <p>80%</p> <p>50%</p> <p>50%</p> <p>50%</p> <p>50%</p> <p>50%, to a lifetime maximum of \$750</p> <p>None</p> <p>\$2000</p>	<p>100%</p> <p>80%</p> <p>50%</p> <p>50%</p> <p>50%</p> <p>50%, to a lifetime maximum of \$750</p> <p>\$50 per person / \$150 per family (waived for diagnostic & preventive)</p> <p>\$1000</p>
<p>Choose In-Network or Out-of-Network Coverage:</p> <p>To receive benefits at the in-network level, use any of the providers in the HealthPartners Open Access network, listed on the HealthPartners web site at www.healthpartners.com. The Open Access network provides members with access to 80% of all Twin Cities metro area dentists and 60% of all dentists statewide. If you go to a provider who is not in the Open Access network, you'll receive benefits at the out-of-network level.</p> <p>This is a benefit summary sheet only. For exact coverage terms and conditions, consult your group dental membership contract, or call HealthPartners Member Services, (952) 883-5000.</p>		
<p>2013 DENTAL RATES and Cost Sharing: Cost to full-time and part-time employees:</p>	<p>Employee</p>	<p>Family</p>
<p>MONTHLY – Employee pays:</p>	<p>\$19.93</p>	<p>\$51.89</p>
<p>Hamline pays:</p>	<p>\$19.94</p>	<p>\$51.89</p>
<p>Total monthly premium:</p>	<p>\$39.87</p>	<p>\$103.78</p>
<p>% Employee pays:</p>	<p>50%</p>	<p>50%</p>
<p>% Hamline pays:</p>	<p>50%</p>	<p>50%</p>

VISION INSURANCE COVERAGE

Hamline offers a comprehensive vision plan through Avesis. You may choose in-network coverage using a participating provider in the Avesis network, or out-of-network coverage (using a provider of your choice).

New Enrollees: On the Benefits Election/Waiver form, indicate your choice of employee only, employee+spouse, employee+ child(ren) or employee+ family coverage, and complete an Avesis Enrollment Form.

Forms: All forms are available on the Human Resources benefits web page of Hamline's web site, at www.hamline.edu/hr. Or, contact the HR office.

WAIVING VISION COVERAGE: If you choose to waive vision coverage, simply indicate this on the Election/Waiver form. If you choose to waive coverage, you will not be able to enroll until the next open enrollment, unless you experience a Change in Family Status during the Plan Year (see Rules for Participation).

COORDINATING YOUR VISION INSURANCE WITH THE FLEXIBLE SPENDING ACCOUNT OPTION

If you anticipate that you'll have certain out-of-pocket expenses under the vision plan (such as co-pays, deductibles, etc.), remember that you can use the Flexible Spending Account (described on page 20) to pay for these expenses on a pre-tax basis. Depending on your tax situation (the amount of your taxable income, the number of tax exemptions you can claim), you can **save approximately 25-40%** off the cost of your eligible expenses by paying for them with pre-tax dollars. The annual limit on contributions to the Flexible Spending Account is **\$2,500**.

The premium for your vision coverage is automatically deducted pre-tax from your paycheck, again saving you money on these costs.

SUMMARY OF BENEFITS AND COST OF COVERAGE

Refer to the following pages for a summary of benefits offered under the plan and the cost. For exact terms and conditions of the plans, consult the vision plan document, or call Member Services at (800) 828-9341.

IN-STORE DISCOUNTS

Sometimes "in-store" promotions are better than the insurance. This is something that is not in control of Hamline or the vision plan provider. Additionally, the providers may not allow individuals to get the store discounts and use their insurance at the same time; however, this is not an Avesis or Hamline rule. If you take advantage of the in-store discount, you will be able to get reimbursed through the insurance for a portion of your purchase by filing an out-of-network claim with Avesis. If you have any questions contact the Human Resources Office at 651-523-2815.

VISION COVERAGE (Continued)

VISION PLAN ID CARD

You will not receive an ID card from Avesis in the mail. However, you can print an ID card from the Avesis website at www.avesis.com. If you have questions contact the Human Resources Office at 651-523-2210.

(50790-1567)	AVESIS NETWORK In Network	Out-of-Network Reimbursement		
Co-Pay(Materials)	\$10			
<u>Spectacle Lenses</u>	100% after co-pay	\$25.00		
Standard Employee Vision	100% after co-pay	\$40.00		
Standard Bifocal	100% after co-pay	\$50.00		
Standard Trifocal	100% after co-pay	\$80.00		
Standard Lenticular	100% after co-pay			
<u>Frames</u>	\$100.00 - \$150.00 retail value	\$45.00		
<u>Contact Lenses</u>				
Elective (up to plan allowance)	\$130.00	\$130.00		
Medically Necessary	100%	\$250.00		
<u>LASIK SURGERY</u>	\$150 one time allowance + discount at participating provider	\$150 one time allowance		
<u>Benefit Frequency</u>				
Spectacle Lenses	Every 12 Months			
Frames	Every 24 Months			
Contact Lens Allowance	Every 12 Months			
Vision Plan– Full & Part-time employees	Employee Only	Employee + Spouse	Employee + Child (ren)	Employee+ Family
MONTHLY – Employee pays (100%):	\$5.62	\$10.63	\$11.58	\$14.90

MEDICAL CARE FLEXIBLE SPENDING ACCOUNT

Hamline offers a Medical Care Flexible Spending Account, also referred to as a FSA, through Eide Bailly. A Flexible Spending Account is a benefit that helps pay for a variety of medical expenses if they're not covered by your medical, dental, or vision insurance plans. When you use this benefit, these non-covered expenses are paid with pre-tax dollars.

For example, you may use your flex dollars to pay for eyeglasses and contact lenses, dental or medical insurance deductibles, office visit co-payments, prescription co-payments, the cost of some nonprescription drugs, orthodontia payments, hearing aids, etc. **Eligible expenses can be incurred by you, your spouse or your dependents.**

All medical, dental, and vision expenses which qualify as medical deductions under IRS rules (other than health insurance premiums and nonprescription drugs) will qualify for tax-free reimbursement under this plan. Examples are listed on the following pages (or refer to IRS publication 502).

The annual **limit on contributions** to the Flexible Spending Account is **\$2,500**.

According to federal regulations, your decision to participate in the plan and the amount of your contribution must be elected prior to the beginning of the Plan Year for which they are effective (when you're first eligible for the plan, or during each annual open enrollment period). Generally, plan participants cannot change or revoke their election of benefits during the Plan Year (January 1 through December 31), except in the event of a family status change. If you choose not to participate during this Plan Year, you must wait until the next Plan Year for another opportunity to participate, unless you have a change in family status. For more information, please refer to Rules for Participation (page 28).

FORFEITURE OF CONTRIBUTIONS

At the time you enroll, you must carefully determine the amount of your anticipated expenses for the benefit period. This money is not transferable to another expense account, **nor can it be returned to you in the event that you have overestimated your expenses.**

HOW YOUR MEDICAL, DENTAL, AND VISION EXPENSES ARE PAID OR REIMBURSED

Eide Bailly One Card You will receive a debit card in the mail from Eide Bailly, this is called the Eide Bailly One Card. It is a debit MasterCard that has been pre-loaded with your annual Health Care Flexible Spending Account (FSA) or Limited Purpose Spending Account. This provides the ease and convenience of not having to pay expenses out of pocket and seek reimbursement manually by submitting a claim form. You present the card as your method of payment to your provider or retailer, and the cost of the product or service is deducted from the balance of your pre-tax account. If asked whether to process your transaction as a debit or credit, respond "credit."

Eide Bailly Medical/ Dental/ Vision Expense Reimbursement. You can also submit for reimbursement for out-of-pocket medical, dental, and vision expenses incurred periodically throughout the plan year if you prefer. You must submit a claim for reimbursement, accompanied by documentation that clearly identifies the nature of the expense, the date the expense was incurred, the provider, and the eligible amount.

HOW YOUR EXPENSES ARE REIMBURSED – Continued

Claim forms are available from Hamline's Human Resources department or on the Hamline Benefits web page. You can mail or fax your claim form and supporting documentation to or submit your claim electronically online with Eide Bailly. Participants in the plan are able to access their account balance and other information using a secure UserName and PIN at www.eidebaillybenefits.com.

Reimbursements are available by check or direct deposit. The debit card (called the Eide Bailly One Card) is a MasterCard that has been pre-loaded with your annual Health Care Flexible Spending Account. This provides employees with the ease and convenience of not having to pay expenses out of pocket and seek reimbursement manually by submitting a claim form.

If you have any questions about your flex account, or you want to check on a claim or your account balance, please call Eide Bailly:

Flex account questions: (phone) (612) 253-6633
(email) benefits@eidebailly.com
Submit Claims: (fax) (612) 253-6622
(website) www.eidebaillybenefits.com
(email) benefits@eidebailly.com

CLAIM DEADLINES

You may not carry over unused elective contributions or benefits from one benefit plan year to the next. **Reimbursable expenses must be incurred during the benefit plan year (January 1 through December 31)**, or your period of coverage under the program if you are not a participant for the entire plan year (as with employees who are newly hired or terminated during the year). **You may submit claims for these expenses up to the last business day in March of the following calendar year.** Balances remaining after the claim deadline will be forfeited.

Expenses will be treated as having been incurred when the care was given, and **not** at the time of the formal billing or charge, or when payment was rendered for the services. You will be reimbursed up to your annual election amount.

TERMINATION OF EMPLOYMENT

If you terminate employment with Hamline, you may spend down the balance of your medical flex spending account by submitting claims for eligible expenses, through the claim deadline date. Eligible expenses must be incurred while you are a participant in the plan. Your participation as an employee ends the last day of the month in which your employment terminates. If you wish to continue your participation in the plan beyond this date, you have the option of electing COBRA and continuing your participation on a monthly basis by paying the monthly premium on an after-tax basis.

Medical Care Flexible Spending Account

Examples of Eligible Expenses:

- Acupuncture
- Alcoholism treatment
- Ambulance service
- Artificial limb\Prosthesis
- Artificial teeth
- Birth control pills prescribed by a doctor
- Braille books and magazines
- Capital expenses essential to medical care
- Chiropractors
- Christian Science practitioners
- Contact lenses and cleaning supplies
- Cosmetic surgery to improve a congenital abnormality,
- personal injury from an accident, or a disfiguring disease
- Crutches
- Dental Treatment
- Drug addiction treatment
- Eyeglasses
- Guide dog \ animal and care expenses
- Health institute treatment for mental/ physical defect or illness
- Hearing aids and batteries
- Hospital services; lodging/meals provided by a hospital during treatment
- Laboratory fees
- Lead-based paint removal (when children are present)
- Legal abortion
- Legal fees authorizing mental treatment
- Medical services
- Medicines prescribed by a doctor
- Mentally retarded, special home for
- Nursing home; lifetime care
- Nursing services; wages; Social Security tax
- Operations, surgeries, transplants
- Optometrist
- Organ donation fees
- Osteopath
- Oxygen equipment
- Psychiatric care / psychoanalysis
- Reproductive sterilization
- Telephone / television for hearing impaired
- Therapy, includes APatterning exercises for mentally retarded
- Transportation essential to medical care
- Tuition for Mentally or physically disabled at a special school
- Wheelchair/autoette and upkeep expenses
- X-ray fees

Examples of Non-eligible Expenses:

- Babysitting / Nursing care for a healthy baby
- Diaper service
- Funeral, burial or cremation expenses
- Health club dues
- Household help; non-nursing aid
- Illegal operations and treatments
- Life insurance or income protection policies, or policies providing payment for loss of life, limb, sight, etc.
- Maternity clothes
- Medical, dental and hospital insurance premiums
- Medical insurance included in a car insurance policy covering all persons injured in or by your car
- Personal use items; toothpaste, toiletries, etc.
- Social activities, such as dancing or swimming lessons
- Stop smoking programs
- Surgery purely for cosmetic reasons
- Trips / vacations
- Weight loss programs

Over-the-Counter (OTC) Medicines FSAs, HSAs, HRAs & Health Care Reform

Important information for people enrolled in a Flexible Spending Account (FSA), Health Savings Account (HSA), and/or Health Reimbursement Arrangement (HRA)

Health care reform legislation passed by Congress and signed by the president in March 2010 changed the rules for health care flexible spending accounts (FSAs), health savings accounts (HSAs), and health reimbursement arrangements (HRAs). Starting January 1, 2012, you can no longer use a health care FSA, HSA or HRA to pay or be reimbursed for over-the-counter (OTC) drugs or medicines without a prescription.

Many OTC supplies such as bandages, will still be eligible for purchase or reimbursement without a prescription.

Examples of OTC items that **will require a prescription** for purchase or reimbursement:

- Acid controllers
- Acne medicine
- Aids for indigestion
- Allergy and sinus medicine
- Anti-diarrhea medicine
- Baby rash ointment
- Cold and flu medicine
- Eye drops
- Feminine anti-fungal or anti-itch products
- Hemorrhoid treatment
- Laxatives or stool softeners
- Lice treatments
- Motion sickness medicines
- Nasal sprays or drops
- Ointments for cuts, burns or rashes
- Pain relievers, such as aspirin or ibuprofen
- Sleep aids
- Stomach remedies

Examples of OTC items that may continue to be purchased with or reimbursed for purchase **without a prescription**:

- Bandages
- Birth control
- Braces and supports
- Catheters
- Contact lens solution and supplies
- Crutches
- Denture cleaners and adhesives
- Diagnostic tests and monitors such as blood glucose monitors
- Elastic bandages and wraps
- First-aid supplies
- Insulin
- Ostomy products
- Reading glasses
- Walkers, wheelchairs and canes

Over-the-Counter (OTC) Medicines (Continued)

For more information

- The Internal Revenue Service (IRS) publishes information about flexible spending accounts. Go to www.irs.gov for additional information.

- Most major grocery, department, retail and drug stores will be able to identify at the cash register what OTC medical supplies may still be purchased with an FSA debit card starting in 2012.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Hamline offers a Dependent Care Flexible Spending Account, through Eide Bailly.

RULES FOR QUALIFYING EXPENSES

Generally, in order for dependent care expenses to be reimbursable, they must be for the care of a qualifying individual as defined below, and only if their primary purpose is to assure the individual's well-being and protection.

Amounts paid to provide food, clothing, or education are not considered as reimbursable expenses for the care of an individual, although they are qualifying expenses if they are incidental to and inseparably a part of that care. Additionally, the cost of school for a child in the first grade or any higher grade will not be considered as a reimbursable expense under this program, nor are expenses for transportation between the home and the place where dependent care services are provided.

Accordingly, the Dependent Care Reimbursement Account allows you to pay expenses for qualified day care for your dependents, if the above and following conditions are met.

1. The day care expenses must be work-related.
2. The day care services must be for the dependents' well-being and protection.
3. Children must be under 13 years old or, if older, mentally or physically incapable of caring for themselves. The expenses must be incurred for either --
 - (a) a dependent under age 13 who is claimed by the employee as an exemption on federal and state tax returns, or
 - (b) a spouse or other dependent of the employee who is physically or mentally incapable of caring for herself or himself, or her or his nutritional or hygienic needs, or requires full-time attention of another person for her or his own safety or the safety of others.
4. You may not claim day care expenses if the services are provided by a **dependent** living in your home.
5. If child care is provided at a day care center and the center cares for six or more children, the facility must be licensed by the state and city where it is located.
6. You may use the dependent care plan to pay for expenses for the care of a mentally or physically incapacitated dependent or spouse, if such care is necessary to enable you to work.
7. The maximum benefit paid from your dependent care expense account during any calendar year shall not exceed **\$5,000** (\$2,500 in the case of filing a separate return by a married individual).
8. Dependent care expense reimbursements cannot exceed your earned income for the year or, if you are married on December 31, your spouse's earned income for the year.
9. Special rules apply in the case of divorced parents. If you are divorced, contact the plan administrator.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (continued)

SUMMER CAMP EXPENSES

The expenses associated with summer camp may be reimbursable under the Dependent Care Program **if the primary purpose of the summer camp is to provide for the dependent's well-being and protection.**

On the other hand, if the primary purpose of the camp is educationally focused, and not "care and protection" focused, the expenses are not reimbursable. **Generally, the cost of overnight camp cannot qualify as a dependent care expense.**

If you are considering summer camp for your dependent as an appropriate expense under the dependent care program, you are strongly encouraged to consult directly with the plan administrator for a ruling prior to making that decision.

According to federal regulations, your decision to participate in the plan and the amount of your contribution must be elected prior to the beginning of the Plan Year for which they are effective. Generally, plan participants cannot change or revoke their election of benefits during the Plan Year (January 1 through December 31), except in the event of a family status change. If you choose not to participate during this Plan Year, you must wait until the next Plan Year for another opportunity to participate, unless you have a change in family status. For more information, please refer to the section of this booklet regarding Rules for Participation.

FORFEITURE OF CONTRIBUTIONS

When you enroll in the dependent care plan, you must carefully determine the monthly reimbursement amount. Funds allocated for dependent care can be reimbursed for this expense only. This money is not transferable to another expense account, **nor can it be returned to you in the event that you have overestimated your dependent care expense.** Therefore, take holidays and vacation into consideration when determining your monthly expenses.

HOW YOUR DEPENDENT CARE EXPENSES ARE REIMBURSED

When dependent care expenses are incurred, you must submit a claim for reimbursement, and provide proof of the expense. You must sign the form, to verify that the submitted claim expenses are, to the best of your knowledge, properly payable under Hamline University's Flexible Benefits Program, and have not been, or will not be claimed as a deduction or credit for income tax purposes, or reimbursed by any person or entity other than under the University's program.

The claim form can serve as a receipt of payment for your dependent care expenses if you have your provider sign the Provider Certification section of the form to certify that the services were provided, or you can attach a third-party receipt or billing statement as proof of the expense (**canceled checks are not acceptable**). The form requires that you provide the federal tax identification number of each provider.

Claim forms are available from Hamline's Human Resources department or on the Hamline Benefits web page. You can mail or fax your claim form and supporting documentation to or submit your claim electronically online with Eide Bailly. Participants in the plan are able to access their account balance and other information using a secure Username and PIN at www.eidebaillybenefits.com.

HOW YOUR DEPENDENT CARE EXPENSES ARE REIMBURSED (continued)

Reimbursements are available by check or direct deposit.

If you have any questions about your flex account, or you want to check on a claim or your account balance, please call Eide Bailly:

Flex account questions: (phone) (612) 253-6633
(email) benefits@eidebailly.com
Submit Claims: (fax) (612) 253-6622
(website) www.eidebaillybenefits.com
(email) benefits@eidebailly.com

CLAIM DEADLINES

You may not carry over unused elective contributions or benefits from one benefit plan year to the next. **Reimbursable expenses must be incurred during the benefit plan year (January 1 through December 31), or your period of coverage under the program, if you became a participant in the plan after the start of the plan year. You may submit claims for these expenses up to the last business day in March of the following calendar year.** Balances remaining after the claim deadline will be forfeited.

Expenses will be treated as having been incurred when the care was given, and **not** at the time of the formal billing or charge, or when payment was rendered for the services.

The dollars you allocate to your Dependent Care Expense Account are contributed to your account each pay period during the plan year. If your claim exceeds the amount accumulated to date, you will receive only the amount in your account.

Dependent care expenses paid on this pre-tax basis are not eligible for the dependent care credit on your taxes, and reduce the amount of expenses that can be claimed for the dependent care credit dollar for dollar.

TERMINATION OF EMPLOYMENT

If you terminate employment with Hamline, you may spend down the balance of your dependent care account by submitting claims for eligible expenses, through the claim deadline date. No further contributions can be made to the dependent care plan after you terminate employment. Plan year expenses incurred after you terminate employment with Hamline cannot be reimbursed from your account.

RULES FOR PARTICIPATING IN THE HAMLINE FLEXIBLE BENEFITS PROGRAM

CONDITIONS OF PARTICIPATION

As a condition of participation, you must agree to abide by all of the terms and conditions of the Flexible Benefits Program, and furnish to the Human Resources department at the times specified, enrollment forms and other pertinent information as the department may require, including, but not limited to, the Hamline University Benefits Election/Waiver Form.

A newly eligible employee may elect to become a participant in the Plan on the first day they are eligible to participate, and must enroll within 30 days of their eligibility date. Thereafter, eligible employees may become a participant on the first day of a Plan Year (January 1), unless there is a relevant Change in Family Status during the year, as defined under the section entitled **Changes to Your Election** (below).

THE PLAN YEAR AND YOUR BENEFIT PERIOD

Your benefit period, or period of coverage, is generally the same as the Plan Year (January 1 through December 31). However, if you become a participant after the Plan Year has started (as with a new employee), your period of coverage consists of your first day of participation, through the remainder of the Plan Year. Also, if you stop paying for these benefits, your period of coverage will end early. For example, if you terminate employment, or become ineligible due to a decrease in your work hours, your period of coverage will end as of the last day for which you pay for coverage (including any months paid for as continuation coverage).

The Flexible Spending Account and Dependent Care Reimbursement Account may only be used to provide reimbursement for eligible expenses incurred during your period of coverage.

CHANGES TO YOUR ELECTION

According to federal regulations, your decision to participate in the plan and the amount of your contribution must be elected prior to the beginning of the Plan Year (or your benefit period, if less than the whole Plan Year) for which they are effective. After the start of the Plan Year, an election may not be altered or changed. Federal regulations strictly forbid election changes to increase or decrease the level of coverage or premium costs during the benefit period, **except for the following circumstances**.

RULES FOR PARTICIPATING IN THE FLEXIBLE BENEFITS PROGRAM

1. If there is a relevant **Change in Family Status** of the benefits-eligible employee, such as:
 - your marriage, separation, or divorce;
 - the birth or adoption of a child;
 - a change in the age of a child which affects eligibility for a plan; a change in dependency of a child;

RULES FOR PARTICIPATING IN THE FLEXIBLE BENEFITS PROGRAM

(continued)

- change in employment status of you or your spouse;
- taking an unpaid leave of absence by you or your spouse;
- death of your spouse or dependent;
- significant change in health coverage of you or your spouse, due to your spouse's employment.

Any such change to your election must be made prior to or within thirty (30) days after the effective date of the Change in Family Status. Mid-year election changes must be consistent with the Change in Family Status (for example, you may increase your flex account contribution as a result of the birth of a child).

2. If the coverage provided by HealthPartners to Hamline University and its employees is significantly curtailed or ceases during a period of coverage, you will be permitted to revoke your election, and, in lieu thereof, to receive similar coverage under another plan. If the cost of medical and/or dental care provided by HealthPartners to Hamline University and its employees increases or decreases during the plan year, the plan may, on a reasonable and consistent basis, automatically increase or decrease such payments as may be warranted.

3. If the coverage provided by Avesis to Hamline University and its employees is significantly curtailed or ceases during a period of coverage, you will be permitted to revoke your election, and, in lieu thereof, to receive similar coverage under another plan. If the cost of vision care provided by Avesis to Hamline University and its employees increases or decreases during the plan year, the plan may, on a reasonable and consistent basis, automatically increase or decrease such payments as may be warranted.

REVOCACTION OF YOUR ELECTION AT THE END OF THE BENEFIT PERIOD

Your election will be deemed to be revoked on the last day of the Benefits Program benefit period for which it was made. You may make a new election during the open enrollment period for the next Plan Year.

FORFEITURES

Federal tax laws require that your medical care reimbursement and dependent care reimbursement benefits for each Plan Year operate on a "use it or lose it" basis. For this reason, if you do not use the entire amount available for reimbursement benefits for the Plan Year, **you will forfeit the unused amount**, and will have no further claim to it.

Reimbursable expenses must be incurred during the benefit plan year (January 1 through December 31), or your period of coverage under the program, if you are not a participant for the entire plan year (as with employees who are newly hired or terminated during the year). You may submit claims for these expenses up to the last business day in March of the following calendar year. Balances remaining after the claim deadline will be forfeited.

LIFE INSURANCE & LONG-TERM DISABILITY INSURANCE

★ **NEW 2013** ★ Life and long-term disability benefit plans will be provided through Lincoln Financial. For the 2013 Annual Open Enrollment, Lincoln Financial Group has agreed to offer a, one time only, open enrollment option for voluntary life insurance and long term disability. Employee premiums are deducted from pay on an after-tax basis.

BASIC GROUP LIFE / AD&D INSURANCE

Hamline University provides employees working at least 30 hours per week (or a .75 full-time equivalency) with a group term life insurance policy inclusive of accidental death and dismemberment benefits (AD&D). Coverage is effective the first of the month following the date of hire (or immediately if the date of hire is the first of the month). The value of the term life and AD&D policy is equal to twice the employee's gross annual base salary, not to exceed \$500,000, with a declining value starting at age 65 (35% of coverage value at age 65, an additional 35% of the in force amount at ages 70 and 75). There is no cost to the employee for the Basic life benefit.

VOLUNTARY LIFE / AD&D INSURANCE

Hamline University also provides a voluntary term life insurance plan to employees who work at least 20 hours per week (.50 part-time equivalency), effective the first of the month following the date of hire (or immediately if the date of hire is the first of the month). The employee pays 100% of the supplemental term life insurance premiums. Coverage is available for the employee, the employee's spouse or domestic partner, and eligible children up to age 26. "Guarantee issue" coverage is available at the time you are first eligible to participate in this plan, if you enroll within 31 days of your eligibility date. Enrollment after the date of initial eligibility, and coverage over the guarantee issue amount, is subject to underwriting approval by the insurance company.

Employee coverage is available in increments of \$10,000, up to five times the employee's annual base salary, to a maximum of \$500,000 (guarantee issue amount is \$200,000). Spouse or domestic partner coverage is available in increments of \$5,000, up to half of the employee's coverage amount (guarantee issue of \$50,000, with a maximum amount of \$250,000). The cost of the coverage is based on employee's age (refer to the chart below). The voluntary life coverage reduces 35% at ages 65 and 70, and reduces 25% at age 75, 80, 85, 90 and 95. Child coverage applies to any number of children and is available up to \$10,000 (with a reduced benefit from birth to six months of age).

Accidental Death and Dismemberment coverage is also available separately. AD&D coverage is not subject to underwriting approval.

Cost of Voluntary Life Coverage:

Monthly cost: Multiply your rate times the # of units of coverage. For example, \$20,000 of coverage for an employee age 52: multiply \$3.40 times 2 units = \$6.80 per month. Your cost will increase as you reach a higher age bracket.

Age	Employee - per \$10,000	Spouse - per \$5,000	Age	Employee - per \$10,000	Spouse - per \$5,000
Under age 30	.40	.20	50-54	3.40	1.70
30-34	.50	.25	55-59	5.40	2.70
35-39	.80	.40	60-64	7.20	3.60
40-44	1.20	.60	65-69	11.60	5.80
45-49	2.00	1.00	70-74+	20.50	10.25

Cost of Supplemental AD&D Coverage: \$.30/month per \$10,000 of coverage for employee, \$.15 per \$5000 for spouse/partner, and \$.06 per \$2000 for child coverage.

LIFE INSURANCE & LONG TERM DISABILITY (Continued)

Each year, during the annual open enrollment period, you have the opportunity to change the amount of your voluntary life insurance coverage. If you enrolled when you were initially eligible for the plan, you may increase your coverage by 2 units at the annual enrollment without evidence of good health, up to the guarantee issue amounts (up to an additional \$20,000 for employee coverage, \$10,000 for spouse/partner coverage). New coverage and coverage amounts over the guarantee issue amounts will require evidence of insurability and approval by the insurance company. However, for the **2013 open enrollment period, benefit eligible employees will have an opportunity to elect coverage up to the guarantee issue amount without evidence of insurability.**

GROUP LONG-TERM DISABILITY INSURANCE

Employees working at least 30 hours per week (or a .75 full-time equivalency) are eligible to participate in the long-term disability plan, effective the first of the month following the date of hire (or immediately if the date of hire is the first of the month). The coverage is “guarantee issue” at the time the employee is first eligible to participate in this plan; if coverage is declined at the time of initial eligibility, coverage will be subject to evidence of insurability and underwriting approval by the insurance company if requested at a later date. However, for the **2013 open enrollment period, full-time benefit eligible employees will have an opportunity to elect disability coverage without evidence of insurability.**

The long-term disability plan protects employees from loss of income due to an illness or injury. Disability income under this plan is equal to 66.67% of the employee’s regular salary, after 90 days of disability (offset by any eligible Social Security payments).

The cost of the long-term disability insurance is shared 50-50% between Hamline and the employee. The premium is based on the employee’s annual base salary and the current rate. The current rate is 37 cents per \$100 of covered salary. For example, an employee with an annual salary of \$35,000 would pay \$5.40 per month for coverage.

SUMMARY PLAN DESCRIPTIONS

For more information on the life and disability plans, please refer to the summary booklets and other information provided to you at the time of your hire, or contact Human Resources. Summary booklets are also available on the Human Resources web page.

EMPLOYEE ASSISTANCE PLAN

EmployeeConnect Services

The employee assistance plan is made available to Hamline employees and their family through Lincoln Financial Group. *EmployeeConnect* offers confidential support, guidance and resources 24/7.

- Assistance for you or an immediate house-hold family member who is age 16 or older.
- In-person help with short-term issues
- Toll-free phone and Web access 24/7
- Phone access to legal counsel and a 25% discount on follow-up services
- Work/life services for assistance with:
 - Childcare, eldercare and adoption
 - Relationships
 - Financial issues

To learn more about the Lincoln Financial *EmployeeConnect* program, visit www.eapadvantage.com (password: connect) or talk with a specialist at (877)757-7587.

COBRA NOTIFICATION

Introduction

Under federal law that is commonly known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), most employers sponsoring “group health plans” are required to offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) in certain instances where coverage under the plan would otherwise end. Hamline University’s health plan, dental plan, vision plan and flex medical reimbursement plan qualify as “group health coverage” for purposes of COBRA. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. Both you and your spouse should take the time to read this notice carefully.

The Plan Administrator is the University’s Director of Human Resources at Hamline University, 1536 Hewitt Avenue, MS-C1904, St Paul, MN 55104, (651) 523-2021. The Plan Administrator is responsible for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent child.”

You Must Give Notice of Some Qualifying Events

For some qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Director of Human Resources, Hamline University, MS-C1904, 1536 Hewitt Avenue, St Paul, MN 55104; phone (651) 523-2021.

How is COBRA Coverage Provided?

Once a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the events described above to inform the University that you want continuation coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

If you do not choose continuation coverage, your group health coverage will end.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The Plan Administrator must receive proof of the SSA's determination of disability prior to the end of the initial 18-month continuation period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage; electing continuation coverage is a means of avoiding such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Each qualified beneficiary is required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you are not required to send any payment with the Election Form. However, you must make your first payment for continuation coverage no later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) The amount of the payment must be retroactive to the first day of COBRA coverage. If you do not make your first payment in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments, on a monthly basis, for each subsequent coverage period. Monthly payments are due on the first day of the month. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although payments are due on the first day of each month, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Director of Human Resources
Hamline University, MS-C1904
1536 Hewitt Avenue
St Paul, MN 55104
Phone (651) 523-2021

Statement of ERISA Rights

As a plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office all plan documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the plan with the US Department of Labor, such as detailed Annual Reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report except as described below. The plan administrator is required by law to furnish each participant with the copy of the Summary of the Annual Report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your 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 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 your claim for welfare benefits is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suite in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suite in a 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 (e.g. if it fins your claim is frivolous). If you have any questions about your plans, contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance of Inquiries, Pension and Welfare Benefits Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington, DC, 20210.

<u>Plan Sponsor and Address:</u>	<u>Agent for Service of Process:</u>
Hamline University	Director of Human Resources
1536 Hewitt Avenue	Hamline University
St Paul, MN 55104	1536 Hewitt Avenue
651-523-2021	St Paul, MN 55104

Employer ID Number: 41-0693960

<u>Plan Name and ID Number:</u>	
Medical and Dental Insurance	506
Cafeteria Plan	507
Life Insurance	503
Long-term Disability Insurance	505

SPECIAL ENROLLMENT NOTICE

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

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

To request special enrollment or obtain more information, contact the Human Resources office.

NEWBORNS' ACT DISCLOSURE

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCR). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the health plan.

Hamline University Health Plans
NOTICE OF PRIVACY PRACTICES
Effective April 14, 2004

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.

If you have any questions about this notice, please contact the Privacy Officer:

Director of Human Resources
Hamline University
1536 Hewitt Avenue, MS-C1904
St Paul, MN 55104
Phone: (651) 523-2021
Fax: (651) 523-3034

Who Will Follow This Notice

This notice describes the medical information practices of the Hamline University Cafeteria Plan, the Hamline University Medical Plan and the Hamline University Dental Plan (“Health Plan”) and that of any third party that assists in the administration of Health Plan claims.

For purposes of HIPAA and this notice, the Health Plan includes the following:

- Cafeteria Plan

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the medical records maintained by the Health Plan. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice tells you about the ways in which we may use and disclose medical information about you. It also describes our obligations and your rights regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you;
and
- follow the terms of the notice that are currently in effect.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will explain what we mean and present some examples. These examples are not exhaustive. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Please note: In most instances, how information is used and disclosed has not changed. The descriptions reflect how the Health Plan has traditionally operated.

For Treatment (as described in applicable regulations). We may use or disclose medical information about you to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

For Payment (as described in applicable regulations). We may use and disclose medical information about you to determine eligibility for benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Health Plan, or to coordinate Health Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Health Plan covers the treatment. We may also share medical information with a utilization review or pre-certification service provider. Likewise, we may share medical information with another entity to assist with the adjudication (legal actions) or subrogation (third party reimbursements) of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations (as described in applicable regulations). We may use and disclose medical information about you for other Health Plan operations. These uses and disclosures are necessary to run the Health Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Health Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Health Plan administrative activities.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order or subpoena.

To Avert a Serious Threat to Health or Safety. The Health Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. However disclosure would be limited to someone able to help prevent the threat.

Special Situations

Disclosure to Health Plan Sponsor. Information may be disclosed to another health plan for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to Hamline University personnel solely for administering benefits under the Health Plan.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report reactions to medications or problems with products;

- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Health Plan benefits. To inspect and copy the medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. 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 in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Health Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Health Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list of accounting of disclosures, you must submit your request in writing to Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). 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 that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery. We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at the Hamline University website, <http://www.hamline.edu>.

To obtain a paper copy of this notice, contact the Privacy Officer.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Health Plan website. The notice will contain on the first page, in the top right hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Health Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Health Plan, contact the Privacy Officer. All complaints must be submitted in writing.

To file a complaint with the Department of Health and Human Services, contact:

Office for Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the other applicable laws will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

IMPORTANT PHONE NUMBERS

MEDICAL INSURANCE PLANS

HealthPartners

Member Services
On-line Resources

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

DENTAL INSURANCE PLAN

HealthPartners

Member Services
On-line Resources

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

VISION INSURANCE PLAN

Avesis

Member Services
On-line Resources

800-828-9341
www.avesis.com

HEALTH SAVINGS ACCOUNT

USBANK

Health Savings Solution Center
On-line Resources

877 470-1771
www.healthsavings.usbank.com

EMPLOYEE ASSISTANCE PROGRAM

★Lincoln Financial★NEW!

EmployeeConnect services (password: connect)

1 (877) 757-7587
www.eapadvantage.com

FLEXIBLE SPENDING ACCOUNTS

Eide Bailly

Medical Care Flexible Spending Account
Dependent Care Flexible Spending Account

Flex Account Questions

Claims Fax Number

On-line Resources

Email Support

952-944-6633
952-918-3622
www.eidebaillybenefits.com
benefits@eidebailly.com

LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT & LONG-TERM DISABILITY INSURANCE

★Lincoln Financial★NEW!

Customer Service

On-line Resources

Policy Numbers

1-800-423-2765
www.LincolnFinancial.com
Life: 01-0166068
LTD: 01-0166069
Voluntary Life: 40-0166070
AD&D: 40-3001856