HAMLINE
UNIVERSITY

2018 Benefit Guide

If you are a member of the International Union of Operating Engineers, Local No. 70, 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. 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. The material contained in this packet supersedes and replaces all prior Flexible Benefits Program informational materials issued. For specific details, please consult the Summary of Benefits and Coverage and/or Certificate of Coverage for each benefit.

Benefits at a Glance

Hamline offers a competitive benefit program that is reviewed annually to ensure it meets the needs of our diverse employee base. See the chart below for a quick look at the information provided in this Benefit Guide. Then, go to each specific section for more detailed information.

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3	Medical	You have four options: • Plan A: $6,000/$12,000-100% HSA Plan • Plan B: $2,700 / $5,400-80% HSA Plan • Plan C: $1,250/$3,750-$35 Copay Plan • Plan D: $500/$1,000-$35 Copay Plan
9	Health Savings Account	Pre-tax savings account for high deductible health plan participants
10	Medical Flexible Spending Account	Pre-tax account used to pay for eligible health care expenses
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General Plan Information

As a Hamline employee, you have a variety of benefit options to choose from. This Benefit Guide provides an overview of the plans available to you to help you make informed enrollment decisions. Please review this Benefit Guide, share it with your family and keep it for future reference. For additional, plan specific information, visit the Hamline Human Resources Benefit website at: http://www.hamline.edu/benefits/.

Eligibility

You are eligible to participate in Hamline University's benefit program on the first of the month following your date of hire if you are an active full-time employee. Spouses (opposite- and same-sex) and children (up to age 26) are eligible for most benefits as outlined in the chart below. Please note, as of January 1, 2018, Hamline benefits do not cover Domestic Partners.

	Full-time (30+ hours per week)	Part-time (20+ hours per week)	Spouse	Child
Medical	✓		✓	✓
Dental	✓	✓	✓	✓
Vision	✓	✓	✓	✓
Basic Life Insurance and AD&D	✓			
Voluntary Life Insurance and AD&D	✓	✓	✓	✓
Long Term Disability Insurance	✓			
Health Savings Account	✓		✓	✓
Medical Flexible Spending Accounts	✓		✓	✓
Dependent Care Flexible Spending Accounts	✓	✓		✓
Worksite Benefits – STD, Cancer, Medical Bridge	✓	✓	✓	✓

Changing Your Elections During the Year

The benefit elections you make during your initial or annual enrollment remain in effect for the entire calendar year due to IRS regulations. You are, however, allowed to modify your elections in certain situations, called "qualifying life events." If you experience a qualifying life event, you may make changes to your benefits within 30 days of the event.

A qualifying life event includes a change in:

- **Legal marital status** – marriage, death of spouse, divorce, legal separation, or annulment
- **Number of dependents** – birth, adoption, placement for adoption, divorce or death of a dependent, or assuming primary support of a child of an unmarried dependent child
- **Employment status** – eligible dependent gains or loses access to employer-sponsored coverage
- **Dependent status** – change due to age or other circumstance which causes your dependent to satisfy or cease to satisfy eligibility requirements under the plan
- **Medicare or Medicaid eligible status** – you or your spouse become Medicare or Medicaid eligible.

Any benefit changes must be consistent with the life event you or your family member experienced. The new election becomes effective as of the date of the change in status or loss of coverage, whichever comes later.

Medical Insurance

MEDICA®

The cornerstone of Hamline's benefits package is medical coverage. Whether you are facing an illness or injury, or simply utilize preventive care, the University offers comprehensive protection against the financial hardship that can accompany a medical need. Read this section to determine which option best meets the needs of you and your eligible dependents.

Medical Plan Choices

Hamline offers four medical plan options. All options provide high-quality, affordable medical care, including preventive care, doctor's visits, hospitalization, and emergency care. However, each plan has unique characteristics and advantages. The plans are offered through Medica, a non-profit organization providing health coverage to approximately 1.5 million members.

Your choices include:

- Plan A: $6,000/$12,000-100% HSA Plan
- Plan B: $2,700 / $5,400-80% HSA Plan
- Plan C: $1,250/$3,500-$35 Copay Plan
- Plan D: $500/$1,000-$35 Copay Plan

For additional information on Medica, your plan options, networks, etc. go to www.welcometomedica.com/hamline.

All Hamline medical plans offer:

- Coverage for the same health care services
- In-network preventive care services at 100% with no deductible or copay
- Higher level of benefit reimbursement when seeing a participating network provider
- An annual out-of-pocket maximum
- Prescription drug coverage

How the Plans Work

- **Plans A & B**
  These plans require covered participants to meet an annual deductible before the plan will start to pay for covered services – with the exception of preventive care which is covered at 100%. Plan A has a higher deductible, but once a participant has met the deductible, the plan pays 100% of all covered in-network expenses for the remainder of the calendar year. Plan B has a lower deductible, but services are subject to coinsurance once the deductible is met. This means that once you have met your deductible, you will share the cost of care with Medica – called coinsurance – until you reach your out-of-pocket maximum. At that time, the plan will pay 100% of all covered in-network expenses for the remainder of the calendar year.

  This plan is paired with a Health Savings Account through Optum. Participants may contribute to a Health Savings Account (HSA) to help cover out-of-pocket costs on a pre-tax basis. Federal rules limit reimbursement to family members who are tax dependents or a legal spouse.

- **Plans C & D**
  These plans require that you pay a co-pay for office visits and prescription drugs. Preventive care is covered at 100%. All other covered services, including lab work and x-rays associated with an office visit, are subject to the deductible, coinsurance and out-of-pocket maximum. Plan C has a higher deductible and out-of-pocket maximum than Plan D. The office visit and prescription copay amounts are the same. Once you've met the annual out-of-pocket maximum, the plan pays 100% of covered services for the rest of the calendar year as long as services are in-network.

  To help pay for qualified health care expenses, Plan C and D participants are eligible to contribute to a Medical Flexible Spending Account on a pre-tax basis through payroll deduction. You can use the medical FSA to reimburse expenses for yourself and your legal tax dependents.

Benefit Summary

This is a summary of your benefits under Hamline's Plan A, Plan B, Plan C and Plan D. It is not a complete listing. Please see your Summary of Benefits and Coverage (SBC) for details.

IN-NETWORK	Plan A	Plan B	Plan C	Plan D
Deductible	$6,000 per person $12,000 per family	$2,700 per person $5,400 per family	$1,250 per person $3,500 per family	$500 per person $1,000 per family
Out-of-Pocket Maximum	$6,000 per person $12,000 per family	$4,500 per person $9,000 per family	$4,000 per person $8,000 per family	$2,500 per person $5,000 per family
PREVENTIVE CARE – ROUTINE				
Well-child, adult physical and eye exams / immunizations	100% coverage	100% coverage	100% coverage	100% coverage
PHYSICIAN SERVICES				
Physician and specialist visits; urgent care	100% coverage after deductible	80% coverage after deductible	$35 co-pay	$35 co-pay
Convenience care	100% coverage after deductible	80% coverage after deductible	$15 co-pay	$15 co-pay
X-rays & Imaging	100% coverage after deductible	80% coverage after deductible	75% coverage after deductible	75% coverage after deductible
HOSPITAL SERVICES				
Inpatient / Outpatient Hospitalization	100% coverage after deductible	80% coverage after deductible	75% coverage after deductible	75% coverage after deductible
EMERGENCY SERVICES				
Emergency room	100% coverage after deductible	80% coverage after deductible	$75 co-pay	$75 co-pay
Ambulance	100% coverage after deductible	80% coverage after deductible	75% coverage after deductible	75% coverage after deductible
MENTAL HEALTH / CHEMICAL DEPENDENCY				
Inpatient	100% coverage after deductible	80% coverage after deductible	75% coverage after deductible	75% coverage after deductible
Outpatient	100% coverage after deductible	80% coverage after deductible	$35 co-pay	$35 co-pay
PHARMACY (on Medica formulary)				
Retail – up to 31-day supply	100% coverage after deductible	80% coverage after deductible	Generic: $11 Preferred: $45 Non-preferred: $60	Generic: $11 Preferred: $45 Non-preferred: $60
Mail Order – up to 93-day supply	100% coverage after deductible	80% coverage after deductible	Generic: $22 Preferred: $90 Non-preferred: $120	Generic: $22 Preferred: $90 Non-preferred: $120
Specialty – up to 31-day supply from designated specialty pharmacy	100% coverage after deductible	80% coverage after deductible	Preferred: You pay 20% up to $200 maximum; Non-preferred: you pay 40%	Preferred: You pay 25% up to $200 maximum; Non-preferred: you pay 45%
OUT-OF-NETWORK	**Plan A**	**Plan B**	**Plan C**	**Plan D**
Deductible	$7,000 per person / $14,000 per family	$4,800 per person / $9,600 per family	$2,500 per person / $7,000 per family	$1,000 per person / $2,000 per family
Out-of-Pocket Maximum	$10,200 per person / $19,400 per family	$10,200 per person / $19,400 per family	$7,000 per person / $14,000 per family	$5,000 per person / $10,000 family
Preventive Care – Routine	75% coverage after deductible	75% coverage after deductible	50% coverage after deductible	50% coverage after deductible
Physician Services	75% coverage after deductible	75% coverage after deductible	50% coverage after deductible	50% coverage after deductible
Hospital Services	75% coverage after deductible	75% coverage after deductible	50% coverage after deductible	50% coverage after deductible
Pharmacy – formulary only	75% coverage after deductible-retail only	75% coverage after deductible-retail only	50% coverage after deductible -retail only	50% coverage after deductible- retail only

Visit http://hamline.welcometomedica.com/home to view your Summary of Benefits and Coverage and much more.

Prescription Drug Coverage

Pharmacy Benefit Manager - CVS Caremark™
In an effort to help keep health care costs as low as possible, while still providing continued access to safe, affordable and effective prescription medication, Medica utilizes CVS Caremark™ as its pharmacy benefit manager.

- You have access to more than 64,000 pharmacies across the country including major chain pharmacies and thousands of independent pharmacies. Members are not limited to CVS pharmacies.

- Tools and resources are available on www.mymedica.com, as well as a mobile app, that makes it easy for you to check drug costs, locate pharmacies and view your prescription history.

Covered drugs are shown on the Medica Preferred Drug List, which is comprised of drugs that provide the most value and have proven safety and effectiveness.

How you pay for your prescriptions will vary by your plan choice and where you fill your prescription.

- **Retail Pharmacy** – Participants in Plans A and B are responsible for the full cost until the deductible has been met. Once the deductible is met, then the plan pays 100% for the remainder of the calendar year. Participants in Plans C and D pay a co-pay based on the type of drug purchased.

- **Mail Order Pharmacy** – Starting January 1, 2018, CVS Mail Service Pharmacy will be Medica's new prescription mail order provider, replacing Fairview Mail Service Pharmacy. Mail order provides the convenience of receiving a 3-month supply mailed directly to your home. Plan C and D participants also get a 3-month supply for the cost of two copays. Before deciding if mail order is right for you, compare prices using the Medica Price a Medication tool available on www.mymedica.com.

  - Members will be able to easily start, manage and refill eligible mail order prescriptions using their CVS Caremark site (accessible through **mymedica.com**) or the CVS Caremark mobile app.

- **90-Day Refill Option** – You can get up to a 90-day supply of ongoing medications from a participating pharmacy with the 90-day refill option. You'll pay three retail copayments or coinsurance amounts (depending on your plan) and get the convenience of saving trips to the pharmacy. To use this option, ask your provider for a 90-day prescription and bring it to a participating pharmacy.

- **Specialty Pharmacy** – These medicines treat health care conditions like cancer, hepatitis, multiple sclerosis and rheumatoid arthritis. Medications considered "specialty" drugs must be filled through an approved specialty pharmacy or there will be no coverage.

  - Medica is partnering with Accredo to provide specialty pharmacy services to you as of January 1, 2018. Accredo's clinical pharmacy model is designed to help you take your medications safely and the way that they were prescribed. The Accredo clinical team offers one-on-one counseling and assistance as well as opportunities to engage through web, mobile, text, chat and email to make refilling medications as easy as possible. Specialty medications are conveniently delivered to members via FedEx or UPS.

  - You can contact Accredo by phone at 1-877-ACCREDO (222-7336) or access their website: www.accredo.com

Your Network Options

It is in your best interest to seek providers who are in-network. If you see a provider that is not in your Medica network, your costs will be significantly higher because you will receive a lower coverage amount under your benefit plan – and your share of the costs will be based on the provider's full charges rather than the discounted rate Medica negotiates with network providers. In addition, the costs above the usual and customary (U&C) rate are not subject to the out-of-pocket maximum. This means that once the total of your out-of-network U&C charges reach your out-of-pocket maximum, the plan will pay 100% of the remaining U&C charges, but you will continue to pay the full cost of any charges above U&C.

The following is a brief description of the **networks** available to you:

Choice Passport
This is Medica's largest, national network. You have access to more than 715,000 providers and more than 5,400 hospitals across the U.S. For care received within the Medica service area, you have the Medica Choice Passport open access network. For care received outside of the Medica service area (students, while traveling, etc.) you have access to the UnitedHealthcare national network.

You are free to see any provider in the Medica network – without a referral – and you are not required to select a primary care clinic.

Elect
This is a separate, smaller network of providers who have agreed to deliver services at lower rates. Therefore you will save money on your monthly premium, as well as the services you receive. For care received outside of the Medica service area (students, while traveling, etc.) you have access to the UnitedHealthcare national network (see next page for specifics).

The Elect network has a number of "care systems." A care system is a group of primary care clinics, specialists and hospitals that work together to give you the care you need. You will need to choose a primary care clinic, within a care system, to be your medical home. So, when you pick your primary care clinic, you're picking a care system, too. Members commit to receiving most of their care from the providers in the associated care system. You do not need a referral when you utilize providers in your care system. However, if necessary, your primary care clinic can issue referrals outside of the care system.

VantagePlus *NEW*
New in 2018, this network combines several major care systems and independent providers in an effort to provide broad geographic access, a greater focus on lowering health care costs and improvements in service experience. VantagePlus includes 3,500 primary and specialty care physicians, 650 clinics, and 12 hospitals in the Twin Cities metro and surrounding areas.

Elect Network		VantagePlus Network
Allina Medical Clinics	RiverWay / North Suburban Clinics	HealthEast
Children's Health Network	St. Luke's	Fairview
Integrity Health Network	Lakeview Medical Group	North Memorial
Hennepin Health	Minnesota HealthCare Network	
Park Nicollet Health Services		

Keep in mind that if you are traveling or have family members who live away from home – a child at school, for example – emergency services will always be considered in-network. For children away at school, coverage for routine services like physical therapy or office visits for the flu or an ear infection will depend on where they are located in relation to the Medica service area (Minnesota, North Dakota, South Dakota and western Wisconsin), as follows:

- Inside the service area: Routine services will be considered out-of-network unless they are received from a provider in their Elect or VantageCare care system.
- Outside the service area: Routine services will be considered in-network as long as they are delivered by a UnitedHealthcare provider. Keep in mind, however, that chiropractic services are not included outside the Medica service area. Your out-of-network benefits would apply in this case.

Referrals

A referral is a written recommendation from your primary care clinic to see a specialist outside of your care system. If your care system can't deliver the care you require, your primary care clinic will write you a referral. Your primary care clinic will notify Medica that you have a referral so the care will be considered in-network. The referral will list the:

- Name of the specialist
- Type of service
- Number of visits
- Date range when you can see the specialist

Please note that your referral provider cannot refer you on to another specialist, this would need to be coordinated by your primary care clinic. However, if your referral says that the specialist can "consult, diagnose and treat" then the specialist can order services such as physical therapy, imaging (X-rays, CT scans, etc.), outpatient surgery and other related care.

Some services can be accessed outside of your care system, as long as they are in your network. Examples would be chiropractic care, convenience care, urgent care, or durable medical equipment. If you have questions regarding referrals (or the need for a referral), contact Medica Customer Service at 800.952.3455.

Elect Network -- Designating or Changing a Primary Care Clinic

When you enroll in the Elect network, you will need to designate a primary care clinic (PCC) for each member of your family. Please note that each family member can choose their own primary care clinic, and they do not need to be within the same care system. If you do not designate a PCC at enrollment, Medica will assign based on your home address.

You can change your primary care clinic as often as once a month by completing the primary care clinic change form. Click on your network (Elect) on the "Find Physician or Facility" page. Then, click on "Learn how to find a PCC or change your current PCC" link. Complete and submit the "Change Your Primary Care Clinic Change Request" form.

Finding a Provider

To find a network provider go to hamline.welcometomedica.com/home:

- Click on "Find a Physician or Facility"
- Select the network you wish to search:
  - Medica Choice Passport
  - Elect
  - VantagePlus
- Search for providers by name, facility, specialty, or condition or click "Get Started" to find doctors who treat specific conditions.

To find a primary care clinic, follow the instructions in the first two bullets above, then:

- Scroll down past the "Get Started" button and click on "Clinic-Primary Care" under Facilities & Services. You can narrow your results by entering your address or choosing a care system, specialty or other criteria.
- In your results, look for the clinic's Care System listing – that's where you will find the clinic's PCCID – which is the number you will use to designate the clinic as your PCC when you enroll. A PCCID looks like this (PCCID: 00000000123). If no PCCID is displayed, you cannot choose that clinic as a primary care clinic.

For assistance locating a Primary Care Clinic or selecting a Care System, call Medica Customer Service at 800.952.3455.

Cost of Medical Coverage

	PASSPORT			ELECT			VANTAGEPLUS		
	Total	Employee Contribution		Total	Employee Contribution		Total	Employee Contribution	
Plan / Tier	Premium	Monthly	%	Premium	Monthly	%	Premium	Monthly	%
Plan A									
Employee	$607.47	$66.82	11%	$564.95	$45.20	8%	$546.72	$43.74	8%
Employee+1	$1,366.81	$287.03	21%	$1,271.13	$228.80	18%	$1,230.13	$221.42	18%
Family	$1,585.50	$491.51	31%	$1,474.52	$412.87	28%	$1,426.95	$399.55	28%
Plan B									
Employee	$681.35	$102.20	15%	$633.65	$63.37	10%	$613.22	$61.32	10%
Employee+1	$1,533.03	$536.56	35%	$1,425.72	$441.97	31%	$1,379.73	$427.72	31%
Family	$1,778.31	$622.41	35%	$1,653.83	$578.84	35%	$1,600.48	$560.17	35%
Plan C									
Employee	$822.28	$164.46	20%	$764.72	$91.77	12%	$740.05	$88.81	12%
Employee+1	$1,850.12	$832.55	45%	$1,720.61	$688.24	40%	$1,665.11	$666.04	40%
Family	$2,146.13	$965.76	45%	$1,995.90	$798.36	40%	$1,931.52	$772.61	40%
Plan D									
Employee	$889.89	$311.46	35%	$827.60	$289.66	35%	$800.90	$280.32	35%
Employee+1	$2,002.24	$1,261.41	63%	$1,862.08	$1,117.25	60%	$1,802.02	$1,081.21	60%
Family	$2,322.60	$1,463.24	63%	$2,160.02	$1,296.01	60%	$2,090.34	$1,254.20	60%

Health Savings Account (HSA)

If you enroll in Plans A or B, you can contribute to an HSA on a pre-tax basis through payroll deduction. Annual contributions are limited by federal law depending on the level of health coverage you elect. You can start, stop or change your HSA contribution at any time during the year.

Eligibility

Because of the tax-advantaged nature of an HSA, there are specific eligibility requirements, including:

- You may not be covered by another non-HDHP health plan (for example, a spouse's traditional medical plan that covers you).
- You and your spouse may not enroll in a medical Flexible Spending Account that could reimburse your medical expenses. Participation in a limited Flexible Spending Account that covers only dental and vision expenses is allowed.
- You may not be enrolled in a government health plan, such as Medicare A and/or B or Medicaid.
- Children who are not your tax dependents are not eligible for reimbursement from the HSA.
- You may not have an HSA and be claimed as a dependent on someone else's tax return.

Health Savings Account Contributions

Coverage Level	Annual Maximum Contribution	Catch-Up Contribution if Age 55+
Employee Only	$3,450	$1,000
Employee + 1	$6,850	$1,000
Family	$6,850	$1,000

Note: If you are married and your spouse is also enrolled in a HDHP through his/her employer, your combined HSA contributions cannot exceed the federal maximum shown above.

Using Your HSA

Funds in an HSA can be used to pay for:

- Qualified medical expenses
- Qualified dental, vision and hearing expenses
- COBRA continuation coverage if you leave employment with the University
- Qualified long-term care insurance

Funds can also be used to build savings to cover future medical expenses on into retirement, including Medicare premiums and out-of-pocket expenses.

HSA participants receive an HSA debit card, which may be used to pay for qualified health care expenses directly. Or, you may reimburse yourself from your HSA at a later date. You own the amount in your account and may take it with you if you leave Hamline.

Managing Your HSA

It's easy to manage your HSA using the Optum portal. You can:

- Check your account balance
- File a claim
- View account activity
- Reimburse yourself
- Designate a beneficiary

You will be charged a $3.25 monthly administration fee if your balance is below $2,500.

You do not need to provide proof of your expense to Optum. However, you should keep your receipts in case you are audited and need to provide proof that your withdrawals were for qualified medical expenses.

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).

For additional information, contact Optum customer service at 844.326.7967 or www.optumbank.com.

Medical Flexible Spending Account

The Medical Flexible Spending Account gives Plan C or D participants the opportunity to set aside pre-tax dollars to pay for qualified medical, dental and vision expenses. Examples of eligible expenses include deductibles and co-pays, prescription drug costs, over-the-counter medicines (if prescribed by a doctor), and other non-covered medical, dental, vision and hearing care expenses.

Plan A & B participants can contribute to a Limited Purpose Flexible Spending Account for dental and vision expenses only

For More Information
Visit www.121benefits.com to:
- File a claim
- Check account balance and claim status
- View account history
- Access forms
- Manage your profile

FSA Contributions

You may contribute up to $2,650 to your Medical FSA through pre-tax payroll deductions. Estimate expenses carefully, as a federal "use-it-or-lose-it" law applies. This means that if you have not incurred enough expenses to reimburse the funds in your account at the end of the year, your remaining account balance will be forfeited. Keep in mind that you cannot change your FSA election mid-year without a corresponding qualifying life event, as described on page 3.

Using Your FSA

You can pay for eligible expenses in one of two ways – using the 121 Benefits debit card or filing a claim.

- **Debit card**: Use the debit card to pay for eligible health care expenses at the point of service or write your debit card number on your provider's bill – just as you would a credit card. Funds will be taken directly from your 121 Benefits medical FSA account.
- **FSA claim form**: Pay the provider directly and then file a claim for reimbursement. You will need to complete an FSA claim form and submit it to 121 Benefits along with your receipts.

Expenses must be incurred between January 1, 2018 and December 31, 2018. You will have until March 31, 2019 to submit claims.

Comparing FSAs and HSAs

	HSA	Medical FSA
Who can have this plan?	Plan A & B participants	Plan C & D participants; Plan A & B participants with an HSA can have a limited purpose flexible spending account
What is the contribution limit?	Employee Only: $3,450 Employee + 1 or Family: $6,900	$2,650
Can I make a catch-up contribution?	Yes, up to $1,000 for 2018 if you are age 55+ and not enrolled in Medicare	No
What are the tax advantages?	• Contributions are tax-free • Investment earnings on balance are tax-free • Withdrawals for eligible expenses are never taxed	• Contributions are tax-free • Withdrawals for eligible expenses are never taxed
What expenses are eligible?	Any out-of-pocket expenses for medical, prescription drugs, dental, vision and hearing	
Can I make a contribution change?	Yes, allowed throughout the year at anytime	Maybe, changes are only allowed if you have a Qualifying Life Event (see page 3)
How can I use the funds?	You can spend them now on eligible health care expenses, or save for future health care expenses	You need to spend them on eligible health care expenses incurred in the year designated
Is there a time limit for using fund balance?	No limit	You must file your 2018 claims by March 31, 2019
Can I roll-over my unused funds from year to year?	Yes	No – unused funds are subject to use-it-or-lose-it
What funds are available to reimburse expenses?	Limited to your current account balance	Entire contribution amount elected for the year
Do I need to provide proof my expense?	No, proof is not required by Optum; if you are audited by the IRS proof will be required, so keep your receipts	Yes, proof is required by 121 Benefits for one-time expenses; no proof after initial substantiation for recurring expenses or for co-pay amounts

Dental Insurance

Staying healthy includes good dental care. Hamline's dental plan provides the comprehensive coverage necessary to help you and your family maintain good dental health. The dental benefit is administered by Delta Dental.

How the Plan Works

Plan participants have the flexibility to see any dentist they choose. But greater discounts and benefits are available by seeing an in-network dentist. The provider options include:

- Delta Dental Premier – larger network; discounts
- Delta Dental PPO – smaller network; larger discounts
- Out-of-Network – all other providers; no negotiated discounts

Benefit Summary

Dental Service	In-Network	Out-of-Network
Diagnostic and Preventive - Exams & cleanings; x-rays; fluoride treatments; space maintainers; sealants	100%, no deductible	100% of plan's allowed amount, no deductible
Basic Services - Emergency treatment; fillings	80% after deductible	80% of plan's allowed amount after deductible
Endodontics - Root canal therapy	50% after deductible	50% of plan's allowed amount after deductible
Periodontics - Surgical /non-surgical treatment of gum tissue	50% after deductible	50% of plan's allowed amount after deductible
Oral Surgery - Surgical and non-surgical extractions; all other oral surgery	50% after deductible	50% of plan's allowed amount after deductible
Major Restorative - Crowns, inlays and onlays	50% after deductible	50% of plan's allowed amount after deductible
Prosthetics Repairs and Adjustments - Dentures and bridges	50% after deductible	50% of plan's allowed amount after deductible
Orthodontics - For covered dependents to age 19	50% up to $750 lifetime maximum	
Annual Deductible	None	$50 per person, $150 per family
Annual Plan Maximum	$2,000 combined	$1,500 combined
Monthly Premiums	Single: $22.10 Family: $57.48	

Finding Network Providers

Dentists who participate in the Delta networks will:

- Save the participant and the plan money,
- File claims on behalf of the covered participant, and
- Agree not to charge more than the plan's negotiated rates (or "allowed amount").

To find in-network preferred providers, go to www.deltadentalmn.org and select Delta Dental PPO or Delta Dental Premier. Enter your zip code and the distance you are willing to travel to find a provider in your area. Or you can also call 651.406.5916 or 800.553.9536.

What Does "Allowed Amount" Mean?
This is a term for the negotiated rate that Delta Dental has set with network providers for a specific service. Out-of-network providers may charge more than the allowed amount, leaving you responsible for the difference in cost.

For more plan information, such as the average cost of dental procedures, claims information, or to print an ID card, go to www.deltadentalmn.org.

Vision

Hamline offers a vision plan administered by EyeMed. This coverage is a voluntary benefit that features coverage for prescription glasses and contact lenses, as well as other vision-related items.

How the Plan Works

As with the dental plan, you have the freedom to receive services from any provider. You will, however, receive a greater level of benefit if you use a provider who participates in the EyeMed Insight network. By using a network provider, you may also receive discounts for services not otherwise covered by the vision plan (i.e., sunglasses and laser vision correction).

Please note: this plan provides coverage for materials and hardware only. Coverage for routine annual vision exams are provided through your Medica medical plan as a preventive appointment.

Benefit Summary

	EyeMed Insight Network	Out-of-Network
Eyeglass Lenses*		
Standard Single Vision	$0 co-pay	Reimbursed up to $30
Standard Bifocal	$0 co-pay	Reimbursed up to $50
Standard Trifocal	$0 co-pay	Reimbursed up to $70
Standard Lenticular	$0 co-pay	Reimbursed up to $70
Standard Progressive	$65 co-pay	Reimbursed up to $50
Premium Progressive		
Tier 1	$85 co-pay	Reimbursed up to $50
Tier 2	$95 co-pay	Reimbursed up to $50
Tier 3	$110 co-pay	Reimbursed up to $50
Tier 4	$65 co-pay; up to $120 allowance	Reimbursed up to $50
Frames	$0 co-pay; $150 allowance; 20% off balance over $150	Reimbursed up to $105
Contact Lenses		
Conventional	$0 co-pay; $130 allowance; 15% off balance over $130	Reimbursed up to $130
Disposable	$0 co-pay; $130 allowance	Reimbursed up to $130
Medically Necessary	$0 co-pay; Paid-in-full	Reimbursed up to $210
Laser Vision Correction	15% off the retail price or 5% off the promotional price	N/A
Frequency	**Lenses or Contact lenses**: Once every 12 months** **Frames**: Once every 24 months	
Monthly Premiums	Employee Only: $ 5.30 Employee + 1: $ 10.08 Employee + Child(ren): $ 10.61 Family: $ 15.60	

**Please refer to the plan document for additional lens options and corresponding copays or % discounts (if applicable).*

***Contact lenses are in lieu of eyeglass lenses and frames. Members may, however, still be able to receive additional discounts off another complete pair of eyeglasses or conventional contact lenses once the covered benefit has been used.*

For More Information

To find network providers, view your benefits and claims information or see special offers, go to www.eyemed.com. Access a list of Lasik providers at www.eyemedlasik.com or call 877-5LASER6.

In-Store Discounts: Certain in-store promotions can be better than insurance – i.e., buy one pair get one free, select styles $99, etc. You can take advantage of a promotion, and you can still submit an out-of-network claim to get reimbursed for the out-of-network portion of your purchase.

Life and AD&D Insurance

Lincoln Financial Group®

You can't always predict – or control – your life. But, you can prepare for it. Protecting the financial interests of your loved ones in the event of your death or serious injury can be invaluable. Hamline provides life and AD&D (accidental death or dismemberment) benefits through Lincoln Financial. The plan provides:

- **Basic Term Life and AD&D** – Eligible employees automatically receive the basic portion of the Life and AD&D benefit – there are no choices to be made. Per IRS regulations, you pay tax on the premium paid by Hamline for coverage over $50,000. Any benefits paid out are tax-free to the recipient.
- **Voluntary Life and AD&D** – You decide if you want to purchase voluntary coverage. You need to choose the level of coverage and who you want to cover – yourself, your spouse and/or your dependent children. You must purchase coverage for yourself in order to elect coverage for your spouse and/or child(ren). Children are eligible to participate up to age 19 (or age 25 if a full-time student).

How the Plan Works

Life benefits are payable to your designated beneficiary in the event of your death. An additional AD&D benefit is payable to you in the event of a covered dismemberment or to your beneficiary if your death is the result of an accident.

Benefit Summary

Feature	Basic Term Life/AD&D	Voluntary Life/AD&D		
		Employee	Spouse	Child(ren)
Benefit Amount	2 x annual salary - Minimum: $10,000 - Maximum: $500,000	Lesser of 5x annual earnings or $500,000 in increments of $10,000 Note: Maximum is $50,000 for age 70+	$250,000, may not exceed 50% of the employee amount in increments of $5,000	$10,000 in increments of $2,000
Guarantee Issue*	$400,000	$200,000	$50,000	$10,000
Age Reduction	- At age 65, benefits will reduce by 35% - At age 70, inforce coverage will reduce by 35%	- At age 70, benefits will reduce by 35% - At age 75, inforce coverage will reduce by 35%		

*Guarantee issue refers to the amount of coverage you can purchase without providing evidence of good health. If you are a current or new participant, you may increase coverage for you and eligible family members by two increments on a guarantee issue basis during open enrollment, provided you have not previously been declined coverage.

Cost of Voluntary Life and AD&D Coverage

You pay the full cost for additional life and AD&D coverage on an after-tax basis. Cost for life coverage for employee and spouse is based on the employee's age. Cost for AD&D is a set amount, as shown below:

Voluntary Life/AD&D Monthly Rates – Per $1,000 of Coverage											
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Life	$0.04	$0.05	$0.08	$0.12	$0.20	$0.34	$0.54	$0.72	$1.16	$2.05	$3.50
AD&D	$0.03	$0.03	$0.03	$0.03	$0.03	$0.03	$0.03	$0.03	$0.03	$0.03	$0.03
Dependent Child(ren)	$0.18 Life $0.03 AD&D										

Long Term Disability Insurance

Lincoln Financial Group®

Being disabled doesn't mean that your income has to stop. Hamline's disability program is designed to replace a portion of your income if you are unable to work due to a non-work related accident or sickness.

How the Plan Works

Employees may be eligible for disability payments if they are unable to perform their job due to a non-work related injury or illness. Disability benefits are insured through Lincoln Financial, and all disability claims are reviewed and approved by Lincoln Financial.

Benefit Summary

When do benefits start?	Qualifying benefits begin after 90 days if you remain disabled according to the terms of the plan
How long will the plan pay a benefit?	Until your disability ends or you reach Social Security Normal Retirement Age
How much will I receive?	66-2/3% of base salary (up to $10,000 a month)
Will I have to pay taxes on the benefit I receive?	You will pay tax on the 50% employer paid portion; the 50% employee-paid portion will be received tax-free
What if I receive other benefit payments?	Your LTD benefit will be offset by any other disability payments, like Social Security or Worker's Compensation
Is there anything that would stop me from receiving a benefit?	Pre-existing condition limitations apply and your disability must be approved by Lincoln Financial on a periodic basis

Your Cost

You and Hamline share the cost of long term disability coverage 50% Hamline / 50% employee. The cost of coverage is $0.34 per $100 of covered monthly earnings.

Calculation Example:
This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Cost Example – Employee Portion

	John Doe	You
Monthly Earnings	**$5,000**	**$**
Multiplied by the rate factor – 0.0017	**$5,000 x .0017**	**$ x .0017**
Estimated Monthly Premium	**$8.50**	**$**

This is an estimate of premium cost. Actual deductions may vary slightly due to rounding and payroll frequency.

Dependent Care FSA

The Dependent Care Flexible Spending Account allows employees to set aside pre-tax dollars to pay for eligible dependent daycare expenses. Contributions are automatically deducted from your paychecks on a pre-tax basis, saving you money by not paying federal, state or Social Security taxes on the portion of your income that you contribute to the plan. The account is administered through 121 Benefits.

How the Plan Works

This account is for eligible work-related daycare expenses. Eligible dependents include children under age 13 and disabled dependents of any age who are incapable of self-care. You can use the funds to pay for daycare, preschool, summer camp, before/after school programs or eligible senior centers while you (and your spouse) are actively working or attending school. The primary purpose should be to provide for the dependent's well-being and protection. Education-focused expenses that can be separated from daycare expenses are not eligible.

By law, any unused funds are forfeited after year-end. You may not carry a balance over to the next year. So estimate your eligible expenses carefully and conservatively.

FSA Contributions

You may contribute up to $5,000 ($2,500 if married and filing separately) to your Dependent Care FSA through pre-tax payroll deductions. Estimate expenses carefully, as a federal "use-it-or-lose-it" law applies. This means that if you have not incurred enough expenses to reimburse the funds in your account at the end of the year, your remaining account balance will be forfeited. Keep in mind that you cannot change your FSA election mid-year without a corresponding qualifying life event, as described on page 3.

Using Your FSA

When you have incurred dependent care expenses, you must submit a claim for reimbursement – along with proof of the expense. The claim form can serve as a receipt for payment if you have your provider sign the Provider Certification section of the form. 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.

Expenses must be incurred between January 1, 2018 and December 31, 2018. You will have until March 31, 2019 to submit claims.

For More Information

At www.121benefits.com, you can:

- File a claim,
- Check account balances,
- Check claim status,
- Access forms, or
- Manage your profile.

You can also call 612.877.4321.

Other Benefits

Short Term Disability

Short term disability (STD) coverage protects your income if you are sick or injured and unable to work. If you do not have enough accrual under the Hamline Sick Time Policy, you can purchase STD to fill the gap until long term disability benefits would begin. For a qualified disability, benefits start after a seven day elimination period for both accident and illness. You can elect the amount you would like to receive based on your personal circumstances. You can choose to purchase up to 60% of your gross income in increments of $100 ($400 minimum monthly). You pay 100% of the cost of this benefit on a post-tax basis.

Cancer Insurance

Cancer insurance helps you and your family maintain financial security in the event of a cancer diagnosis. The plan pays a set dollar amount toward services such as:

- Certain cancer screening tests ($25 screening benefit)
- Initial diagnosis benefit – options from $1,000 to $10,000
- Hospital confinement and surgical benefits
- Radiation/chemotherapy
- Transportation and lodging

Your cost is based on your age and the tier you select. You can choose from four levels of coverage, including employee only, employee and spouse, 1-parent family or 2-parent family. You pay 100% of the cost of this benefit on a post-tax benefit.

Medical Bridge Insurance

The Medical Bridge Plan available through Colonial Life Insurance is designed to supplement your existing medical coverage. It pays lump sum benefits to help cover out-of-pocket expenses related to hospital stays, outpatient surgeries, diagnostic procedures, transportation and health screenings. You decide between a $1,500 or a $2,500 hospital confinement benefit. Your cost is based on your age and the tier you select. You can choose from four levels of coverage, including employee only, employee and dependent children, employee and spouse or employee, spouse and dependent children. You pay 100% of the cost of this benefit on a post-tax basis.

For additional information regarding the Short Term Disability, Cancer and Medical Bridge plans, visit the Hamline Benefit website at: http://www.hamline.edu/offices/human-resources/benefits/financial-planning-and-security/

MetLaw

MetLaw provides you with an unlimited number of telephone and office consultations with the attorney of your choice. The monthly cost of $18 covers you, your spouse and dependents. Your premium is automatically deducted from your paycheck on a post-tax basis. Additional services for legal representation and family matters are available at an additional fee. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action. Areas of legal consultation include:

- Estate planning
- Family law
- Juvenile matters
- Money matters
- Traffic offenses
- Consumer protection
- Real estate matters
- Document preparation
- Defense of civil lawsuits
- Elder law matters
- Immigration assistance
- Personal property protection

For More Information
Visit info.legalplans.com and enter access code GETLAW.

You can also call 800.821.6400.

Employee Assistance Program – EAP through Medica

The Employee Assistance Program available through Optum is an excellent source for confidential support, expert information and valuable resources, when you need it the most. You have access 24/7 to master's-level clinicians. Counselors have a wide range of expertise to assist you, including specialty teams for tobacco and gambling problems. Management consultation counselors are also available to help with workplace issues.

When appropriate, Optum will connect you with a local counselor who can address your concerns in person. If you need additional assistance, the counselors can help you get care through your Medica health plan or refer you to affordable community resources.

For more information or to speak to a clinician, call Optum at 800.626.7944.

EmployeeConnect Plus – EAP through Lincoln Financial

Everyone needs help solving problems sometimes. Lincoln Financial Group provides you and your family with confidential support to help you with a variety of issues 24/7, 365 days per year. You have access to unlimited phone counseling for legal, financial and work-life services. You can also receive up to six in-person sessions per person, per issue, per year to help you deal with:

- Depression
- Stress management/anxiety
- Marital or family conflict
- Relationship problems
- Financial concerns
- Legal questions
- Addictions

For more information, call (855) 327-4463 or visit www.GuidanceResources.com (Web ID = Lincoln)

Identity Theft

Lincoln Financial Group's identity theft program provides access to a wealth of information that will help you recognize and prevent ID theft. Take steps to protect your cell phone, computer and tax records from fraud. Lessen the damage and repair your credit if identity theft occurs. Call 855-891-3684.

Will Preparation

You have access to an online will preparation tool that allows you to build state-specific customized wills and other legal documents such as last wills, living wills and power of attorney documents. Learn more by visiting www.lincoln4benefits.com (Web ID = LifeKeys)

Travel Assistance

If you are 100 or more miles from home with a medical problem or emergency, this benefit can help you evaluate, troubleshoot and make immediate recommendations for any emergency situation. Issues may range from a lost prescription to hospital admission to the need for medical evacuation. For assistance, call 800-527-0218 and provide them with ID number 322541.

Terms Defined

Coinsurance
Coinsurance is the rate at which you and the plan share expenses. The coinsurance percentages noted in this guide are the covered percentage paid by Medica. For example, 80% coverage indicates 80% of the cost is paid by the plan and it is your responsibility as a participant to pay the remaining 20% of the cost of service. The coinsurance rates vary depending on the medical plan and whether the services are incurred in-network or out-of-network. (Note: coinsurance shown in other documents may indicate the participant's coinsurance percentage rather than the plan's percentage.)

Copay
The fixed-dollar amount you pay for specific services in Plans C and D. After you pay this amount, the plan pays the rest of the cost of your service or prescription.

Deductible
The annual amount you must pay for non-preventive services before the plan starts to pay benefits.

Embedded Deductible
The IRS regulates the minimum deductible level at which a high deductible health plan may have an embedded deductible. For 2018, this minimum is $2,700/$5,400. Plans with an embedded deductible have a single deductible "embedded" within the family deductible to help limit an individual's expenses. This means that if one person in a family meets the single deductible, the plan coinsurance would start. Without an embedded deductible, one person in a family would need to meet the entire family deductible before the plan coinsurance would go into effect.

Flexible Spending Account (FSA)
An account that an employee may contribute to in order to pay for certain expenses on a pre-tax basis. An employee can have a medical flexible spending account to pay for medical, dental, vision and hearing expenses (limited to dental, vision and hearing if you also have an HSA) and/or a dependent care flexible spending account to pay for dependent care expenses. Use-it or lose-it rules apply.

Health Savings Account (HSA)
A savings account used in conjunction with a high deductible health insurance policy that allows users to save money tax-free against medical expenses. Funds roll over from year to year.

Out-of-Pocket Maximum
For your protection, both plans have annual out-of-pocket maximums that "cap" the amount you must pay toward covered expenses. Once you meet your out-of-pocket maximum, the plan pays 100% of your covered expenses for the rest of the calendar year. Deductibles, co-pays and coinsurance count toward your out-of-pocket maximum. Out-of-pocket maximums differ for in-network and out-of-network services.

Pharmacy Formulary
A list of prescription drugs used by practitioners to identify drugs that offer the greatest overall value. A team of physicians and pharmacists regularly reviews new and existing drugs to be sure the Preferred Drug List continues to meet the needs of members and providers. Drugs may be added to the list at any time during the year; however, Medica strives to limit removing drugs to no more than twice a year. If a change to the list affects a drug you are taking, we'll send you a letter telling you about the change.

Premium
The amount you pay out of your paycheck toward the cost of coverage.

Preventive Care
Routine preventive care is critical to maintaining your health and uncovering problems early. All Hamline medical plans cover certain preventive services at 100% (no deductible or co-pay) from in-network providers. Services include annual wellness exams and certain screenings based on age for you and your covered dependents.

Prior Authorization
Prior Authorization approval is needed by Medica for coverage of a certain medications, services or supplies. Medications that require Prior Authorization are noted on the Preferred Drug List with a "PA" next to the drug name. Examples of services or supplies that require Prior Authorization are listed in your Certificate of Coverage. To verify whether a specific service or supply requires prior authorization, call Customer Service. As a provider in the Medica network, your doctor will know how to request Prior Authorization.

Step Therapy
Step Therapy is a program focused on using cost-effective prescription drugs as first-line treatment when appropriate. The program is used for certain conditions where there are many treatment options available. Drugs that require Step Therapy are noted on the Preferred Drug List. In Step Therapy, you try the preferred (Step 1) drug or drugs first. Step 1 drugs are cost efficient and effective options. If the Step 1 drug isn't effective, you can then try the Step 2 drug. In some cases, you may need to try more than one Step 1 drug before trying a Step 2 drug. If you don't try the Step 1 drug or drugs first, then a Step 2 drug won't be covered. Your doctor can request an exception to this process.

Usual and Customary (U&C)
Payment for health care services received out-of-network is based on the U&C rates. The rate will be used to determine how much will be paid for a specific service. When out-of-network, you are responsible for the difference between what your provider charges and what the plan considers U&C, plus any co-insurance. The amount above and beyond the U&C rate is your responsibility and does not count towards the plan deductible or the out-of-pocket maximums.

Important Notices

According to federal and state legal directives, we are required to provide the following information.

Special Enrollment Rights

You may be eligible to enroll yourself and your dependents in a medical plan without waiting for an open enrollment period if:

- You or your eligible dependents declines the Medical Plan because you have other group medical coverage, then you lose the other coverage because you are no longer eligible, or because the employer failed to pay the required premium. In such cases, you must enroll in the Medical Plan within 30 days after losing the other coverage. You will have to provide proof that you had other coverage.

- You or your eligible dependents declines the Medical Plan because you have COBRA coverage under another group medical plan, then you exhaust your COBRA coverage. In such cases, you must complete your entire COBRA coverage period, and you must enroll in the Medical Plan within 30 days after completing your COBRA coverage period. You will have to provide proof that you completed your COBRA coverage period.

- You decline the Medical Plan and then a new dependent is added to your family due to marriage, birth, adoption, or placement for adoption. In such cases, you must enroll in the Medical Plan within 30 days after the marriage, birth, adoption or placement for adoption. You will have to provide proof of the event.

- You and your eligible dependents become eligible for premium assistance through a state Medicaid or Children's Health Insurance program (CHIP) and when you lose coverage under one of these programs. In such a case, you must request enrollment not later than 60 days after the loss of Medicaid or CHIP coverage or not later than 60 days of the determination of eligibility for Medicaid or CHIP premium assistance.

Newborns' and Mothers' Health Protection Act

Under federal law, health care plans may not restrict any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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 and with the mother's consent, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Women's Health and Cancer Rights Act of 1998

Under the Women's Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, plans that provide medical and surgical benefits for a mastectomy must also provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;

- External breast prostheses (breast forms that fit into a bra) that are needed before or during the reconstruction; and

- Treatment of physical complications in all stages of mastectomy, including lymphedemas.

Coverage is determined by the health plan, in coordination with the physician and patient.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility:

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+ : Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

Hamline University Health Plans Notice of Privacy Practices

Effective April 14, 2004 (updated 2013)

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:

Manager of Employee Benefits
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.

MNsure Coverage Options and Your Health Coverage: For Employees Whose Employers offer health coverage

General Information

When key parts of the health care law known as the Affordable Care Act take effect, there will be a new place to buy health insurance in Minnesota; MNsure. To assist you as you evaluate options for you and your family, this notice provides some basic information about MNsure and employment-based health coverage offered by your employer.

What is MNsure?

MNsure is designed to help you find health insurance that meets your needs and fits your budget. MNsure offers "onestop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium for health insurance plans sold through MNsure or free or low-cost insurance from Medical Assistance or MinnesotaCare. Open enrollment for health insurance coverage through MNsure begins November 1, 2017 for coverage starting as early as January 1, 2018.

Can I Save Money on my Health Insurance Premiums through MNsure?

Yes. You may qualify to save money and lower or eliminate your monthly premium. You may qualify for a tax credit or MinnesotaCare only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through MNsure?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit or MinnesotaCare through MNsure and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, a reduction in certain cost- sharing, or MinnesotaCare if your employer does not offer coverage that meets certain standards. If the cost of a plan from your employer for you, the employee only, is more than 9.5% of your household income for the year, or if the coverage does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

If you are seeking help paying costs for health coverage through MNsure, you will need information about the cost and value of your employer coverage to complete an online or paper application. If your employer offers health coverage to you, ask your employer to complete and give you the Health Coverage from Jobs (Appendix A) form. If your employer does not offer coverage to you, you do not need your employer to complete the Health Coverage from Jobs (Appendix A) form.

Note: If you purchase a health plan through MNsure instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer in contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for Federal and State income tax purposes. Your payments for coverage through MNsure are made on an after –tax basis.

How Can I Get More Information?

There is help available to you to evaluate your coverage options through MNsure, including your eligibility for coverage through MNsure and its cost. Please visit **www.mnsure.org** for more information, including an online application for health insurance coverage, or call 1-855-3MNsure (1-855-366-7873).

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[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Provided by:

NFP

This Benefit Guide provides a summary of benefits under the Hamline University health and welfare plans. It is not intended to give advice and it does not provide every plan detail. Every effort has been made to ensure the accuracy of this brochure. However, if there are any discrepancies between this brochure and the actual plan documents that govern the plans, the plan documents will control in all cases.

Human Resources Contact Information

"We Are Here to Help"

Office of Human Resources

MS-C1904, 1536 Hewitt Avenue
Saint Paul, MN 55104-1284
P: 651-523-2210
F: 651-523-3034
Web Address: http://www.hamline.edu/offices/human-resources/

Lisa Todd
DIRECTOR, HUMAN RESOURCES
651-523-2021
ltodd01@hamline.edu

Lynn Willmert
MANAGER, HUMAN RESOURCES
651-523-2947
lwillmert01@hamline.edu

Annie Hanebuth
BENEFITS ADMINISTRATOR, HUMAN RESOURCES
651-523-2815
ahanebuth01@hamline.edu

Rachel Perry
HR BUSINESS PARTNER, HUMAN RESOURCES
651-523-2094
ahanebuth01@hamline.edu

Brian Tiegs
HR BUSINESS PARTNER, HUMAN RESOURCES
651-523-2859
ahanebuth01@hamline.edu

Paula Goncalves
HR BUSINESS PARTNER, HUMAN RESOURCES
651-523-2677
ahanebuth01@hamline.edu

Insurance and Benefit Information	
Medical Insurance **Medica** - Group #s vary – see your ID card Networks: Passport, Elect and VantagePlus Member Services: 952-945-8000	www.mymedica.com -Access benefit and claim information -Order replacement or temporary cards -Participate in My Health Rewards Programs -Estimate health care and pharmacy costs
Dental Insurance **Delta Dental** – Group #493770 Network: PPO & Premier Member Services: 651-406-5916 or 800-553-9536	www.deltadentalmn.org -Access benefit and claim information -Locate participating dentists
Vision Insurance **EyeMed** – Group #1008703 Member Services: 888-203-7437	www.eyemed.com -Locate participating provider -Print benefit cards
Life Insurance & Long Term Disability **Lincoln Financial Group** Group Life #1480858 Group LTD # 1481307 Member Services: 800-423-2765	www.LincolnFinancial.com Life Policy#: 01-0166068 LTD Policy #: 01-0166069 Voluntary Life Policy#: 40-0166070 AD&D Policy #: 40-3001856
Health Savings Account (HSA) **Optum**: 844-326-7967	www.optumbank.com -Request replacement debit cards -Check account balances -Update Beneficiary Information
Flexible Spending Accounts (FSA) **121 Benefits** Flex Account Questions: 612-877-4321 Claims Fax Number: 952-877-918-3622	www.121benefits.com - Request replacement debit cards -Check account balances -Submit claims for reimbursement -Submit documentation for debit card transactions
Short Term Disability, Cancer & Medical Bridge **Colonial Life Insurance** Policyholder Contact: 800-325-4368 Fax Claims: 800-880-9325	www.coloniallife.com -Access policy information -File a claim -See important service contact numbers
Long Term Care Insurance **Genworth**: 800-416-3624 **TransAmerica**: 800-322-1434	https://longtermcare.genworth.com/
Legal Insurance **MetLaw** Client Services: 800-821-6400	www.legalplans.com -Locate an attorney -Request a claim number
Retirement **TIAA** Client Services: 800-842-2252	https://www.tiaa.org/public/tcm/hamline- Update Beneficiary Information -Change investment allocations -Check account balances
Employee Assistance Program (EAP) **Lincoln Financial Group** EmployeeConnect Services: 855-327-4463	www.GuidanceResources.com -Available to all Hamline Employees -100% Confidential -Available 24/7
Employee Assistance Program (EAP) **Medica** 800-626-7944	www.medica.com/eap -Available to all Hamline Employees -100% Confidential -Available 24/7