This piece is not a contract, but a summary of your benefits. Please refer to your contract (Summary Plan Description or Certificate of Coverage(s)) for more detailed information. In case of conflict, your contract will prevail for all claim adjudication.
This document includes the benefits and enrollment material offered at Carleton College for 2018. We encourage you to take the time to read through and explore your benefits options. At Carleton College, we value our employees and are committed to providing a comprehensive and competitive benefits package.
# HEALTH PLAN SUMMARY

We offer a health plan through HealthPartners for all benefit-eligible employees.

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Blue Plan In-network</th>
<th>Maize Plan In-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible per calendar year</td>
<td>$1,500/single</td>
<td>$1,000/single</td>
</tr>
<tr>
<td></td>
<td>$3,000/single + 1</td>
<td>$2,000/single + 1</td>
</tr>
<tr>
<td></td>
<td>$3,000/family</td>
<td>$2,000/family</td>
</tr>
<tr>
<td>Out of Pocket Max per calendar year</td>
<td>$2,500/single</td>
<td>$2,000/single</td>
</tr>
<tr>
<td></td>
<td>$5,000/single + 1</td>
<td>$5,000/single + 1</td>
</tr>
<tr>
<td></td>
<td>$5,000/family</td>
<td>$5,000/family</td>
</tr>
<tr>
<td>Health Savings Account (HSA) Carleton contribution</td>
<td>$1,000/single</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>$2,000/single + 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$2,000/family</td>
<td></td>
</tr>
<tr>
<td>preventive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Physicals, Well child care, Immunizations, Prenatal, Screening</td>
<td>You pay $0</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Physician Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits, Urgent Care Clinic, Chiropractic Manipulation</td>
<td>You pay 20% after deductible</td>
<td>You pay $45</td>
</tr>
<tr>
<td>Retail Clinic</td>
<td>You pay 20% after deductible</td>
<td>You pay $15</td>
</tr>
<tr>
<td>Mental/Behavioral/Substance Use Outpatient</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Emergency Room, Ambulance</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Outpatient, Inpatient Hospital</td>
<td>You pay 20% after deductible</td>
<td>You pay 20% after deductible</td>
</tr>
<tr>
<td>Prescription Drugs Formulary generic Formulary brand Non-formulary brand</td>
<td>20% after deductible</td>
<td>You pay $15</td>
</tr>
<tr>
<td></td>
<td>20% after deductible</td>
<td>You pay $50</td>
</tr>
<tr>
<td></td>
<td>20% after deductible</td>
<td>You pay $100</td>
</tr>
<tr>
<td>Select Preventive Drugs Formulary Generic Formulary Brand</td>
<td>You pay $12</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>You pay $45</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>20% after deductible</td>
<td>You pay 20% up to $50 maximum per script per month</td>
</tr>
</tbody>
</table>

## SUMMARY OF BENEFITS COVERAGE

Refer to your summary of benefit coverage (SBC) for a more detailed explanation about your health plan benefits, including mail order prescriptions and other health services.

Always use a network provider for highest benefit levels from your plan. Our health plans use the **Open Access** network. When you are out of the HealthPartners area, use the **CIGNA** network for best coverage. No referrals are needed when you use an Open Access or CIGNA provider.

## ABOUT THE BLUE PLAN

This high deductible health plan offers preventive and catastrophic coverage with an employer funded health savings account (HSA). Preventive care is covered at 100%. Prescription drugs are covered at 80% after your deductible has been met, with the exception of some preventive medications that have a copay and are not subject to the deductible.

## ABOUT THE MAIZE PLAN

This traditional PPO has a copay for office visits, a deductible for other types of care, and covers eligible services at 80% after the deductible is met. Preventive care is covered at 100%. Prescription drugs have a copay based on the type of prescription filled.

## DOMESTIC PARTNER COVERAGE

If you enroll a domestic partner on your plan, their portion of the premium coverage will be considered taxable income.

## QUESTIONS?

Call customer service at 952-883-5000 or call the phone number on the back of your ID card or visit [www.healthpartners.com](http://www.healthpartners.com).
HEALTH SAVINGS ACCOUNT ADVANTAGES

Is a health savings account right for me?

Like any health care option, an HSA has advantages and disadvantages. As you weigh your options, think about your budget and what health care you are likely to need in the next year.

If you are generally healthy and want to save for future health care expenses, an HSA may be an attractive choice.

Or if you are near retirement, an HSA may make sense because the money in the HSA can be used to offset costs of medical care after retirement.

Or if you think you might need expensive medical care in the next year and are able to meet the higher deductible, an HSA account can help maximize your tax savings.

Contributions made to the HSA are not available to those members who are enrolled in any part of Medicare, or other disqualifying coverage. Medicare Part A enrollment is automatic when you sign up for Social Security, so please carefully check your coverage.

If you are covered on the High Deductible Health Plan (HDHP), but you are also covered on another group health plan (such as your spouse’s group plan) that is not an HDHP, you would also be ineligible to accept or make contributions to an HSA.

An HSA is not available to employees who are enrolled in a spouse’s medical spending account (FSA), unless the spouse’s medical FSA is a limited medical FSA.

How much can you put in the health savings accounts?

Maximum contributions are $3,450 for single coverage and $6,850 for family coverage for 2018 (employer and employee contributions combined). If the employee is age 55+ they can contribute an additional $1,000 into their HSA account. The amounts contributed by Carleton ($1,000 for individual or $2,000 for employee plus one or family) are included in these annual totals.

Your Health Savings Account will be administered by Optum.

TOP REASONS TO HAVE AN HSA

Tax Saving & Earned Interest — Contributions are tax-deductible and earn tax-free interest.

Portability — You own your account, so even if you change jobs, your HSA funds are yours to keep.

Affordable Health Coverage — Use the HSA to cover 100% of out-of-pocket costs for routine medical expenses, such as office visits, lab tests, and prescription medications.

Reduced Insurance Premiums — The cost of coverage under the Blue plan is lower than the Maize plan.

Long-Term Savings — Contributions to your HSA accumulate and roll over year-to-year with no limit, which allows the account to grow tax-deferred.

Retirement Bonus — After age 65, funds may be withdrawn for any reason with no penalties. (If used for non-medical purposes, however, taxes will be imposed.)

Safety Net — An HSA has no “use it or lose it” restrictions, so balances can be built up to use for major medical events.

Coverage for the “Extras” — HSA funds may be used to pay for services often not covered by a medical plan, including dental and vision expenses.

Money That Works for You — Balances over $2,000 can be invested.

Empowerment — Take control of your health care decisions, including which providers you want to use, to ensure your health care dollars are spent wisely.
How do I use the HSA to pay for medical care?

It is rather simple. Here are the steps:

1. You and/or Carleton puts money into the HSA.
2. You or a dependent receives medical services.
3. A bill for medical services is submitted as a claim to HealthPartners.
4. You receive an Explanation of Benefits for the service, which will reflect the amount due to the provider.
5. At this time you can choose to:
   - Use your HSA funds to pay the provider directly for the amount due
   - Pay the provider with personal funds and request reimbursement
   - Use your funds and save your HSA dollars for future medical expenses
6. Process repeats until deductible and out-of-pocket maximums are met, after which benefits are paid for the remaining plan year.

How do I find information about medical costs and quality so I can make informed choices?

Call Member Services or log on to healthpartners.com to search for providers and clinics that offer the medical services you need at the best cost.

Can I withdraw money from an HSA for nonmedical expenses?

Yes, but if you withdraw funds for nonmedical expenses before you turn 65, you have to pay taxes on the money and a 20% penalty. If you take money out after you turn 65, you pay normal income taxes but no penalties.
HEALTH PLAN PREMIUMS

Premiums are shown per month effective for 2018:

Exempt Employees – Monthly Rates

<table>
<thead>
<tr>
<th>Status</th>
<th>Blue</th>
<th>Maize</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$122.66</td>
<td>$135.95</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$252.40</td>
<td>$281.80</td>
</tr>
<tr>
<td>Family</td>
<td>$367.17</td>
<td>$427.86</td>
</tr>
</tbody>
</table>

Non-Exempt Employees - Bi-weekly Rates

<table>
<thead>
<tr>
<th>Status</th>
<th>Blue</th>
<th>Maize</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$56.61</td>
<td>$62.75</td>
</tr>
<tr>
<td>Employee + 1</td>
<td>$116.49</td>
<td>$130.06</td>
</tr>
<tr>
<td>Family</td>
<td>$169.46</td>
<td>$197.47</td>
</tr>
</tbody>
</table>
VALUE – ADDED SERVICES

Resources available through HealthPartners:

**Care Line Service**: Receive advice from registered nurses, open 24 hours, by calling **800-551-0859**.

**Babyline Service**: Whether you’re pregnant or planning a pregnancy, this is an exciting time. Get your questions answered 24/7 while you are pregnant or if you have a new baby who is six weeks old or younger. Call the Babyline at **800-845-9297**.

**Behavioral Health Personalized Assistance Line (PAL)**: Find a behavior health professional when you have questions about mental health and chemical dependency networks, benefits and services. Call **952-883-5811** or **888-638-8787** for help.

**virtuwell**: Your 24/7 online clinic, virtuwell is a great option for simple medical conditions like cold and flu, ear pain and sinus infections. A visit is only $45 or less depending on your benefit plan. If you are with HP, you will pay same amount as a convenience clinic visit. Log on to [www.virtuwell.com](http://www.virtuwell.com).

**yumPower**: Find tasty foods that power your body and help you live the best life. Search healthy recipes, find tools, tips and great videos at [www.yumPower.com](http://www.yumPower.com).

**Tobacco Cessation**: HP wants to help you quit smoking and lead a healthier life. We offer several resources and tools to make quitting easier. Count on us to help you overcome the obstacles and get on the path to a healthier, smoke-free lifestyle. Sign up with a health coach at **800-311-1052**.

**Travel Assistance**: If you have an emergency while traveling, we can assist with lost luggage, find translators, medical assistance, and more. Call **800-872-1414**.

**OnTrackRx**: A program that provides ways for you to manage your medicines. Use this resource to help you save time and money through MyMailRx and the Drug Cost Calculator, get support from pharmacist through RxCheckup and Pharmacy Navigators, and set reminders for taking your prescriptions on time. More information is at [www.healthpartners.com](http://www.healthpartners.com).

**Convenience Clinics**: HP has joined with various convenience clinics, including MinuteClinic, to provide healthcare for many common illnesses and vaccinations. Your health plan convenience care benefit applies.

SAVE MONEY!

**Fitness Discounts**: When you visit fitness clubs like Lifetime Fitness, YMCA, YWCA, Gold’s Gym, or Snap Fitness and work out 12 times per month, you and an adult dependent can receive a $20 discount, per person (2 max) for each qualifying month. HP does offer discounts on other club joiner’s fees and dues as an option.

**Healthy Discounts**: As part of your HealthPartners plan, you get special discounts or prices with our program. Receive discounts on eyewear, allergy relief supplies, fitness classes, Nutrisystem, fitness equipment, children’s swim lessons, spa services and saunas. Just show your Member ID card at stores and companies that are part of the program, and receive discounts to help you feel and look great!

**Vision Discounts**: Save up to 35% on eyewear at HealthPartners Eye Care Centers, Target, Pearl Vision, Lens Crafters and more by simply showing your HealthPartners ID card.
DENTAL PLAN SUMMARY

About the Dental Plan: These plans cover preventive care at 100% in-network, and cover many standard dental procedures at 80%. For more major procedures and orthodontics, the comprehensive plan covers 50%. You may use any dentist for your dental services; however, using an in-network provider will reduce your out-of-pocket costs.

<table>
<thead>
<tr>
<th>Features</th>
<th>Value Plan In-network</th>
<th>Comprehensive Plan In-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Maximum</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$50/person; $150/family</td>
<td>$50/person; $150/family</td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive</td>
<td>You pay $0</td>
<td>You pay $0</td>
</tr>
<tr>
<td>Basic Restorative Care</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>Endodontic Therapy</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>You pay 20%</td>
<td>You pay 20%</td>
</tr>
<tr>
<td>Major Restoratives</td>
<td>No coverage</td>
<td>You pay 50%</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>No coverage</td>
<td>You pay 50%; $1,500 lifetime maximum benefit</td>
</tr>
</tbody>
</table>

Dental Plan Premiums: This is a voluntary plan, meaning you pay 100% of the premiums. These rates are effective January 1, 2018:

Exempt Employees – Monthly Rates

<table>
<thead>
<tr>
<th>Status</th>
<th>Value Plan</th>
<th>Comprehensive Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$34.24</td>
<td>$45.58</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$68.72</td>
<td>$91.60</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$64.68</td>
<td>$86.10</td>
</tr>
<tr>
<td>Family</td>
<td>$111.16</td>
<td>$147.98</td>
</tr>
</tbody>
</table>

Non-exempt Employees – Bi-weekly Rates

<table>
<thead>
<tr>
<th>Status</th>
<th>Value Plan</th>
<th>Comprehensive Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$15.80</td>
<td>$21.04</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$31.72</td>
<td>$42.28</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$29.85</td>
<td>$39.74</td>
</tr>
<tr>
<td>Family</td>
<td>$51.30</td>
<td>$68.30</td>
</tr>
</tbody>
</table>

We offer two plans through Delta Dental. Always use an in-network provider to obtain the highest level of benefits.

When accessing care out of network, there are no provider discounts and the member is responsible for the difference between what is charged/billed over the Usual and Customary percentile.

DOMESTIC PARTNER COVERAGE

If you enroll a domestic partner on your plan, their portion of the premium coverage will be considered taxable income.

INFORMATION ON THE GO!

Access your dental account information from your smartphone or mobile device with Dental Delta app. With this app, you can:

- View your summary of benefits or claims
- Access your ID card
- Find a network dentist
- Brush with Toothbrush Timer

AMPLIFON HEARING HEALTH CARE

As a Delta Dental member, you receive discounts and savings on hearing diagnostic testing, along with the guaranteed lowest pricing on hearing aids. Call 877-846-7074 or visit www.amplifonusa.com for information.

QUESTIONS?

Call customer service at 800-553-9536 or call the phone number on the back of your ID card or visit www.deltadentalmn.org.
**VOLUNTARY VISION SUMMARY**

Our vision plan is offered through VSP.

**About the Vision Plan:** This is a comprehensive plan for all vision services. You may use any provider for your vision services; however, using an in-network provider will reduce your out-of-pocket costs.

<table>
<thead>
<tr>
<th>Features</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Exam</strong> (1x per calendar year)</td>
<td>You pay $10</td>
<td>Allowance up to $45</td>
</tr>
<tr>
<td><strong>Prescription Glasses</strong> (1x per calendar year)</td>
<td>You pay $25</td>
<td>Allowance up to: $30, Single $50, Bifocal $65, Trifocal</td>
</tr>
<tr>
<td><em>Single, Bifocal, Trifocal</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Standard Progressive</em></td>
<td>You pay $55</td>
<td>Allowance up to $50</td>
</tr>
<tr>
<td><em>Premium Progressive</em></td>
<td>You pay $95-$105</td>
<td></td>
</tr>
<tr>
<td><em>Custom Progressive</em></td>
<td>You pay 150-$175</td>
<td></td>
</tr>
<tr>
<td><strong>Frames</strong> (1x every other calendar year)</td>
<td>$130 allowance for frames</td>
<td>Allowance up to $70</td>
</tr>
<tr>
<td></td>
<td>$150 allowance for featured frames</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% discount on any amount over the allowance</td>
<td></td>
</tr>
<tr>
<td><strong>Contacts</strong> (1x per calendar year)</td>
<td>$130 allowance</td>
<td>Allowance up to $105</td>
</tr>
<tr>
<td><em>Elective or necessary, in lieu of glasses</em></td>
<td>You pay up to $60</td>
<td></td>
</tr>
<tr>
<td><strong>Contact lens fitting</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Vision Plan Premiums:** This is a voluntary plan, meaning you pay 100% of the premiums. Premiums are effective January 1, 2018:

### Exempt Employees – Monthly Rates

<table>
<thead>
<tr>
<th>Status</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$7.99</td>
</tr>
<tr>
<td>Employee + Spouse/Partner</td>
<td>$12.78</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$13.05</td>
</tr>
<tr>
<td>Family</td>
<td>$21.03</td>
</tr>
</tbody>
</table>

### Non-exempt Employees – Bi-weekly Rates

<table>
<thead>
<tr>
<th>Status</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$3.69</td>
</tr>
<tr>
<td>Employee + Spouse/Partner</td>
<td>$5.90</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$6.02</td>
</tr>
<tr>
<td>Family</td>
<td>$9.71</td>
</tr>
</tbody>
</table>

Always use an in-network provider to obtain the highest level of benefits.

When accessing care out of network, you receive an amount that the provider will pay up to. You are then responsible for the difference.

**Note:** This is a voluntary plan, participation is optional. You may waive this coverage if you don’t need eyeglasses or contacts.

**DOMESTIC PARTNER COVERAGE**

If you enroll a domestic partner on your plan, their portion of the premium coverage will be considered taxable income.

**QUESTIONS?**

Call customer service at 800—877-7195 or call the phone number on the back of your ID card or visit [www.vsp.com](http://www.vsp.com).
FLEXIBLE SPENDING ACCOUNTS

We sponsor flexible spending accounts to help you pay for everyday expenses on a pre-tax basis. The FSA plan year is January 1, 2018 through December 31, 2018. The FSA benefit helps you pay for everyday medical expenses on a pre-tax basis by:

- **Premiums**: Pre-tax contributions for medical, dental and vision premiums.
- **Medical care**: You can set aside pre-tax contributions for medical, dental and vision expenses not paid by your (or your spouse’s) insurance plans up to $2,650 depending on your election. As a reminder, you need to obtain a prescription for over-the-counter medications in order to use your FSA dollars for reimbursement (one prescription per OTC med, per year needed).
- **Dependent care**: You can set aside pre-tax contributions for dependent care expenses up to $5,000 per plan year.

Participants **must enroll annually** for the plan year.

Each component of the FSA requires a separate election. Funds cannot be moved from one component to another. Contributions cannot be changed unless a qualifying life event occurs and must be made within 30 days of the event. All components are “use it or lose it.” No dollars will roll over to the next plan year.

EMPLOYEE ASSISTANCE PROGRAM

Employees and their family members have access to an Employee Assistance Program (EAP) provided by HealthPartners. This program can help you cope with life’s every day, and not-so-everyday, challenges. You have unlimited phone and web access to receive confidential counseling on personal issues, legal matters, resources for work-life needs, financial information, in addition to many online tools and services. Professional counselors are available 24/7/365.

Call **866-326-7194** or visit [www.hpeap.com](http://www.hpeap.com)

Password: Carleton

HR SIMPLIFIED

We offer our Flexible Spending Plan through HR Simplified.

You can use the debit card associated with your account to pay for eligible medical expenses, or to file a claim, you can go online to [www.hrsimplified.com](http://www.hrsimplified.com) or fax your claim form and accompanying receipts to **877-723-0146**.

QUESTIONS?

Call customer service at **888-318-7472** or call the phone number on the back of your ID card or visit [www.hrsimplified.com](http://www.hrsimplified.com).
FOCUS ON BENEFITS 2018
Carleton College

LIFE AND AD&D

All benefit eligible employees are enrolled in life and accidental death & dismemberment (AD&D) insurance. You are covered for 3 ½ times your annual salary up to $250,000. The original amount of the Life and AD&D benefits will reduce as you age. The cost for this plan is paid for by Carleton. Now is a great time to review or update your beneficiary.

VOLUNTARY LIFE INSURANCE AND AD&D

Employees may elect optional life insurance and accidental death and dismemberment (AD&D) insurance. These plans are paid 100% by you and are intended to supplement the provided Basic Life and AD&D Insurance described above. Evidence of insurability may be required if you have declined coverage previously or if you are applying for increased coverage. Please note the guaranteed issue amounts available for newly eligible employees.

<table>
<thead>
<tr>
<th>Employee/Spouse Benefit</th>
<th>Maximum benefit is $500,000. Sold in $10,000 increments. Guaranteed issue amount of $150,000 with no evidence of insurability for newly eligible employees.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse Benefit</td>
<td>Maximum benefit is $250,000, not to exceed 50% of the employee’s benefit. Sold in $5,000 increments. Guaranteed issue amount of $40,000 with no evidence of insurability for newly eligible employees.</td>
</tr>
<tr>
<td>Child(ren) Benefit (birth to age 26)</td>
<td>Maximum benefit is $10,000. Sold in $5,000 increments. Under 6 months the benefit is $500. These are all guaranteed amounts.</td>
</tr>
</tbody>
</table>

VOLUNTARY LONG TERM DISABILITY

All benefit eligible employees may purchase long term disability, which provides a benefit of 60% of your earnings up to a maximum monthly benefit of $10,000 in the event of a qualifying disability claim. Benefits begin after 90 days. Carleton and the employee share in the after-tax premium by each paying half of the total cost. Evidence of insurability will be required if you have previously declined coverage.

VOLUNTARY LIFE & AD&D INSURANCE RATES

The premiums are shown per $1,000 increments:

<table>
<thead>
<tr>
<th>Employee/Spouse</th>
<th>Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30</td>
<td>$.046</td>
</tr>
<tr>
<td>30-34</td>
<td>$.052</td>
</tr>
<tr>
<td>35-39</td>
<td>$.077</td>
</tr>
<tr>
<td>40-44</td>
<td>$.127</td>
</tr>
<tr>
<td>45-49</td>
<td>$.216</td>
</tr>
<tr>
<td>50-54</td>
<td>$.363</td>
</tr>
<tr>
<td>55-59</td>
<td>$.615</td>
</tr>
<tr>
<td>60-64</td>
<td>$.753</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.114</td>
</tr>
<tr>
<td>70+</td>
<td>$2.212</td>
</tr>
</tbody>
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VALUE – ADDED SERVICES

Resources available through CIGNA.

HEALTHY REWARDS DISCOUNT PROGRAM

From spin and yoga classes to natural supplements, CIGNA’s Healthy Rewards provides discounts of up to 60% on health programs and services as part of CIGNA’s ongoing effort to promote wellness. There’s no time limit or maximum to enjoy these instant savings when you visit a participating provider or shop online. No referrals or claim forms needed. The programs available include weight management and nutrition, vision and hearing care, tobacco cessation programs, alternative medicine, mind/body, fitness, vitamins and other health and wellness products. Once enrolled in the insurance plan, you can learn more about Healthy Rewards by visiting www.cignabehavioral.com/cgi (username: rewards and password: savings) or calling 800-258-3312.

WILL PREPARATION PROGRAM

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. You can also find information on estate planning, identity theft information and insurance planning kits to help protect you and your family. Learn more by visiting www.CIGNAWillCenter.com.

IDENTITY THEFT PROGRAM

Identity theft is a fast growing crime, victimizing over 11 million people a year. CIGNA’s identity theft program provides access to personal case managers who give step-by-step assistance and guidance to employees who have had their identity stolen. This program provides real time support, 24/7/365 in every country. Features include access to personal case managers, education website with helpful tips, an identity theft resolution kit and assistance with credit reports and documents. Call 888-226-4567.

CIGNA SECURE TRAVEL

Whenever you travel domestically or internationally, this program will provide emergency medical, financial, legal and communication assistance. Services include 24 hour multi-lingual assistance, pre-departure services, medical evacuation services, assistance with lost or stolen items, travel arrangements for companion or dependent child and prescription refill services.

CIGNASSURANCE

This program is available for beneficiaries at no cost to provide peace of mind during times of need. Services include bereavement assistance, counseling, telephonic legal and/or financial consultation.
RETIREMENT PLANS

Invest in your future by taking advantage of Carleton’s voluntary retirement plan options. Employees have access to Supplemental (pre-tax) 403(b) and Roth (after-tax) 403(b) options.

Employees can enroll or change their participation in the plans at any time. Those who wish to enroll in the Supplemental 403(b) or Roth 403(b) should complete a Retirement Salary Reduction Agreement Form and set up their voluntary retirement plan with TIAA ([www.tiaa.org](http://www.tiaa.org)).

CONTRIBUTIONS TO YOUR RETIREMENT

The maximum amount you can contribute to your retirement in 2018 is the lesser of 50% of your annual income or the maximum as determined by the IRS. The 2018 maximum is $18,500.

Special catch-up provisions are available for employees age 50 and older. If you are, or will be, age 50 or older by December 31, 2018, you are eligible to contribute an additional $6,000 into the plan for 2018. Some special restrictions may apply. An addition lifetime catch-up may also apply.

ENROLLMENT OR CHANGES

You may change your contribution by completing a new retirement salary reduction agreement at any point. You may change your investment elections, obtain balance information and achieve a variety of other transactional activities by calling TIAA-CREF at 1-800-842-2252. Or visit [www.tiaa.org](http://www.tiaa.org).
NEXT STEPS!

ENROLLMENT INSTRUCTIONS
To enroll in your benefits, log in to benefitsCONNECT.

If you enroll in your benefits and change your mind, you are able to make changes anytime during the open enrollment period, however you’ll need to contact Human Resources to reset your enrollment session.

For more information about the online benefits enrollment, attend one of the in-person sessions or contact Human Resources.

QUESTIONS?
Andrea Zunkel        x5989        azunkel@carleton.edu
Kerstin Cardenás    x4068        kcardena@carleton.edu

MAKING CHANGES TO YOUR BENEFIT ELECTIONS THROUGHOUT THE YEAR
To protect the tax advantages of your benefits, Carleton is required to follow certain IRS rules. These rules effect when you may change your benefits and what changes you may make.

You may change your benefit elections mid-year for the following events:

- The addition of dependents due to the birth or adoption of a child
- Marriage
- Your divorce, legal separation, annulment, dissolution of domestic partnership
- The death of one of your dependents
- A change in the employment status of your spouse or dependent, including the termination or commencement of employment, loss of work due to a strike or lockout
- The commencement or return from an unpaid leave of absence
- Your dependent loses or gains benefit eligibility of an employer’s benefit
- Your spouse or dependent's employer’s open enrollment

Notification must be made within 30 days of the event.
WHAT ARE THESE GOVERNMENT NOTICES ALL ABOUT?

Following this page are several notices that the federal government requires us to give individuals who are covered under our group health plan(s). The purpose of these notices is to inform you of certain rights you and your family may have under federal law. In addition to rights under federal law, you may have rights under state law.

You may find it helpful to review this information as you make your benefit enrollment decisions. Please keep this information with your other written plan materials.

1. HIPAA Portability Notice
2. Initial COBRA Notice
3. Notice of Exchange
4. Medicare Part D Coverage Notice
5. HIPAA Notice of Privacy Practices
6. CHIP Notice
7. WHCRA Notice
HIPAA PORTABILITY NOTICE

Our records show that you are eligible to participate in the company’s Group Health Plan (to actually participate, you must complete an enrollment form and pay your share of the premium). A federal law called HIPAA requires that we notify you about some important provisions in the plan.

Special enrollment rights
If you are declining 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 towards 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.

If you are declining enrollment because you and/or your dependents are covered under a Medicaid plan or state Child Health Plan (CHIP) and that coverage is terminated due to a loss of eligibility, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after the date that termination of such coverage occurred and meet certain other important conditions described in the Summary Plan Description.

If you and/or your dependents are determined to be eligible under a state’s Medicaid plan or state Child Health Plan (CHIP) for premium subsidy assistance, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days of the determination of eligibility for premium subsidy assistance for you or your dependents and meet certain other important conditions as described in the respective Summary Plan Description.

To request special enrollment or obtain more information, contact Andrea Zunkel, Benefits Coordinator, 507-222-5989 or azunkel@carleton.edu.
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. 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 for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

• Your spouse dies;
• Your spouse’s hours of employment are reduced;
NOTICES

- 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 of the following qualifying events:

- 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.”

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other 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: Andrea Zunkel, Benefits Coordinator, 507-222-5989 or azunkel@carleton.edu.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that 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. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have 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 COBRA continuation coverage.

**Second qualifying event extension of 18-month period of continuation coverage**
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA continuation coverage?**
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**If you have questions**
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 [www.dol.gov/ebsa](http://www.dol.gov/ebsa) (addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website). For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Keep your plan informed of address changes**
To protect your family’s rights, let the Plan Administrator know about 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:**
Andrea Zunkel, Benefits Coordinator, **507-222-5989** or azunkel@carleton.edu.
NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Part A: General information

Since 2014, individuals can purchase health insurance through the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November for coverage starting as early as January 1st.

Can I save money on my health insurance premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but 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 the Marketplace?
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 through the Marketplace 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, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace 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 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 the Marketplace are made on an after-tax basis.

How can I get more information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Andrea Zunkel, Benefits Coordinator, 507-222-5989 or azunkel@carleton.edu.

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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.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**Part B: Information about health coverage offered by your employer**

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

3. Employer name: Carleton College
4. Employer Identification Number (EIN): 41-0694747
5. Employer address: 1 North College Street
6. Employer phone number: **507-222-5989**
7. City: Northfield
8. State: MN
9. ZIP code: 55057
10. Who can we contact about employee health coverage at this job? Andrea Zunkel
11. Phone number (if different from above): same
12. Email address: azunkel@carleton.edu

**Here is some basic information about health coverage offered by this employer**

As your employer, we offer a health plan to:

- [ ] All employees. Eligible employees are:
  - ✗ Some employees: Eligible employees are defined as those working 0.46 FTE or greater

With respect to dependents:

- [x] We do offer coverage.
- [ ] We do not offer coverage.
- [ ] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important notice from Carleton College about your Prescription Drug Coverage and Medicare

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

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

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

2. Carleton College has determined that the prescription drug coverage offered by the Carleton College Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.
What happens to your current coverage if you decide to join a Medicare drug plan?
If you decide to join a Medicare drug plan, your current Carleton College coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Carleton College coverage, be aware that you and your dependents may not be able to get this coverage back right away or at all. Please review the Carleton College health plan documents for details regarding eligibility and enrollment rights.

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

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

For more information about this notice or your current prescription drug coverage...
Contact Human Resources at 507-222-7471. NOTE: You’ll get this notice each year. You will also get it if this coverage through Carleton College changes. You also may request a copy of this notice at any time.

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

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help

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

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

Date: 1/1/18
Name of Entity/Sender: Carleton College
Contact--Position/Office: Human Resources
Address: One North College St., Northfield, MN 55057
Phone Number: [507-222-7471](tel:507-222-7471)
NOTICE OF PRIVACY PRACTICE

Your information. Your rights. Our responsibilities.
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.

Your rights
You have the right to:
• Get a copy of your health and claims records
• Correct your health and claims records
• Request confidential communication
• Ask us to limit the information we share
• Get a list of those with whom we’ve shared your information
• Get a copy of this privacy notice
• Choose someone to act for you
• File a complaint if you believe your privacy rights have been violated

Your choices
You have some choices in the way that we use and share information as we:
• Answer coverage questions from your family and friends
• Provide disaster relief
• Market our services and sell your information

Our uses and disclosures
We may use and share information as we:
• Help manage the health care treatment you receive
• Run our organization
• Pay for your health services
• Administer your health plan
• Help with public health and safety issues
• Do research
• Comply with the law
• Respond to organ and tissue donation requests and work with a medical examiner or funeral director
• Address workers’ compensation, law enforcement, and other government requests
• Respond to lawsuits and legal actions
YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.
YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: a doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: we use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: we share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.
How else can we use or share your health information?
We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the department of health and human services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
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 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 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 August 10, 2017. Contact your State for more information on eligibility.

<table>
<thead>
<tr>
<th>State</th>
<th>Program Details</th>
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<tbody>
<tr>
<td>ALABAMA – Medicaid</td>
<td>Website: <a href="http://myalhipp.com/">http://myalhipp.com/</a>  Phone: 855-692-5447</td>
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<tr>
<td>ALASKA – Medicaid</td>
<td>The AK Health Insurance Premium Payment Program  Website: <a href="http://myakhipp.com/">http://myakhipp.com/</a>  Phone: 866-251-4861  Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a>  Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
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<tr>
<td>State</td>
<td>Medicaid Information</td>
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<td><strong>FLORIDA – Medicaid</strong></td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp/">http://flmedicaidtplrecovery.com/hipp/</a> Phone: 877-357-3268</td>
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<tr>
<td><strong>GEORGIA – Medicaid</strong></td>
<td>Website: <a href="http://dch.georgia.gov/medicaid">http://dch.georgia.gov/medicaid</a> Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507</td>
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<tr>
<td><strong>MASSACHUSETTS – Medicaid and CHIP</strong></td>
<td>Website: <a href="http://www.mass.gov/eohhs/gov/departments/masshealth/">http://www.mass.gov/eohhs/gov/departments/masshealth/</a> Phone: 1-800-862-4840</td>
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<tr>
<td><strong>INDIANA – Medicaid</strong></td>
<td>Website: <a href="http://www.in.gov/fssa/hip/">http://www.in.gov/fssa/hip/</a> Phone: 877-438-4479 All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a> Phone 800-403-0864</td>
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<tr>
<td><strong>IOWA – Medicaid</strong></td>
<td>Website: <a href="http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp">http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp</a> Phone: 888-346-9562</td>
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<td><strong>MISSOURI – Medicaid</strong></td>
<td>Website: <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a> Phone: 573-751-2005</td>
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<td><strong>KANSAS – Medicaid</strong></td>
<td>Website: <a href="http://www.kdheks.gov/hcf/">http://www.kdheks.gov/hcf/</a> Phone: 1-785-296-3512</td>
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<td><strong>MONTANA – Medicaid</strong></td>
<td>Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a> Phone: 1-800-694-3084</td>
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<td><strong>KENTUCKY – Medicaid</strong></td>
<td>Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570</td>
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<td><strong>NEBRASKA – Medicaid</strong></td>
<td>Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a> Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178</td>
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<td><strong>LOUISIANA – Medicaid</strong></td>
<td>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a> Phone: 1-888-695-2447</td>
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<tr>
<td><strong>NEVADA – Medicaid</strong></td>
<td>Medicaid Website: <a href="https://dwss.nv.gov/">https://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900</td>
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<tr>
<td>State</td>
<td>Program</td>
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<td>NEW JERSEY – Medicaid and CHIP</td>
<td>Medicaid Website:</td>
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<td>CHIP Website:</td>
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<td>RHODE ISLAND – Medicaid</td>
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<td>NEW YORK – Medicaid</td>
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<td>SOUTH CAROLINA – Medicaid</td>
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<td>NORTH CAROLINA – Medicaid</td>
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<td>SOUTH DAKOTA - Medicaid</td>
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<td>OKLAHOMA – Medicaid and CHIP</td>
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<td>UTAH – Medicaid and CHIP</td>
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<td>CHIP Website:</td>
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<td>OREGON – Medicaid</td>
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<td>VIRGINIA – Medicaid and CHIP</td>
<td>WISCONSIN – Medicaid and CHIP</td>
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<td>Medicaid Website:</td>
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<tr>
<td>Medicaid Phone: 1-800-432-5924</td>
<td>Phone: 1-800-362-3002</td>
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<td>CHIP Website:</td>
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<tr>
<td><a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a></td>
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<tr>
<td>CHIP Phone: 1-855-242-8282</td>
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<td><strong>WASHINGTON – Medicaid</strong></td>
<td><strong>WYOMING – Medicaid</strong></td>
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<td>Website:</td>
<td>Website:</td>
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<tr>
<td>Phone: 1-800-562-3022 ext. 15473</td>
<td>Phone: 307-777-7531</td>
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<tr>
<td><strong>WEST VIRGINIA – Medicaid</strong></td>
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<tr>
<td>Website:</td>
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<tr>
<td>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</td>
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</table>

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

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
[www.cms.hhs.gov](http://www.cms.hhs.gov)
877-267-2323, Menu Option 4, Ext. 61565
NOTICE OF RIGHTS UNDER THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

On October 21, 1998, the federal government enacted the Women’s Health and Cancer Rights Act. This law requires that all group health plans that provide coverage for mastectomies must also provide coverage for breast reconstruction surgery in connection with that mastectomy. This memo is intended to provide participants and beneficiaries with notice of their rights under the Women’s Health and Cancer Rights Act.

Participants and beneficiaries who receive benefits under the group health plan in connection with a mastectomy and elect breast reconstruction surgery in connection with that mastectomy are entitled to coverage for that reconstruction in a manner determined in consultation with the attending physician and the patient. Such coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These benefits may be subject to deductibles and coinsurance limitations consistent with those established for similar benefits under the group health plan.

Please contact the Human Resources Department or the company’s health insurance carrier directly for more information on your rights under the Women’s Health and Cancer Rights Act.
This Focus on Benefits provides a brief summary of your benefits. It does not contain all of the details described in the official plan documents and contracts. If there is any discrepancy between what is summarized here or any verbal descriptions of the plan and the official plan documents and contracts, the plan documents and contracts will govern.

Carleton College reserves the right to change, amend, suspend, or terminate any or all of the plans described in the guide at any time and for any reason. This Focus on Benefits is not a contract, and participation in any of the plans does not guarantee employment.

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