Employee Benefits Summary 2024

Saint Joseph's College of Maine
Human Resources

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Human Resources

Human Resources Department Mission

The mission of Human Resources is to support the goals of Saint Joseph's College by aligning our initiatives with the Strategic Plan and providing a values-centered work environment. We promote fairness, diversity, learning and solution-focused practices, while fostering a strong academic community of high-performing, talented, and engaged faculty, staff, and student employees.

The Funding of Your Benefits 2024

Saint Joseph's College provides an annual defined contribution amount to each eligible employee to purchase benefits for the year. The full-year amounts for 2024 are as follows:

Employee Only = $8,550
Employee + Spouse/LDA = $17,100
Employee + Child(ren) = $14,070
Employee + Family/LDA = $17,310
Waive: No Medical = $500

The employee is responsible for paying costs of elected benefits beyond the annual defined contribution amount through bi-weekly payroll deductions.

Benefit Plan Eligibility

Benefit plan eligibility is defined for the following groups at Saint Joseph's College:

- Employees who work 30 or more hours per week are eligible for the defined contribution and any of the benefits offered in the online benefit enrollment system.
- Employees who work 24 - 29 hours per week are eligible for any of the benefits offered in the online benefit enrollment system with no defined contribution.
- Employees working less than 24 hours per week are not eligible for any benefits offered in the online benefit enrollment system. These employees are eligible to enroll in voluntary contributions to the SJC 403(b) plan through AIG.

Election of Benefits

For 2024 benefits, College employees will make elections through the PlanSource enrollment platform. This online benefits enrollment system guides employees through the decision-making process allowing them to elect the most appropriate plans for their individual and family needs.

2024 SUMMARY OF EMPLOYEE BENEFITS

MEDICAL

Medical coverage is offered through Harvard Pilgrim Healthcare. We offer three (3) plans, which allow employees to choose the best option to meet their personal needs. They include a PPO with a $2,000 deductible, an PPO HSA with a $3,200 deductible and an HMO HSA with a $5,000 deductible.

Medical Plan Summaries

	PPO $2,000		PPO HSA $3,200		HMO HSA $5,000	
Type of Service	**In-Network**	**Out-of-Network (OON)**	**In-Network**	**Out-of-Network (OON)**	**In-Network**	**Out-of-Network (OON)**
Deductible (Individual/Family)	$2,000/$4,000	$4,000/$8,000	$3,200/$6,400	$9,000/$18,000	$5,000/$10,000	$10,000/$20,000
Coinsurance	80%	N/A	80%	60%	90%	60%
Inpatient Hospital (% paid after Deductible)	80%	60%	80%	60%	90%	60%
Outpatient Hospital (% paid after Deductible)	80%	60%	80%	60%	90%	60%
Coinsurance Limit	$2,000/$4,000	$4,000/$8,000	$3,000/$6,000	$9,000/$18,000	$1,550/$3,100	$10,000/$20,000
Maximum Out of Pocket	$4,000/$8,000	$8,000/$16,000	$6,000/$12,000	$18,000/$36,000	$6,550/$13,100	$20,000/$40,000
Emergency Room/ Urgent Care Services	$75 Copay Urgent Care/ $200 copay Emergency		80% after Deductible, Urgent Care OON 60% after Deductible		90% after Deductible, Urgent Care OON 90% after Deductible	
Prescriptions	$15 / $30 / $50	In-Network Only	After Deductible, $15/$30/$50	In-Network Only	After Deductible, $15/$30/$50	In-Network Only
Prev. Rx Deductible	N/A		Waived for preventive		Waived for preventive	
Preventive Care	$0 copay	Not Covered	$0 copay	Not Covered	$0 copay	Not Covered
Office Visits						
Primary Care (Copay or % paid after Deductible)	$25 Copay	60%	80%	60%	90%	60%
Specialist (Copay or % paid after Deductible)	$50 Copay	60%	80%	60%	90%	60%
Chiropractic Services (Copay or % paid after Deductible)	$25 or $50 Copay 20 Days	60%	80%	60%	90%	60%
PT, OT & Speech Therapy (Copay or % paid after Deductible)	$25 or $50 Copay	60%	80%	60%	90%	60%
Diagnostic Outpatient Testing						
Lab & X-Ray Services (Copay or % paid after Deductible)	Place of Service Copay		80%	60%	90%	60%
MRI, CT, PET Scans (Copay or % paid after Deductible)	Place of Service Copay		80%	60%	90%	60%

Medical Payroll Contributions

Level of Coverage	Medical Biweekly Deductions		
	PPO $2,000	HSA $3,200	HMO HSA $5,000
Employee Only	$143.32	$51.24	$15.36
Employee + Spouse/LDA	$461.79	$238.88	$151.50
Employee + Child(ren)	$394.45	$207.92	$135.24
Employee + Family/LDA	$501.39	$267.66	$176.61

DENTAL

For 2024, dental coverage is offered through The Standard. We continue to offer three plans: a High Option, Medium Option and Low Option.

VISION

Vision coverage is offered through The Standard. We offer one plan that allows you to access quality vision care, including a comprehensive vision and eye-health exam. Benefits include coverage for glasses and/or contact lenses. Members can visit in-network or out-of-network providers.

LIFE INSURANCE and ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Employer Paid Life Insurance

Saint Joseph's College provides an employer-paid $25,000 group term life and accidental death and dismemberment benefit at no cost to the employee. These plans are offered through The Standard.

For full-time eligible employees, at age 65 the term life insurance will reduce to $16,250, at age 70 to $11,250, at age 75 to $7,500 and at age 80 to $5,000.

Voluntary Group Life Insurance

In addition to the core benefit provided by Saint Joseph's College, employees working 24 or more hours are offered an opportunity to purchase additional term life insurance at group discounted rates. Purchase of voluntary group life insurance coverage may be made in $10,000 units up to eight (8) times your salary or a maximum of $500,000 of coverage. You may also purchase insurance for your spouse or LDA and dependent children.

As with the core benefit, coverage reduces for employees who continue to work and have reached the ages listed above. Applying for voluntary benefit amounts in excess of $250,000 for yourself or $25,000 for your spouse or LDA will require evidence of insurability (EOI). Late subscribers may also be asked for evidence of insurability.

LONG-TERM DISABILITY

Long Term Disability coverage is offered through The Standard. We offer one plan with a 60% benefit amount, up to $10,000 per month. The maximum amount is based on your salary.

WORK-LIFE BALANCE SUPPORT PROGRAMS

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) offered by The Standard is through an arrangement with Health Advocate. This service provides a multitude of options designed to assist you and family members in dealing with the stresses of daily life.

EAP services can help with:

- Depression, grief, loss, and emotional well-being
- Family, marital, and other relationship issues
- Life improvement and goal setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program which includes WorkLife Services. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

To access the Employee Assistance Program offered by The Standard, call **1-888-293-6948** or visit healthadvocate.com/standard3.

RestoreResilience Program

RestoreResilience is a digital program that focuses on helping you manage stress, build resiliency, improve your sleep, learn mindfulness and so much more. It is designed to help you overcome life stressors and is delivered through the combination of personalized content, live coaching, a best-in-class app, and community engagement.

SPENDING ACCOUNTS

Flexible Spending Accounts (FSA) - Medical

The Medical Reimbursement Account allows you to set aside pre-tax dollars for medical, dental and eyeglass expenses that you have in 2024. By setting this money aside in the Medical Reimbursement Account, you pay for these expenses with pre-tax dollars, meaning that you save the Federal, State and FICA taxes you would have paid if the money to pay these expenses were paid for with after tax dollars. Remember, an FSA account is not a "rainy day" fund to set aside in case a need arises. You must spend the money on qualified expenses in the plan year or you are likely to lose it. You may deposit up to $3,200 into the Medical Reimbursement Account.

Flexible Spending Accounts (FSA) – Dependent Care

In addition to the Medical Reimbursement Account, you also have the opportunity to set money aside into a Dependent Care Account that will allow you to pay for qualified expenses for childcare up to your child's age 13, or for elder care if you need to pay for daycare for an adult dependent that needs supervision while you are away at work. You may set aside up to $5,000 ($2,650 if you are married, filing separately) for qualified Dependent Care expenses.

Limited Purpose FSA

If you choose to participate in any of the Harvard Pilgrim Healthcare HSA plans, you may not use the above FSA account for most general medical expenses. You can however set aside pre-tax money into a Limited Purpose FSA for **dental and vision expenses**. Although these expenses may be paid out of your HSA, the advantage of using funds you have committed to into an FSA are available immediately, while HSA money is only available after it is deposited. As with any FSA money, if you do not use that money in a given year, you forfeit it.

Health Savings Accounts (HSA)

If you enroll in any of the Harvard Pilgrim Healthcare HSA medical plans, you may also elect to contribute to a separate Health Savings Account (HSA). This savings account allows you to put in your own money on a pre-tax basis to fund future medical expenses that may not be covered by your plan. Money that goes into the HSA account on your behalf immediately becomes your money. Money can accrue from year to year with interest, and, if you leave the College for any reason, you can take that money with you.

The 2024 limits for HSA deposits are $4,150 if you choose single coverage and $8,300 if you are insuring family members. If you are over age 55, there is an additional $1,000 catch-up contribution allowed.

ACCIDENT INSURANCE

Employees can purchase an Accident plan offered through Unum. This plan covers you, your spouse or LDA or dependent children for accidents on and off the job. This plan also includes a $50 wellness benefit per person per year.

CRITICAL ILLNESS

This benefit is offered through Unum. This benefit will pay a lump sum of money to you or your spouse or LDA at the time of diagnosis. The maximum benefit for you is $10,000 and your spouse or LDA is $5,000, depending on the illness. This plan also includes a $50 wellness benefit per person per year.

PREPAID LEGAL

You can choose from two benefit options offered through Hyatt Legal Plans, a Metlife company. These plans will cover attorney fees for many services when you use a network attorney. It's like having an attorney on retainer. There are no limits on the number of times you may use the plan.

IDENTITY THEFT

You can choose from two Identity Theft protection plans through ID Watchdog. Every two seconds someone has their identity stolen. You can choose either $25,000 or $1 million in reimbursement options.

HOSPITAL INDEMNITY

Saint Joseph's College offers the option to enroll in a Hospital Indemnity Insurance plan through Unum. This plan provides coverage in the event of a hospital stay. Should you opt in, the plan will pay up to a $1,000 lump sum for a qualified hospital stay per year, as well as $100 a day to a maximum of 60 days per year for a regular hospital stay, and $200 a day to a maximum of 15 days per year for an Intensive Care Unit hospital stay. This coverage is available to employees and their family members. For more information on this benefit and its features, including any pre-existing condition limitations, refer to the Explanation of Benefits in the PlanSource online benefits enrollment system.

PET INSURANCE

You can purchase pet insurance through Nationwide. Enrollment is directly with Nationwide and is then payroll deducted based on coverage elected.

ROUTINE PREVENTIVE SERVICES

Saint Joseph's College will make available up to 4 hours of paid time off for you to seek your preventive medical services. This benefit is extended to all full-time benefit eligible employees, regardless of coverage under the College plan.

LONG TERM ILLNESS (LTI)

The LTI benefit is an accrued sick time bank and is offered to full-time administrative staff and 12-month faculty. It is available for use when work is missed during an approved medical leave.

403(b) RETIREMENT SAVINGS PLAN

Corebridge Financial (formerly AIG)

Saint Joseph's College offers an IRS Section 403(b) defined contribution pension plan to regular full-time employees. Individual participation is voluntary and available to all regular employees at any time. The amount that an employee may choose to contribute individually is subject to a maximum exclusion allowance calculation pursuant to IRS guidelines.

TUITION BENEFITS

Tuition Remission

After a six-month waiting period, full-time employees are eligible for tuition remission. The equivalent of four courses per academic year may be taken, but no more than one Sebago Lake Program per semester at a time. They can be undergraduate and/or graduate courses.

Undergraduate tuition remission is tax exempt. Graduate tuition remission is tax exempt up to $5,250 per calendar year. Graduate tuition remission amounts above $5,250 in a calendar year are subject to Federal and State taxes.

After a one year waiting period IRS eligible dependents/spouses of full-time employees are eligible for undergraduate and graduate course tuition remission. Graduate tuition is a taxable benefit to the employee.

Tuition Exchange

The College is a member of two national scholarship exchange programs for institutions of higher education: Tuition Exchange Inc. (TE) and the Council of Independent Colleges (CIC). Through these organizations, this tuition scholarship exchange program is available for the dependent children of full-time college employees, at over 350 colleges, most of which are private.

Educational Assistance Benefit Plan

Saint Joseph's College has established an Educational Assistance Benefit Plan for the exclusive benefit of its eligible full-time tenured faculty members in good standing. Tenured faculty in the departments of Nursing, Business, and Communications who do not already have doctorate degrees are eligible to participate in the Plan. The purpose of the plan is to provide financial assistance to eligible full-time tenured faculty in these departments for meeting all or a portion of the cost of attending qualified educational courses towards the completion of a doctoral degree.

Tuition Remission Part-time Nursing Clinical Faculty

Part-time clinical nursing faculty are eligible for the equivalent of one course in the Master of Science in Nursing Program for each clinical taught with a maximum of four per academic year. A faculty member has up to one year from the end of their teaching responsibilities to start an eligible course, must be actively teaching in the Nursing Program at the time of taking the course and be in good standing in the Department of Nursing. Continued eligibility for tuition remission benefits will be contingent on the student's ability to meet the Satisfactory Academic Progress Policy set forth by the Chief Learning Officer and the Financial Aid Department. All fees and other costs owed to the College must be paid prior to receiving the tuition remission. Failure to complete a teaching contract will result in revoking eligibility for tuition remission.

HOLIDAYS

The College provides defined paid holidays each year for all eligible employees. The holidays are posted on the Human Resources website (https://my.sjcme.edu/resources/human-resources/holidays/) and through the ADP Portal.

TIME OFF

Earned Time

Earned time (ET) is a form of paid time off and combines sick and vacation time. Administrative staff and 12-month Faculty accrue ET based on regular hours worked and longevity. This form of paid time off gives the most flexibility to staff to use their valued time away. The College encourages the use of earned time as a necessary time for staff to recharge. The use of earned time should be planned and scheduled when at all possible. Individual departments may develop departmental procedures for scheduling and approving time off.

Maine Earned Paid Leave

For every 40 hours worked, a covered employee is entitled to accrue 1 hour of Paid Time Off up to 40 hours/year.

LEAVES (9M Faculty, please also refer to the Faculty Handbook)

Bereavement Leave

Any regular full-time or regular part-time staff may take up to five (5) working days of bereavement leave upon request. This leave is to be used to make arrangements for and to attend services for an immediate family member. Immediate family member is understood to include: mother, father, spouse, child, mother-in-law, father-in-law, brother, sister, brother-in-law, sister-in-law, employee's grandparents, grandchildren, stepchildren, any minor child for whom the employee is standing in loco parentis; and any relative or significant other living in the household of the employee. Bereavement days are meant to be taken consecutively.

One (1) day may be taken to attend the funeral of other relatives of the employee or for any friend living in the household. If additional time is required, earned time may be used.

Federal Family Medical Leave

The Family Medical Leave Act (FMLA) legally entitles eligible employees to take time off up to a maximum of 12 work weeks during any rolling 12-month period. If you are taking a leave to care for a covered service member with a serious injury or illness, FMLA grants up to 26 weeks of unpaid leave in a single 12-month period. Employees who have 12 months of service and have worked at least 1250 hours during the current or preceding FMLA year at Saint Joseph's College are entitled to up to 12 weeks of family medical leave under provisions of the Federal Family and Medical Leave Act. Further information regarding FMLA is available on the last page of this booklet.

College Medical Leave

This is an unpaid leave for full-time administrative staff with a maximum of six (6) consecutive months. Such leaves will be evaluated against institutional needs, length of requested leave, and budgetary restraints. The College will have sole discretion in determining if an employee's position will or will not be held for the duration of the leave.

Jury Duty and Appearance Witness Leave

Employees who actively serve on jury duty or are under subpoena as a witness during regular working hours will continue to receive regular pay. Any employee appearing in a judiciary setting on behalf of the College will also be excused with pay.

Military Leave

Reservists and members of the National Guard. Full-time and regular part-time employees serving in the reserve or National Guard will be granted military leave to enable them to attend training as reservists or guard members. Regular employees will be eligible for unpaid leave for up to ten days of training leave each year.

Active Duty. Employees entering active duty either voluntarily or through the draft will be granted unpaid leave. Upon completion of service, those employees who satisfy the reporting, notification, reapplication, and honorable service provision of USERRA will be accorded the reemployment and benefits rights as provided by USERRA. In general, you must return to your regular work schedule without delay.

Employees who will require leave are expected to show their orders to the Human Resource Director as soon as they are received.

Personal Leave

An employee who wishes to take time off to further their education, for public service, or needs additional time to care for a family member or household member for an extended period of time may request this leave. This is an unpaid leave, which may be granted for up to 12 months. The College will have sole discretion in determining if an employee's position will or will not be held.

Violence Leave

Saint Joseph's College will provide a leave of absence for victims of violence that is reasonable and necessary for a staff or faculty member, or a staff or faculty member's daughter, son, parent, or spouse who is a victim of domestic abuse, sexual assault, or stalking under Title 17-A, chapter 11, stalking or any act that would support an order for protection under Title 19-A, chapter 101.

The College will grant time for an employee to do the following:

1. Prepare for and attend court proceedings
2. Receive medical treatment or attend to medical treatment for a victim who is the employee's daughter, son, parent or spouse; or
3. Obtain necessary services to remedy a crisis caused by domestic violence, sexual assault or stalking.

Request will be denied or delayed if the employer would sustain hardship from the employee's absence, the request is not presented in a timely manner, or if the request is impractical, unreasonable or unnecessary based on the facts then made known to the employer.

WORKER'S COMPENSATION

The Maine Worker's Compensation Act protects employees against accidental injury and/or illness occurring in or arising out of the workplace.

When an employee is injured while performing assigned job duties, an Injury Report must be completed within 24 hours. This report is to be completed by the injured employee or, if necessary, a co-worker or supervisor who witnessed the injury. The Human Resource Office will refer all work-related injuries to the College's Preferred Provider Physician for evaluation. Employees must avail themselves of this medical referral within the first ten days following notice of injury. The Human Resource Office will work with an injured employee to coordinate lost time wage payments, medical treatment, and work accommodation. Failure to give notice or to accept medical services may deprive the employee the right to Worker's Compensation payments.

CAFETERIA PLAN

The College offers a cafeteria benefits plan under Section 125 of the Internal Revenue Code of 1986 to enable eligible employees to pay their share of health, dental and vision insurance premiums on a pre-tax basis, and to offer medical and dependent care reimbursement account options.

Cafeteria Plan status requires that the eligible employee make an annual election to participate in the pre-tax reduction of their salary for elected medical, dental and vision.

QUALIFYING EVENTS

After the Open Enrollment Period, you cannot make changes to your coverage during the year unless you experience a change in family status, such as:

- Loss or gain of coverage through your spouse
- Loss of eligibility of a covered dependent
- Death of your covered spouse or child
- Birth or adoption of a child
- Marriage, divorce or legal separation
- Switch from part-time employment to full-time employment

You have 30 days from a change in family status to make changes to your current coverage.

LEGALLY DOMICILED ADULT (LDA) BENEFITS

Saint Joseph's College offers benefit-eligible employees the opportunity to enroll a Legally Domiciled Adult (LDA) in our benefit plans. An LDA is a qualified adult dependent over age 18 who has lived in the same principal residence as the employee for at least 12 months and remains a member of the employee's household throughout the coverage period. The College has adopted the IRS criteria for LDA Benefit Eligibility.

Legal Notices

Summary of Benefits and Coverage

To help you make informed plan decisions, Saint Joseph's College will make available a Summary of Benefits and Coverage (SBC) for 2024. The SBCs are standardized nationwide by the government and summarize information you need to best compare your benefits across your options. Contact your Human Resources representative for a paper copy.

Women's Health and Cancer Rights Act Enrollment Notice

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

1. All stages of reconstruction of the breast on which mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of the mastectomy, including lymphedema.

These will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this benefits plan. If you would like more information on WHCRA benefits, please contact your health plan administrator at 207-893-7757.

HIPAA Notice of Privacy Practices

The Plan's HIPAA Notice of Privacy Practices is available upon request. To obtain a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the HR Department. For more information on the Plan's privacy policies or your rights under HIPAA, contact Human Resources at 207-893-7757.

HIPAA Special Enrollment Rights

HIPAA requires we notify you about your right to later enroll yourself and eligible dependents for coverage in Saint Joseph's College's health plan under "special enrollment provisions" briefly described below.

- Loss of Other Coverage. If you decline enrollment for yourself or for an eligible dependent because you have other group health plan coverage or other health insurance, you may be able to enroll yourself and your dependents under Saint Joseph's College's health plan if you or your dependents lose eligibility for that other coverage, or if the other employer stops contributing toward your or your dependents' other coverage. You must request enrollment within 30 days after your or your dependents' other coverage ends, or after the other employer stops contributing toward the other coverage.
- New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you gain a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents under Saint Joseph's College's health plan. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. In the event you acquire a new dependent by birth, adoption, or placement for adoption, you may also be able to enroll your spouse, if your spouse was not previously covered.
- Enrollment Due to Medicaid/CHIP Events. If you or your eligible dependents are not already enrolled in Saint Joseph's College's health plan, you may be able to enroll yourself and your eligible dependents if: (i) you or your dependents lose coverage under a state Medicaid or children's health insurance program (CHIP), or (ii) you or your dependents become eligible for premium assistance under state Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. The CHIP Model Notice containing additional information about this right as well as contact information for state assistance is included below. You may also request a copy from the Plan Administrator.

Please contact the Plan Administrator at 207-893-7757 for details, including the effective dates of coverage applicable to each of these special enrollment provisions. Additional information regarding your rights to enroll in group health coverage is found in the applicable group health plan summary plan descriptions or insurance contract.

Disclosure of Creditable Prescription Drug Coverage

Important Notice from Saint Joseph's 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 Saint Joseph's 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. Saint Joseph's College has determined that the prescription drug coverage offered by the CIGNA Medical Plans 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 Saint Joseph's College coverage will not be affected (e.g., you can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage). If you decide to join a Medicare drug plan and drop your current Saint Joseph's College coverage, be aware that you and your dependents will be able to get this coverage back at the next open enrollment.

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 Saint Joseph's 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 the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Saint Joseph's 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
- 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
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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: October 13, 2023
Name of Entity/Sender: Saint Joseph's College
Contact--Position/Office: Heidi Jacques, Assistant Director of Human Resources
Address: 278 Whites Bridge Road, Standish ME 04084
Phone Number: (207) 893-7756

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 July 31, 2023. Contact your State for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment ProgramWebsite: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
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: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/ medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
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	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/ HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other healthcare provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a healthcare facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of- network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain states have enacted balance billing protections for patients receiving emergency services. For example, New Hampshire, Maine, Massachusetts and Vermont all have laws protecting patients from balance billings. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

State law prohibitions against balance billing may also apply. Specific laws related to balance billing are different in each state. If you have questions, check with your plan administrator or state insurance regulator.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of- network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your insurance carrier by calling the number on your insurance card. You may also contact the state insurance regulator or the No Surprises helpdesk at 1-800-985-3059.

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Newborns' and Mothers' Health Protection Act of 1996

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

Patient Protection Notice

Your carrier generally may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members. Until you make this designation, your carrier may designate one for you.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre- approved treatment plan, or procedures for making referrals.

Employee Benefits and Remote Work

To the extent that Saint Joseph's College permits remote work, you must notify Human Resources of your remote work location and any changes to that location, especially if that location is in another state. Different states have specific requirements such as workers compensation, state and local taxes, and state paid family leave requirements. Failing to provide Human Resources with accurate information may result in state-imposed fines or other adverse consequences. Please contact Human Resources at 207-893-7757 with any questions or updates.

COBRA Rights

If you are an Employee and are covered by this Employee Benefits Plan, you have the right to choose continuation coverage at group rates if you lose your group health coverage because of reduction in hours or termination of employment (for reasons other than gross misconduct on your part). If you are a spouse of an Employee and are covered by this Group Health Plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under this Group Health Plan for any of the following reasons:

- The death of your spouse
- The termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

In the case of a dependent child of an Employee covered by this Health Plan, he or she has the right to continuation coverage if group health coverage under this Group Health Plan is lost for any of the following reasons:

- The death of a parent;
- A termination of parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment with Saint Joseph's College;
- Parent's divorce or legal separation;
- A parent becomes entitled to Medicare;
- The dependent child ceases to be a "dependent child" under this Group Health Plan.

Your Responsibilities: Under the law, you and your family member(s) have the responsibility to inform the Benefits Department of a divorce, legal separation, or child losing dependent status under this Health Plan within 30 days of the date of the event or the date in which coverage would end under the Plan because of the event, whichever is later. You are responsible for notifying the Human Resources Department of reduction in work, or Medicare entitlement. Similar rights may apply to certain retirees, your spouse, and dependent children if the employer commences a bankruptcy proceeding and these individuals lose coverage. Once notified that one of these events has happened, the Benefits Department will notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date the election notice is sent to you, whichever is later, to inform the Benefits Department that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end. If you choose continuation coverage, Saint Joseph's College is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to non-COBRA participants or family members. For more information on your rights under COBRA, please refer to the Initial COBRA Notice you received at the time you were hired or contact Human Resources (humanresources@sjcme.edu or 207-893-7757).

Notice Regarding Health Insurance Marketplace Coverage Options

PART A: General Information

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 November 1, 2023, and ends December 15, 2023, for coverage starting as early as January 1, 2024.

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. For Plan Years beginning in 2024, if the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% 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.[1]

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 Human Resources.

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.

[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.

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or childbirth
- to care for the employee's child after birth, or placement for adoption or foster care
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active-duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings. FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.*

*The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

*Special hours of service eligibility requirements apply to airline flight crew employees.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job or prevents the qualified family member from participating in school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures. Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA- protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. FMLA does not affect any Federal or State law prohibiting discrimination or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures. For additional information: 1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627 WWW.WAGEHOUR.DOL.GOV

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Please direct any questions you have about this notice to the privacy contact identified in the notice. You can reach the privacy contact through the Human Resources Department.

Protected Health Information (or PHI) is information, including demographic information, that may identify you and that relates to: (1) your physical or mental health or conditions, in the past, present, or future; (2) health care services provided to you, or (3) the payment of health care services provided to you. This Notice of Privacy Practices describes how the Saint Joseph's College Medical Reimbursement Plan (the "Plan") may use your PHI and disclose your PHI to other entities, including to the College as the "Plan Sponsor". The Notice also describes your rights to access and control your PHI to the extent it is created or received by the Plan.

The Plan is required by federal Health Insurance Portability and Accountability Act of 1993 ("HIPAA") to maintain the privacy of your PHI and to provide you with this Notice of the Plan's privacy practices and related legal duties. The Plan document has been amended to reflect your rights as described in this Notice, and the Plan and the Plan Sponsor are required to abide by the terms of this Notice. However, the Plan and the College reserves the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI maintained by the Plan at that time. If a change is made to this Notice, a copy of the revised Notice will be provided within 60 days of the date the change takes effect.

Permitted Uses and Disclosures

Treatment, Payment, and Health Care Operations
Under HIPAA, the Plan may use and disclose PHI, for the purposes of treatment, payment, and health care operations, without your consent or authorization. Examples of the uses and disclosures that the Plan may make under each section are listed below:

- **Treatment**: Treatment refers to the provision and coordination of health care by a doctor, hospital, or other health care provider. The Plan itself does not provide treatment but could conceivably need to disclose PHI to a health care provider in connection with your treatment.
- **Payment**: Payment refers to the activities of the Plan in collecting premiums and paying claims for health care services you receive. Examples of uses and disclosures under this section include sending PHI to an external medical review company to determine the medical necessity of experimental status of a treatment; sharing PHI with other payers (such as insurance companies) to determine coordination of benefits or settle subrogation claims; providing PHI to the Plan's third part administrator for the pre-certification or case management services; providing PHI in the billing, collection, and payment of premiums and fees to Plan vendors such as preferred provider networks, prescription drug card companies and reinsurance carriers; and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the Plan.
- **Health Care Operations**: Health Care Operations refers to the basic business functions necessary to operate the Plan many of which are carried out by the Plan Sponsor. Examples of uses and disclosures under this section include conduction quality assessment studies to evaluate the Plan's performance or the performance of a particular health care provider, network, or vendor; the use of PHI in determining the cost impact of benefit design changes; the disclosure or PHI to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the plan; the disclosure of PHI to stop-loss or reinsurance carries to obtain claim reimbursements to the plan; disclosure of PHI to plan consultants who provide legal, actuarial, and auditing services to the plan; and use of PHI in general data analysis used in the long term management and planning for the Plan.

Other Uses and Disclosures Without Authorization
HIPAA also allows the Plan to use and disclose PHI, without your consent or authorization, in the following ways:

- To you, as the covered individual
- To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of a child, or the surviving family members or representative of the estate of a diseased individual.
- To the Secretary of Health and Human Services ("HHS") or any employee of HHS as a part of an investigation to determine our compliance with the HIPAA privacy rule.
- To a "business associate" of the Plan under an agreement to perform services for the Plan.
- To a "health oversight agency" such as the U.S. Department of Labor, or the Internal Revenue Service to respond to inquiries or investigations of the Plan, or requests to audit the Plan.
- In response to a court order, subpoena, discover request or other lawful judicial or administrative proceeding.
- As required for a law enforcement purposes (for example, to notify authorities of a criminal act), or to avert a threat to public health or safety.
- As required to comply with Workers' Compensation or other similar programs established by law.
- To the Plan Sponsor, as necessary to carry out administrative functions of the Plan such as evaluating renewal quotes for reinsurance of the Plan, funding check registers, reviewing claim appeals, approving subrogation settlements, evaluating the performance of the Plan and the Plan management.
- In providing you with information about treatment alternative and health services that may be of interest to you as a result of a specific condition that the Plan is case managing.

Please note that the examples are permitted uses and disclosures listed above are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

Other Uses and Disclosures With Authorization
Other uses and disclosures of your PHI will only be made upon receiving you written authorization. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. The Plan will honor a request to revoke as of the day it is received and to the extent that it has not already used or disclosed your PHI in good faith with the authorization.

Certain Other Health Information

Please note that not all of your health information is considered PHI and therefore may not be subject to these rules. In particular, the use or disclosure of health information that you provide (or that is provided by someone else at your request) to your employer, and is maintained as part of your employment records, is not subject to these rules. Your employer may use or disclose such health information for employment-related purposes, for example, to fulfill its legal obligations under the federal Family Medical Leave Act or under the Americans With Disabilities Act, or to provide life insurance or disability benefits to you (or your beneficiaries). In addition, information created or received by your employer in connection with workers' compensation benefits is not protected under the HIPAA privacy rule.

Your Rights Under HIPAA Regarding Protected Health Information

Right to Request Restriction on Uses and Disclosures
You have the right to request that the plan limit its uses and disclosures of PHI in relation to treatment, payment, and health care operations or not use or disclose you PHI for these reasons at all. You also have the right to request the plan restrict the use of disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact listed in this Notice and must state the specific restriction requested and to whom that restriction would apply.

The Plan is not required to agree to a restriction that you request. However, if it does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communications
You have the right to request communications involving PHI be provided to you at an alternative location or by an alternative means

of communication. The Plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed in this Notice.

Right to Access to Your Protected Health Information
You have the right to inspect and copy your PHI that is contained in a "designated record set" for as long as the Plan maintains the PHI. A designated record set contains claim information, payment, and billing records and any other records the Plan has created in making claim and coverage decisions relating to you. You may not have access to the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. Requests for access to your PHI should be made in writing and directed to the Privacy Contact listed in this Notice.

Right to Amend Protected Health Information
You have the right to request that PHI in a designated record set be amended for as long as the Plan maintains the PHI. The Plan may deny your request for amendment if it is determined that the PHI was not created by the Plan, is not part of the designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declines, you have the right to have a statement of disagreement included with the PHI, and the Plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be in writing and directed to the Privacy Contact listed in this Notice.

Right to Receive an Accounting of Disclosures
You have the right to receive an accounting of disclosures of your PHI that the Plan has made, if any, other than disclosures: (1) for treatment, payment, and health care operations, as described above, (2) disclosures made to you or your personal representative, (3) disclosures made pursuant to your written authorization, and (4) certain other permitted or required under HIPAA. Your right to an accounting of disclosures applies only to PHI created by the plan after April 14, 2004 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of you PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive a Paper Copy of this Notice
If you have received this Notice in electronic form and you would like to receive a paper copy of this Notice, please direct your request for a paper copy to the Privacy Contact listed in this Notice. You have the right to receive a paper copy even if you have previously agreed to accept this Notice electronically.

Complaints

If you believe your privacy rights under HIPAA have been violated, or if you believe that the College has violated the policies adopted by the Plan Sponsor for the protection of your rights, you may file a complaint with the Privacy Contact listed in this Notice. Upon your request, the Privacy Contact will provide to you a complete copy of the Plan's complaint procedure and the forms necessary to file a complaint. Neither the Plan nor the College will retaliate against you for filing a complaint. If you are not satisfied with the handling of your complaint, you are free at any time to file a complaint with the Secretary of Health and Human Services.

Privacy and Official Privacy Contact

The Plan Sponsor and the Plan have designated a Privacy Official, who has a general duty to oversee compliance with the privacy standards of HIPAA under the Plan and a Privacy Contact who can answer question and provide information to you about your privacy rights. As of the effective date of this Notice, the Privacy Official is the Director of Human Resources and the Privacy Contact if the Assistant Director of Human Resources. You may contact the Privacy Official and the Privacy Contact through the Human Resources Department of the College, 278 Whites Bridge Rd, Standish, ME 04084, 207-893-7757.

Effective Date of Privacy Practices Notice

This notice was published and became effective on April 14, 2004.

DISCLOSURE

The information contained in this document is for illustration purposes only and is not intended to change the Summaries of Benefits and Coverage. While care has been used in preparing this information, all data is governed by the provisions of the appropriate Summaries of Benefits and Coverage. In the event of a conflict between the language in this document and the Summaries, the Summaries of Benefits and Coverage will prevail.