Employee Benefits Guide
2022 - 2023

Medical | Dental | FSAs | Life | Disability & more

CURRY COLLEGE

June 1, 2022 - May 31, 2023

TABLE OF CONTENTS

INTRODUCTION

Curry College is proud to offer a comprehensive program of benefits designed to serve the diverse needs of our unique workforce, and we are committed to continually enhancing and expanding our offerings. The information in this document is meant to familiarize you with the benefits and programs currently in place.

Eligibility and required contributions for these benefits and programs depend on both your employee classification and whether you elect to extend coverage to your dependents.

To ensure you elect the benefits that best suit you and your family in 2022, we encourage you to review your plan choices.

Curry College will continue to offer Medica, Dental, and Life & Disability coverage to employees. The medical plan contributions will be increasingly slightly, and the dental contributions will be decreasing slightly. The vendor for the dental plan is changing to Delta Dental of MA for 2022. Your current elections in these benefit will rollover if you do not make change but if you are enrolling for the first time or making changes to your current enrollment status, please submit all necessary paperwork to the Human Resources Team no later than May 6, 2022.

Employee deductions for Flexible Spending Accounts, Medical, and Dental are generally pretax; Supplemental Life Insurance deductions are after-tax.

Dependents eligible for coverage under the Medical, Dental, and Supplemental Life insurance plans are your spouse (or domestic partner*) and your children. Children can be covered for medical up to age 26 regardless of student, dependent or marital status. For dental, dependent children can be covered up to age 26 regardless of student status. For the Supplemental Life and Supplemental Accidental Death and Dismemberment insurance plan you can add coverage for your unmarried dependent children under age 19 (or under age 25 only for an unmarried full-time student).

Please take the time to familiarize yourself with the benefit offerings provided by Curry College.

***Note: Employees and domestic partners must certify their arrangement by completing and signing a Domestic Partner Affidavit. Please contact Human Resources for more information.**

Please note this guide is intended as a brief overview of benefits only. The policies, contracts or booklets for each benefit plan will govern the benefits and include more details on how the benefit plan operates.

OVERVIEW

The information in this guide can help you make decisions regarding your benefits by providing an overview of what is offered. This booklet also contains information on how to enroll in each benefit plan. Your medical, dental and flexible spending account payroll deductions are through a pre-tax plan. The plan provides tax savings by reducing employee premiums from gross salary prior to calculation of federal income and Social Security taxes.

Below are the Core Benefits & Voluntary Benefits that are available to you.

Core Benefits	Voluntary Benefits
Medical / Rx	Health Care Flex Spending Account
Health Reimbursement Account (HRA)	Dependent Care Flex Spending Account
Dental	Voluntary Life Insurance
Basic Life/AD&D Insurance	
Long Term Disability	

ENROLLMENT CHECKLIST

Use this checklist to help you through the enrollment process. Open enrollment this year will take place from **April 25th through May 6rd**. Changes to all benefit plans are effective on **June 1, 2022**

Before Enrollment:

- ☐ Before enrollment begins, take the time to educate yourself on all of the benefit options that are available to you. Curry College provides a variety of tools and resources to help you make your benefits decisions.

- ☐ Decide if you want to enroll in the Health Care Flexible Spending Account. Remember: you must actively enroll each year per IRS regulations.

- ☐ Review this 2022 Benefits Guide carefully as you consider your plan choices.

- ☐ Review the Schedules of Benefits by logging onto the myCurry web portal and going to the Human Resources page.

During Enrollment:

- ☐ Your current medical election will remain in the Best Buy HMO or the Best Buy PPO plans, unless you submit changes through the enrollment form.

- ☐ You may actively make a Medial plan change (switching plans, adding a family member, etc.) during open enrollment. In order to do so, please visit www.harvardpilgrim.org and make your changes. Please see details on this process within the Brainshark Presentation or reach out to HR for more direction.

- ☐ There is a new carrier for the dental plan, Delta Dental of MA. Your current election will carry over unless you submit changes via an enrollment form.

- ☐ If you are currently enrolled in our Health Care FSA plan and you would like to continue for the next plan year, you must actively elect this plan by visiting www.hrcts.com and make your enrollments directly on the portal. Please see details on this process within the Brainshark Presentation or reach out to HR for more direction.

- ☐ The Open Enrollment for the Dependent Care FSA plan will take place in the fall as this plan runs from 1/1 – 12/31.

During Enrollment (continued):

- The Life and Disability coverage will continue with Mutual of Omaha, there are no changes to the pricing or benefit plan designs.

After Enrollment:

Medical coverage: If you newly elect coverage or change plans, you will receive an ID card in the mail that you should use for all medical and prescription services.

Your ID card contains important information about you, your employer group, and the benefits to which you are entitled. Always remember to carry your ID card with you, present it when receiving health care services or supplies, and make sure your provider always has an updated copy of your ID card.

Dental coverage: Delta Dental will send new ID cards to all participant employees. Be sure to provide your card to your provider at the time of service.

Flexible Spending Accounts: If you newly elect to participate in our Health Care FSA program, you will receive a debit card in the mail that you should use for all qualified expenses. There may be some instances where the debit card is not accepted and you will have to submit paper claims and supporting documents for reimbursement. If you are currently enrolled and re-elect, your current debit card will be loaded with new funds.

For the Dependent Care FSA program (Plan Year: 1/1 -12/31), you will need to submit paper claims and supporting documentation for reimbursement.

General:

The plan year runs from June 1st through May 31st. The medical deductibles and out-of-pocket maximums also run from June 1st through May 31. Please note that the dental maximums and deductibles run from January 1st through December 31st (Calendar Year).

ELIGIBILITY AND ENROLLMENT

If you are a benefits eligible employee, you may enroll yourself and your eligible dependents in our group health plan.

For all benefits, eligible dependents shall include:

- Any lawful spouse
- Domestic Partners, when certified through completion of a Domestic Partner Affidavit
- Your biological, adopted, step-or foster children who are ages 26 and younger (Note: dependent children are eligible for voluntary life insurance until age 19, 25 if full time student)
- Dependents who are 26 or older, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap

Changing benefit elections

As an employee who is eligible for benefits, you are allowed to make changes to your medical, dental, FSA and life insurance plan choices during the annual open enrollment period. After the open enrollment period ends, you will not be allowed to make changes to your elections unless you experience a qualifying event. Some qualifying events include:

Life Events
• Change in marital status (marriage, death of spouse, divorce, legal separation)
• Change in number of dependents (birth, death, adoption, eligibility status, child support order)
• Change in employment status for you or your spouse (new employment, termination, leave of absence, full- time to part-time or vice versa)
• Change in dependent location for school purposes.
• Special enrollment rights under HIPAA
• Medicare coverage

MEDICAL INSURANCE OVERVIEW

As a Curry College employee, you have access to comprehensive medical and prescription coverage to protect you and your family from catastrophic medical costs. In this section, you will find information on the medical plans that Curry College offers. Take the time to understand how these plans work, the coverage they provide, and how to use them to best meet the needs of you and your family.

Harvard Pilgrim Health Care

To meet the needs of our employees and to remain competitive in the marketplace, Curry College offers two plans - a deductible HMO and a deductible PPO, which are available to all eligible employees. This coverage is provided through Harvard Pilgrim Health Care.

These medical plans will have an upfront deductible for *some* services (i.e. inpatient stays, MRI's, Emergency Room, etc.). For the plan year of June 1, 2022 - May 31, 2023, employees will continue to be responsible for the first 50% of the deductible or ($1,000 for single and $2,000 for family). Curry College will cover the remaining deductible expenses thereafter.

This process will be done through a Health Reimbursement Arrangement and will be seamless to you. Further details regarding the HRA are explained on page 10.

Deductible Rollover: The HMO & PPO plans have a Deductible Rollover that applies to any Deductible amount that is incurred for services during the last 3 months of the Plan Year (March – May). The deductible is applied toward the Deductible requirement for the next Plan Year!

The HMO (Health Maintenance Organization) Plan, will continue to require the election of a primary care physician (PCP) that is part of the Harvard HMO network. This PCP serves as a "Gatekeeper" or resource for referrals to other specialists within the HMO Network. You are not covered if you see a physician outside of the HMO network, unless in an emergency situation.

The PPO (Preferred Provider Organization) Plan has a network of providers and the amount the plan pays varies based on your use of that network. You always have the choice to go to any provider, but you'll pay less if you use an in-network doctor or hospital. Referrals are not required on the PPO Plan.

In any of the six New England States (MA, NH, ME, VT, CT or RI) you will have access to the local Harvard Pilgrim Network of providers on either the HMO or PPO. In any other state you will access the United Healthcare National Network of providers (only available on the PPO).

MEDICAL INSURANCE - HMO

	Best Buy HMO $2,000 In-Network Only
Annual Deductible Individual / Family	$2,000 / $4,000 *EE Pays*: $1,000 / 2,000 *Curry Pays*: $1,000 / $2,000
Annual Out-of-pocket Maximum (Benefit Plan Year)* Individual / Family	$4,000 / $8,000
Office Visit PCP / Specialist / Urgent Care / Telehealth	$20 copay (no deductible)
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	No charge
Lab, X-Ray and Major Diagnostics CT, PET, MRI	Ded, then covered at 100%
Emergency Health Services (In & Out of Network)	Ded, then covered at 100%
Hospital– Inpatient Stay	Ded, then covered at 100%
Day Surgery	Ded, then covered at 100%
Prescription Drugs Retail (30-day supply)	*Deductible Does Not Apply*
Generic	$10 copay
Preferred Brand	$25 copay
Non-Preferred Brand	$40 copay
Mail-Order (90-day supply)	*Deductible Does Not Apply*
Generic	$10 copay
Preferred Brand	$25 copay
Non-Preferred Brand	$40 copay

*All deductibles, copays (including medical & Rx) and coinsurance apply to the Annual Out-of-Pocket Maximum

* The Annual Deductible and Out-of-Pocket Maximum resets every June 1st

This is not a complete list of covered services. For more details, please visit Harvard Pilgrim Health Care at www.harvardpilgrim.org or call HPHC Member Services at (888) 333-4742.

MEDICAL INSURANCE - PPO

	Best Buy PPO $2,000	
	In-Network	Out-of-Network
Annual Deductible (Benefit Plan Year)* Individual / Family	$2,000 / $4,000 *EE Pays*: $1,000 / $2,000 *Curry Pays*: $1,000 / $2,000	
Annual Out-of-pocket Maximum (Benefit Plan Year)* Individual / Family	$4,000 / $8,000	
Office Visit PCP / Specialist / Urgent Care	$20 copay (no deductible)	20% after deductible
Preventive Care / Well-women Care Routine Physical Exams / Immunizations (Adult and Child)	No charge	20% after deductible
Lab, X-Ray and Major Diagnostics CT, PET, MRI	Ded, then covered at 100%	20% after deductible
Emergency Health Services	Ded, then covered at 100%	
Hospital– Inpatient Stay	Ded, then covered at 100%	20% after deductible
Day Surgery	Ded, then covered at 100%	20% after deductible
Prescription Drugs Retail (31-day supply)	*Deductible Does Not Apply*	
Generic	$10 copay	$10 copay
Preferred Brand	$25 copay	$25 copay
Non-Preferred Brand	$40 copay	$40 copay
Mail-Order (90-day supply)	*Deductible Does Not Apply*	
Generic	$10 copay	$10 copay
Preferred Brand	$25 copay	$25 copay
Non-Preferred Brand	$40 copay	$40 Copay

*All deductibles, copays (including medical & Rx) and coinsurance apply to the Annual Out-of-Pocket Maximum

* The Annual Deductible and Out-of-Pocket Maximum resets every June 1st

This is not a complete list of covered services. For more details, please visit Harvard Pilgrim Health Care at www.harvardpilgrim.org or call HPHC Member Services at (888) 333-4742.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

An HRA is an account funded by Curry that helps pay your in-network deductible expenses. For the plan year that runs June 1, 2022 - May 31, 2023, Curry College's reimbursement will begin after employees reach 50% of the total in-network deductible ($1,000 for individuals and $2,000 for families). After your 50% deductible is met, the HRA pays for any remaining in-network deductible expenses.

Any deductible expenses after your 50% will be integrated between Harvard Pilgrim and HRC Total Solutions. You are not involved in the payment process as your providers will be paid directly.

Members will still need to pay all copays—i.e. office visits and prescription drug coverage (can use FSA to pay for these services)

Both plans will continue to have the following deductible:

- The deductible is $2,000 per person up to a family maximum deductible of $4,000
- You will be responsible for the first 50% of the in-network deductible
    - Individual $1,000 (50% of $2,000)
    - Family $2,000 (50% of $4,000)
        - You will be billed for these first dollar deductible services directly from your provider. It is your responsibility to pay these bills either through a checking/savings account or an FSA
        - Please check your Explanation of Benefits (EOB) from Harvard Pilgrim before paying your provider, as the EOB will confirm the amount paid out of pocket
        - Curry will then cover any remaining in-network deductible expenses for the year

Qualified Deductible Expenses

Please refer to your Summary Plan Description for full details, however services such as Inpatient Hospital, Outpatient Surgery or advanced imaging (MRI, PET & CT scans, MRA, etc.) are all qualified deductible expenses that HRA dollars can help offset. Only deductible expenses are eligible for reimbursement through the HRA. Copays still apply for office visits and prescriptions and are not eligible for reimbursement.

What Happens After My Deductible Has Been Met?

Once you have fulfilled your deductible amount, deductible services such as the ones mentioned above, would be covered in full. Any copays or coinsurance would continue to apply toward your out-of-pocket maximum ($4,000 Individual / $8,000 Family) until you or your family have exhausted that dollar limit.

HPHC MEMBER DISCOUNTS

veEmployees of Curry College who are enrolled in a Harvard Pilgrim Health Care plan has access to a wide variety of discounts. Visit the “Discounts & Savings” Section of the HPHC website for additional details. Don’t miss out!

Harvard Pilgrim offers numerous ways for you to save on things like:

- Up to $150 Fitness Reimbursement
- Eyewear savings – including a FREE eyewear program and discounts at many popular retailers (*VisionWorks, LensCrafters, Sears Optical* and *Target Optical)*
- Free Health Coaching
- Alternative complementary medicine (acupuncture, yoga chiropractic, massage therapy, mindfulness)
- Online drugstore for over-the-counter health products
- *Universal Dental Plan*
- Childproofing and home safety items
- *Marathon Sports* and *Northampton Running Company* (MA), *Runner’s Alley* (NH) and *Maine Running Company* (ME)
- *Diet.com*
- *Appalachian Mountain Club* membership
- *CareScout* Eldercare Program

Please visit the below website for more information:

https://www.harvardpilgrim.org/public/discounts-savings

Telehealth: Doctor On Demand

Harvard Pilgrim partners with Doctors on Demand to provide telehealth coverage to enrolled employees and family members. Doctors on Demand provides video visits for members with licensed doctors, psychologists, and psychiatrists from the phone, tablet, or computer. The cost per visit is a $20 copay!

Virtual video visits with licensed doctors, psychologists and psychiatrists

Medical urgent care visits:

Fast and easy
Connect with a physician in minutes.[1]

You're covered
Harvard Pilgrim members pay the PCP-level cost sharing. No referral is required to see a Doctor on Demand provider.

Great physicians
Board certified and licensed in your state.[2] Multiple languages available.[3]

Treat many conditions
Treat nearly any non-emergency medical condition.

Get a prescription
Fast and paperless prescription fulfillment to your pharmacy.[4]

Top Medical Issues Treated:

- Coughs, colds
- Sore/Strep throat
- Flu
- Pediatric issues
- Sinus and allergies
- Nausea/diarrhea
- Rashes and skin issues
- Women's health: UTIs, yeast infections
- Sports injuries
- Eye issues

Behavioral health visits[1]:

Based on your needs
Licensed, U.S.-trained providers.[2] Psychologists support you using talk therapy, while psychiatrists will also look for biological imbalances and can prescribe medicine as part of a treatment plan.[3]

Easy to schedule
You will need to schedule an appointment at least 24 hours in advance; however, psychology visits are typically available within 48 hours to one week and psychiatry visits are typically available within 2 – 3 weeks.

- Psychology appointments are scheduled for either 25 or 50 minutes.
- Psychiatry appointments start with a 45-minute visit, with 15-minute follow-up visits after that.

Get help with many common conditions
Support for non-emergency conditions and situations.

You're covered
Harvard Pilgrim members pay the plan's cost share for behavioral health office visits. No referral is required to see a Doctor on Demand provider.

- Telemedicine visits relating to the treatment of COVID-19 will be covered at 100% for all members

DENTAL INSURANCE

Good dental health is important to your overall well-being. At the same time, we all need different levels of dental treatment. It is for this reason that Curry College offers eligible employees dental coverage, now through Delta Dental of MA.

Curry College will continue to offer two dental plan both of which offer comprehensive coverage. The Low plan provides an annual calendar year maximum benefit of $1,500, while the High plan provides an increased calendar year maximum benefit of $2,500. See below for details.

Delta Dental – PPO $1,500 Dental Plan – Low Dental Plan

Plan Details	PPO Low Plan When you use a PPO dentist, you pay	PPO Low Plan When you do not use a network dentist, you pay
Annual Deductible (Single/Family)	$50 / $150*	
Calendar Year Maximum	$1,500 *(next slide for rollover max benefit feature)*	
Reimbursement Levels	Based on contracted Rates	Pay as billed
Class I Preventive & Diagnostic	100% coverage (deductible is waived)	100% coverage (deductible is waived)
Class II Basic Restorative Care	100% coverage after deductible	100% coverage after deductible
Class III Major Restorative Care	50% coverage after deductible	50% coverage after deductible
Class IV Orthodontia	100% coverage (no deductible)	100% coverage (no deductible)
	Available to children under age 19	
Orthodontia Lifetime Maximum	$1,000	
Class IX Implants	50% coverage after deductible	50% coverage after deductible

**Deductible does not apply to preventive services or orthodontia; deductible applies to Basic & Major benefit categories*

*****The annual deductible & maximum resets every January 1st

Delta Dental PPO & Premier Networks: Members have access to seeing a provider in either the Delta Dental PPO or Delta Dental Premier networks to receive benefits. The deepest discounts and greatest benefits are achieved by seeing a dentist in the PPO network due to the pre-negotiated contracts. Delta Dental Premier network dentists will be reimbursed based on either the dentist's pre-negotiated fee or the maximum allowed fee, whichever is less. Visiting an out-of-network dentist may result in being balance-billed by the dentist for any charges that exceed what your plan reimburses for covered expenses.

Delta Dental – PPO $2,500 Buy-Up Dental Plan – High Dental Plan

Plan Details	PPO High Dental Plan When you use a PPO dentist, you pay	When you do not use a network dentist, you pay
Annual Deductible (Single/Family)	$50 / $150	
Calendar Year Maximum	$2,500 *(see below for rollover maximum details)*	
Reimbursement Levels	Based on contracted Rates	Pay as billed
Class I Preventive & Diagnostic	100% coverage (deductible is waived)	100% coverage (deductible is waived)
Class II Basic Restorative Care	100% coverage after deductible	100% coverage after deductible
Class III Major Restorative Care	50% coverage after deductible	50% coverage after deductible
Class IV Orthodontia	100% coverage (no deductible) Available to children under age 19	100% coverage (no deductible)
Orthodontia Lifetime Maximum	$1,000	
Class IX Implants	50% coverage after deductible	50% coverage after deductible

Deductible does not apply to preventive services or orthodontia; deductible applies to Basic & Major benefit categories

*The annual deductible and maximum resets every January 1st

Please Note: If you choose to switch into the High plan from the Low Plan on 6/1/2022, your new $2,500 maximum will be pro-rated based on services you may have incurred from 1/1/22 through 5/31/22

- For example—if you have had $500 in services through 5/31/22 you will be eligible to receive up to $2,000 more through 12/31/22
- If you have met your deductible as of 5/31/22 you will not be required to pay a new deductible until 1/1/23

Delta Dental PPO & Premier Networks: Members have access to seeing a provider in either the Delta Dental PPO or Delta Dental Premier networks to receive benefits. The deepest discounts and greatest benefits are achieved by seeing a dentist in the PPO network due to the pre-negotiated contracts. Delta Dental Premier network dentists will be reimbursed based on either the dentist's pre-negotiated fee or the maximum allowed fee, whichever is less. Visiting an out-of-network dentist may result in being balance-billed by the dentist for any charges that exceed what your plan reimburses for covered expenses.

Delta Dental Rollover Maximum : When you or your family members receive any preventative care during the calendar year and do not have claims exceeding the annual limit, you can roll over a portion of unused spending to increase your maximum for nest year. Please see the chart below:

Your Plan's Annual Max Benefit Amount	If Your Total Yearly Claims Don't Exceed This Threshold Amount…	Then You Can Roll Over This Amount To Use Next Year, And Beyond	Rollover Total Cap
$1,500	$700	$500	$1,250
$2,500	$900	$700	$1,500

FLEXIBLE SPENDING ACCOUNT (F.S.A.)

Curry College will continue to offer a Health Care and Dependent Care flexible spending account (FSA), through HRC Total Solutions. You may continue to pay for eligible health care expenses with pretax dollars. The Dependent Care FSA runs on a 1/1 – 12/31 basis and is used to pay for eligible dependent care expenses.

Flexible Spending Accounts (FSAs) are voluntary accounts that allow you to use your pre-tax wages for certain expenses as determined by IRS regulations.

How FSAs Work

- You decide how much you wish to set aside for eligible expenses for the coming year
- That amount is deducted from your paycheck, in equal installments throughout the year, before taxes are withheld, and deposited into your FSA account(s)
- After you pay for an eligible expense, you request reimbursement from your FSA
- You are reimbursed from your account(s) with tax-free dollars. You save money on your eligible expenses because you pay for them with tax-free dollars

Changing Your Elections

Once you enroll, you may not change the amount you elect to contribute unless you experience a qualified change in family status (see page 6). It is important to estimate carefully and conservatively when deciding how much to set aside in your account(s). **During Open Enrollment, you must submit an Enrolment form to sign up again for the new plan year.**

FSA Account	Maximum Plan Year Contribution	Remaining Funds at the end of the Plan Year
Health Care FSA **Plan Year: 6/1 – 5/31**	**$2,850**	**Use It or Lose It w/ $570 Rollover** - At the end of the plan year, employees have a 60-day run-out period to submit claims for any expenses they incurred during the plan year. If after that there are any funds that were not spent by the employee, **any amount over $570 is forfeited.**
Dependent Care FSA **Plan Year: 1/1 – 12/31**	**$5,000 if single or married & filing jointly;** **$2,500 if married & filing separately**	**Use It or Lose It** - At the end of the plan year, employees have a 60-day run-out period to submit claims for any expenses they incurred during the plan year. If after that there are any funds that were not spent by the employee, **all amounts are forfeited.**

ELIGIBLE EXPENSES (F.S.A.)

An eligible expense is defined as those expenses paid for care as described in Section 213 (d) of the Internal Revenue Code. Below are two lists which may help determine whether an expense is eligible. For more detailed information, please refer to IRS Publication 502 titled, "Medical and Dental Expenses," If tax advice is required, you should seek the services of a competent professional Please note Curry College cannot provide tax advice. You are responsible for making sure all expenses submitted for reimbursement are eligible. For more information, refer to IRS Publication 502 at: www.irs.gov/pub/irs-pdf/p502.pdf or consult your tax advisor

Sample Qualified Expenses List:

- Acupuncture
- Alcoholism/Drug addiction treatment
- Ambulance services
- Artificial limb or prosthesis
- Birth control pills
- Chiropractors
- Christian science practitioners
- Contact lenses (including saline solution and cleaner)
- Crutches
- Dental treatment
- Diagnostic devices (such as a blood sugar test kit)
- Eyeglasses (including eye examinations)
- Eye surgery (including laser eye surgery)
- Fertility treatment
- Guide dog (for visually-impaired or hearing-impaired)
- Hearing aids and hearing aid batteries
- Hospital services (including meals and lodging)
- Insulin
- Laboratory fees
- Prescription medicines or drugs
- Operations or surgery
- Telephone equipment for hearing/visually impaired
- Therapy or counseling
- Transportation for medical care
- Vasectomy
- Wheelchair
- X-rays

Sample Non-Qualified Expenses:

- Acid controllers
- Allergy and Sinus medications
- Babysitting and nursing services for a normal, healthy baby
- Cold, Cough and flu medications
- Cosmetic surgery
- Dancing lessons
- Diaper service
- Electrolysis or hair removal
- Funeral expenses
- Hair transplant
- Health club dues
- Household help
- Maternity clothes
- OTC medications (without a doctor's prescription)
- Personal use items
- Swimming lessons
- Teeth whitening
- Vacation or travel
- Vitamins for general health (OTC)
- Weight loss programs for improvement of appearance, general health, or sense of well-being

Important reminders about qualified medical expenses

- **Items that are merely beneficial to an individual's general good health, such as vitamins or dietary supplements, are not qualified medical expenses.**
- **Drugs must be purchased legally.**

BASIC LIFE/AD&D INSURANCE (SURVIVOR BENEFITS)

Curry College offers an Employer Paid Life and Accidental Death and Dismemberment (AD&D) benefit through Mutual of Omaha. This benefit provides a lump sum benefit to you or your beneficiaries in the event of death or dismemberment.

Employee — All Full-time Staff Employees who were hired on or before August 31, 2008, and who are regularly working at least 30.0 hours each week; Full-time Staff Employees who were hired September 1, 2008 or later and who are regularly working at least 35.0 hours each week; Full-time Faculty working 20.0 hours per week, and Senior Lecturers working 10.0 hours per week and Grandfathered Retirees.

Benefit Amount and Maximum – 2x Covered Annual Earnings to a maximum of $200,000

- Grandfathered Retiree Amount – Flat $2,000
- Benefit Reduction Schedule – Benefits will reduce to 50% at age 70
- Basic AD&D pays you and your beneficiary a benefit for the loss of life or other injury resulting from a covered accident (in addition to your life benefit; not applicable for retirees)

Accelerated Death Benefit — Terminal Illness - If you are diagnosed by two unaffiliated physicians as terminally ill with a life expectancy of 24 months or less, the benefit for terminal illness provides for up to 90% of the Term Life Insurance coverage amount inforce or $200,000, whichever is less, to be paid to the insured. This benefit is payable only once in the insured's lifetime (not applicable for retirees).

Waiver of Premium - If you are totally disabled prior to age 60 and can't work for at least 6 months, you won't need to pay premiums for your coverage while you are disabled, provided the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until Social Security Normal Retirement Age (SSNRA), subject to proof of continuing disability each year.

Conversion - If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can convert to an individual policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Converted policies are subject to certain benefits and limits. Premiums may change at this time.

Portability - If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can port to an individual policy. To port, you must apply for the portability policy and pay the first premium payment within 31 days after your group coverage ends. Converted policies are subject to certain benefits and limits. Premiums may change at this time (not applicable for retirees).

VOLUNTARY LIFE INSURANCE

You may also choose to purchase supplemental life and AD&D insurance coverage for yourself and your family in addition to any company-paid benefits. AD&D insurance pays a benefit if you or your covered family members suffer a covered loss as a result of death while under the plan. You pay for the total cost of these benefits through convenient payroll deductions.

Employee — All Full-time Staff Employees who were hired on or before August 31, 2008, and who are regularly working at least 30.0 hours each week; Full-time Staff Employees who were hired September 1, 2008 or later and who are regularly working at least 35.0 hours each week; Full-time Faculty working 20.0 hours per week, and Senior Lecturers working 10.0 hours per week.

Benefit Amount – Increments of $10,000 up to a maximum of $500,000

Your Spouse* — is eligible provided that you apply for and are approved for coverage for yourself.

Benefit Amount – Increments of $5,000 to a maximum of $250,000, not to exceed 100% of the employee's coverage amount

Your Unmarried, Dependent Children — Live birth to age 19 (or until age 25 if they are full-time students), as long as you apply for and are approved for coverage for yourself

Benefit Amount – $10,000, not to exceed 50% of the employee's coverage amount

Guaranteed Coverage for Voluntary Term Life Insurance Coverage
Guaranteed Coverage Amount is the amount of coverage you can elect without answering any medical questions or taking a health exam. When initially eligible, if you apply for coverage that is above the Guaranteed Coverage Amount, or if you are applying for coverage after 31 days after you become eligible, you must fill out a Medical Evidence of Insurability form. All dependent child benefits are guaranteed issue.

**Wherever the term Spouse appears it shall also include Domestic Partner or Civil Union Partner. Your domestic partner is eligible for insurance if he or she meets specific criteria stated in the Group Policy*

VOLUNTARY LIFE INSURANCE (continued)

How Much Your Coverage will Cost per Month

Age	Employee Cost per $1,000	Spouse Cost Per $1,000
<20-34	$0.05	$0.05
35-39	$0.07	$0.07
40-44	$0.10	$0.10
45-49	$0.18	$0.18
50-54	$0.30	$0.30
55-59	$0.47	$0.47
60-64	$0.73	$0.73
65-69	$1.30	$1.30
70-99	$2.09	$2.09
Voluntary Child Life Benefit (Per $1,000)		$0.08

Conversion - If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can convert to an individual policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Family members may convert their coverage as well. Converted policies are subject to certain benefits and limits. Premiums may change at this time.

Portability - This plan allows you to continue all of your voluntary coverage if you leave your employer. Premiums may change at this time. Just pay your premiums directly to the insurance company. Coverage may be continued for you and your spouse until age 70. Coverage may also be continued for your children.

LONG TERM DISABILITY INSURANCE (INCOME PROTECTION)

Curry College offers an Employer Paid Long Term Disability benefit through Mutual of Omaha. This benefit provides replacement income in the event you become disabled due to an injury or illness.

Eligibility – All Full-time Staff Employees who were hired on or before August 31, 2008, and who are regularly working at least 30.0 hours each week; Full-time Staff Employees who were hired September 1, 2008 or later and who are regularly working at least 35.0 hours each week; Full-time Faculty working 20.0 hours per week, and Senior Lecturers working 10.0 hours per week.

Monthly Benefit – This plan pays a benefit of up to 70% of your monthly covered earnings — to a maximum of $7,500 per month.

Definition of Disability – You are considered disabled when, because of injury or sickness, you are under the regular care of a doctor, you are unable to perform the material and substantial duties of your regular occupation and your disability results in a loss of income of at least 20%. After receiving benefits for 24 months, you are considered disabled when, due to the same sickness or injury, you are unable to perform the material and substantial duties of any gainful occupation for which you are reasonably fitted by education, training or experience, and disability results in a loss of income of a specified percentage determined by your plan.

Covered Earnings – Covered earnings means your wages or salary, not including overtime, bonuses, commissions, and other extra compensation.

Elimination Period – You must be disabled for 90 days before benefits may be payable.

Benefit Duration – If you meet the definition of disability, your benefits will begin 90 days following an accidental injury or sickness. The benefit duration is up to your normal retirement age under the Social Security Act. However, if you become disabled at or after age 65 benefits are payable according to an age-based schedule. Refer to the Booklet-Certificate for details.

Cost – The cost of this insurance program is paid by your employer.

Pre-existing Conditions
LTD benefits will not be paid for a disability that begins during the first 12 months of coverage and due to a pre-existing condition. A pre-existing condition is an injury or sickness for which you received medical treatment, consultation, diagnostic measures, prescribed drugs or medicines, or for which you followed treatment recommendations during the 3 months prior to your effective date of coverage.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employee Assistance Program (EAP)

Curry is proud to offer a free and confidential Employee Assistance Program through AllOne Health that can assist you and your family members to address any concern(s) which impact your overall wellbeing. The program offers a variety of services designed to promote total well-being, which include assistance with family, financial, and personal challenges. Issues stemming from relationship and marital conflicts, stress, anxiety, depression, and substance abuse are some of the many areas the program can help you deal with. This integrated solution is designed to drive health, productivity, and well-being for all.

What are the benefits?

- Face-to-Face Counseling sessions
- Unlimited telephonic support – 24/7/365 access to counselors
- Online portal and mobile application to access resources
- Work/Life Resources & Referrals
- Mental Health services
- Legal Assistance services
- Financial Assistance services
- Life & Work Related Coaching
- Personal Assist
- Elder Care Referrals
- Parenting Referrals
- Work Life Counseling

How do you contact the EAP?

- ✓ **Call: 1-800-451-1834**
- ✓ **Visit the website: www.mylifeexpert.com,**

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Mutual of Omaha

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family.

We're Here to Help

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

What to Expect

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is ***no cost*** to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

*Face-to-face visits can also be used toward legal consultations

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period.

EAP Benefits

- Access to EAP professionals 24 hours a day, seven days a week
- Provides information and referral resources
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)
- Legal assistance and financial resources
  - Online will preparation
  - Legal library & online forms
  - Financial tools and resources
- Resources for:
  - Substance use and other addictions
  - Dependent and elder care resources
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

Don't delay if you need help

Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

COST OF COVERAGE – MEDICAL & DENTAL

We are happy to announce that medical premiums will increase only slightly by two percent (2%) and dental premiums are decreasing by ten percent (10%).

HPHC Best Buy HMO $2,000

Contribution	Active Full-Time Staff and Faculty		Senior Lecturers	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Employee Only:	$89.63	$41.37	$107.55	$49.64
Employee + Family:	$587.75	$271.27	$705.30	$325.53

HPHC Best Buy PPO $2,000

Contribution	Active Full-Time Staff and Faculty		Senior Lecturers	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Employee Only:	$255.44	$117.90	$273.37	$126.17
Employee + Family:	$1,022.70	$472.02	$1,140.25	$526.27

Delta Dental $1,500 (Low Plan)

Contribution	Active Full-Time Staff and Faculty		Senior Lecturers	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Employee Only:	$5.47	$2.52	$6.56	$3.03
Employee + Family:	$39.67	$18.31	$46.28	$21.36

Delta Dental $2,500 (High Plan)

Contribution	Active Full-Time Staff and Faculty		Senior Lecturers	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Employee Only:	$16.14	$7.45	$17.23	$7.95
Employee + Family:	$65.48	$30.22	$72.09	$33.27

BROWN & BROWN ADVOCATE

The Brown & Brown Advocate acts as an additional level of support to your HR Team and is available to educate you on Curry College's benefits programs and, most importantly, to research and resolve health insurance billing and claims issues. The Brown & Brown Advocate serves as your private, confidential and dedicated benefits resource. This service is provided free of charge to all Curry College employees and their families who are enrolled in the company's benefits.

The Brown & Brown Advocate is not just a 1-800 number into a call center but instant access to the same benefits expert anytime you have an issue or question about our benefits.

The Hays Advocate can help you:

- **Investigate and Resolve Insurance claims**
- **Answer benefit related questions**
- **Correct billing mistakes**
- **Assist with eligibility issues**
- **Manage grievances**
- **Help you find a doctor/specialist**

CURRY COLLEGE Brown & Brown

Advocate Card

All information provided will be kept strictly confidential.

For any claim related concerns or issues on any of the benefit programs including medical, prescription, dental, disability, and life insurance benefits, please contact:

Toll Free Number: 1-844-714-7621
Email: Curryadvocate@hayscompanies.com
Fax: (617) 723-5155
Hours: 9 a.m. – 5 p.m. EST

Be sure to have your full information available including any pertinent insurance information.

HAYS PERKS

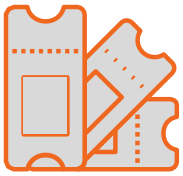
Hays Perks is a discount program available free to all employees.

Powered by PerkSpot, the leading corporate discounts provider, Hays Perks brings you a one-stop shop for hundreds of online discounts, in-store coupons and hot deals.

Use Hays Perks to find discounts and deals from dozens of great categories such as:

HOTELS

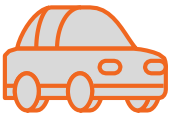
COMPUTERS



TICKETS

CELL PHONES

RESTAURANTS



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APPAREL

TOYS & KIDS

GIFTS

WELLNESS

access your perks at

HAYS.PERKSPOT.COM

COMPLIANCE NOTICES

Summary of Material Modifications

The Curry College Guide to Benefit Enrollment constitutes a Summary of Material of Modifications ("SMM") which describes changes to your health care program effective June 1st, 2022.

This SMM is a summary of the changes made to the program and the partial terms of Curry's medical, dental, vision, flexible spending account, life and accident insurance and disability plans. The SMM is not an official plan document. The actual terms of the plans are contained in the plan documents. In the event of any discrepancy, or any conflict between the SMM and the official plan documents, the official plan documents will govern. This SMM should be retained with your other benefits information.

Curry College reserves the right to change, amend, or cease these benefits at any time.

Newborns' and Mothers' Health Protection Act

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

Continued Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may be able to continue your medical and dental coverage if you lose your health care coverage as the result of certain qualifying events. Contact the Human Resources Department for more information.

Women's Health and Cancer Rights Act of 1998

Under the Women's Health and Cancer Rights Act, group health plans must make certain benefits available to participants of health plans who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy was performed

COMPLIANCE NOTICES (continued)

- Any necessary surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical conditions related to the mastectomy, including lymphedema.

Our medical plans comply with these requirements. Benefits for these items are similar to those provided under the plan for similar types of medical services and supplies.

HIPAA Regulations Help to Protect Your Privacy

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) help to ensure that your health care-related information stays private. New employees will receive a Privacy Practice Notice which outlines the ways in which the medical plan may use and disclose protected health information (PHI). The notice also describes your rights. For more information, contact the Human Resources Department.

Your Rights under Michelle's Law

Effective January 1, 2010, full-time students covered under the group health plan, that would otherwise lose eligibility under the plan because of a reduction in their full-time class status due to a medically necessary leave of absence from school, may be eligible to extend their coverage under the plan for up to one year, or to age 26, whichever occurs first. The child must be a dependent child of a plan participant and be enrolled in the company group health plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the leave.

Mental Health Parity

Effective January 1, 2010, the Company sponsored medical plans were modified to cover mental health and substance abuse expenses subject to the same treatment limits, deductibles, copayments, co-insurance and out-of-pocket requirements that apply to other medical and surgical expenses. This change applies to both inpatient and outpatient services.

Creditable Coverage Disclosure Notice

If you are Medicare-eligible, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage. First, 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. Second, it was determined that the prescription

COMPLIANCE NOTICES (continued)

drug coverage offered by Harvard Pilgrim Health Care 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. If you are considering joining Medicare's prescription drug coverage, 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. For more information about Medicare's prescription drug coverage please visit: www.medicare.gov

Children's Health Insurance Program Reauthorization Act of 2009 (CHIP)

Signed into expand state CHIP eligibility to more children and expectant mothers with an extended 60-day time frame to coordinate any changes to employer health elections in the event of gain or loss of eligibility and/or a subsidy under Medicaid or CHIP.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services. The Act also states that if an employee leaves their job to perform military service, they have the right to elect to continue existing employer-based health plan coverage for the employee and their eligible dependents for up to 24 months while in the military. Even if the employee doesn't elect to continue coverage during their military service, they have the right to be reinstated in their employer's health plan when they are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Notice of HIPAA 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

COMPLIANCE NOTICES (continued)

request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at (617) 333-0500

Termination of Health Coverage for Cause, Including Fraud or Intentional Misrepresentation

Curry College reserves the right to terminate health care coverage for you and/or your dependent prospectively without notice for cause (as determined by the Plan Administrator), or if you and/or your dependent are otherwise determined to be ineligible for coverage under the plan. In addition, if you or your covered dependent commits fraud or intentional misrepresentation in an application for health coverage under the plan, in connection with a benefit claim or appeal, or in response to any request for information by Curry College or its delegees (including the Plan Administrator or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30-days' notice.

Failure to inform any of such persons that you or your dependents are covered under another group health plan or knowingly providing false information in order to obtain or continue coverage for an eligible dependent are examples of actions that constitute fraud under the plan.

Important Notice from Curry 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 Curry 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. **Curry College has determined that the prescription drug coverage offered by Harvard Pilgrim Health Care 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 to 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 HPHC coverage may not be affected. If you or your dependents are Medicare Part D eligible, there are certain options available to you:

- Retain your existing coverage and choose not to enroll in a Part D plan; or
- Enroll in a Part D plan as a supplement to your existing coverage with Curry College. Note: Information about the prescription drug plan provisions/options available to Medicare Part D eligible individuals is available at http://www.cms.hhs.gov/CreditableCoverage/

If you do decide to join a Medicare drug plan and drop your current Curry College coverage, be aware that you and your dependents will be able to get this coverage back during the qualified life event or the annual open enrollment period for Curry College group plan.

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 Curry 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 or call Mirlen Mal at (617) 333-2263. **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 Curry 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:	April, 2022
Name of Entity/Sender:	Curry College
Contact--Position/Office:	Human Resources,1071 Blue Hills Avenue,
Address:	Milton, MA 02186
Phone Number:	(617) 333 - 2263

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 must pay 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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA (continued)

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;
- 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: Mirlen Mal – Vice President of Human Resources

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.

CONTINUATION COVERAGE RIGHTS UNDER COBRA (continued)

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. (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.

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:

Molly DeQuinzio
Benefits and Compensation Admin
molly.dequinzio@curry.edu
(617) 333 - 2263
1071 Blue Hill Avenue Milton,
Massachusetts 02186

MARKETPLACE EXCHANGE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new 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 October 2013 for coverage starting as early as January 1, 2014.

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.[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 Molly DeQuinzio _____.

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.

MARKETPLACE EXCHANGE NOTICE

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	4. Employer Identification Number (EIN)
Curry College	04-2199867
5. Employer address	**6. Employer phone number**
1071 Blue Hills Avenue	(617) 333-2263

7. City	8. State	9. ZIP code
Milton	MA	02186

10. Who can we contact about employee health coverage at this job?
Molly DeQuinzio

11. Phone number (if different from above)	12. Email address
	molly.dequinzio@curry.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:
    Full Time Employees, Senior Lecturers
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Up to age 26
  - ☐ 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.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – 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	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	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

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137
(expires 1/31/2023)

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

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 your 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.

continued on next page

Your Rights *continued*

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 complain if you feel we have violated your rights by contacting us using the information on page 1. • 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 1-877-696-6775, 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 • Contact you for fundraising efforts *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.*

continued on next page

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.

6/1/2019

This Notice of Privacy Practices applies to the following organizations.

Curry College

Mirlen Mal, Vice President of Human Resources
Mirlen.Mal@post03.curry.edu
(617) 333-2263

PREGNANT WORKERS FAIRNESS ACT

The Pregnant Workers Fairness Act ("the Act") amends the current statute prohibiting discrimination in employment, G.L. c. 151B, §4, enforced by the Massachusetts Commission Against Discrimination (MCAD). The Act, effective on April 1, 2019, expressly prohibits employment discrimination on the basis of pregnancy and pregnancy-related conditions, such as lactation or the need to express breast milk for a nursing child. It also describes employers' obligations to employees that are pregnant or lactating and the protections these employees are entitled to receive. Generally, employers may not treat employees or job applicants less favorably than other employees based on pregnancy or pregnancy-related conditions and have an obligation to accommodate pregnant workers.

Under the Act:

• Upon request for an accommodation, the employer has an obligation to communicate with the employee in order to determine a reasonable accommodation for the pregnancy or pregnancy-related condition. This is called an "interactive process," and it must be done in good faith. A reasonable accommodation is a modification or adjustment that allows the employee or job applicant to perform the essential functions of the job while pregnant or experiencing a pregnancy-related condition, without undue hardship to the employer.

• An employer must accommodate conditions related to pregnancy, including post-pregnancy conditions such as the need to express breast milk for a nursing child, unless doing so would pose an undue hardship on the employer. "Undue hardship" means that providing the accommodation would cause the employer significant difficulty or expense.

• An employer cannot require a pregnant employee to accept a particular accommodation, or to begin disability or parental leave if another reasonable accommodation would enable the employee to perform the essential functions of the job without undue hardship to the employer.

• An employer cannot refuse to hire a pregnant job applicant or applicant with a pregnancy-related condition, because of the pregnancy or the pregnancy-related condition, if an applicant is capable of performing the essential functions of the position with a reasonable accommodation.

• An employer cannot deny an employment opportunity or take adverse action against an employee because of the employee's request for or use of a reasonable accommodation for a pregnancy or pregnancy-related condition.

• An employer cannot require medical documentation about the need for an accommodation if the accommodation requested is for: (i) more frequent restroom, food or water breaks; (ii) seating; (iii) limits on lifting no more than 20 pounds; and (iv) private, non-bathroom space for expressing breast milk. An employer, may, however, request medical documentation for other accommodations.

PREGNANT WORKERS FAIRNESS ACT (continued)

• Employers must provide written notice to employees of the right to be free from discrimination due to pregnancy or a condition related to pregnancy, including the right to reasonable accommodations for conditions related to pregnancy, in a handbook, pamphlet, or other means of notice no later than April 1, 2019.

Employers must also provide written notice of employees' rights under the Act: (1) to new employees at or prior to the start of employment; and (2) to an employee who notifies the employer of a pregnancy or a pregnancy-related condition, no more than 10 days after such notification.

The foregoing is a synopsis of the requirements under the Act, and both employees and employers are encouraged to read the full text of the law available on the General Court's website here: https://malegislature.gov/Laws/SessionLaws/Acts/2017/Chapter54.

If you believe you have been discriminated against on the basis of pregnancy or a pregnancy-related condition, you may file a formal complaint with the MCAD. You may also have the right to file a complaint with the Equal Employment Opportunity Commission if the conduct violates the Pregnancy Discrimination Act, which amended Title VII of the Civil Rights Act of 1964. Both agencies require the formal complaint to be filed within 300 days of the discriminatory act.

DEFINITIONS

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act (ACA) is a United States federal statute signed into law by President Obama in March 2010. The law puts in place comprehensive health insurance reforms.

Out-of-Pocket Maximum: The maximum amount of coinsurance a Plan member must pay towards covered medical expenses in a calendar year for both network and non-network services. Once you meet this out-of-pocket maximum, the Plan pays the entire amount of covered services for the remainder of the calendar year. Deductibles and copays apply to the annual out-of-pocket maximum.

Coinsurance: A percentage of the medical costs, based on the allowed amount, that you must pay for certain services after you meet your annual deductible.

Copayment: A set dollar amount you pay for network doctors' office visits, emergency room services and prescription drugs.

Deductible: Total dollar amount, based on the allowed amount, you must pay out of pocket for covered medical expenses each calendar year before the plan begins to pay for services. The deductible does not apply to network preventive care and any services where you pay a copayment rather than coinsurance. The dental plans also have an annual deductible for basic and major dental care services.

Generic Drugs: These drugs are usually most cost-effective. Generic drugs are chemically identical to their brand-name counterparts. Purchasing generic drugs allows you to pay a lower out-of-pocket cost than if you purchase preferred or non-preferred brand name drugs.

Preferred Brand Drugs: Preferred Brand drugs are approved & recommended by the insurance carrier. The drugs are at a lower cost than Non-Preferred Brand Drugs.

Non-Preferred Brand Drugs: These drugs are not recommended by the insurance carrier, and are more expensive than Preferred Brand Drugs.

Specialty Drugs: prescription medications that require special handling, administration or monitoring. These drugs may be used to treat complex, chronic and often costly conditions.

DEFINITIONS

Pre-tax Plan: A plan for active employees that is paid for with pre-tax money. The IRS allows for certain expenses to be paid for with tax-free dollars. The state takes premiums out of your check before taxes are calculated, increasing your spendable income and reducing the amount you owe in income taxes. Consequently, the IRS has tax laws that require you to stay in the plans you select for a full plan year. You can only make changes during Open Enrollment or if you have a qualifying event.

Primary Care Physician (PCP): The health care professional who monitors your health needs and coordinates your overall medical care, including referrals for tests or specialists on the HMO Plan.

Provider: Any type of health care professional or facility that provides services under your plan.

Network: A group of health care providers, including dentists, physicians, hospitals and other health care providers, that agrees to accept pre-determined rates when serving members.

Qualifying Event: an occurrence that qualifies the Employee to make an insurance coverage change outside of the Open Enrollment.

Conversion: an Employee can change or "convert" her/his Group Life coverage to an Individual Life Insurance policy. Conversion is for an Employee who is leaving her/his job, reducing hours, or has reached the age when coverage may be reduced or eliminated, and still wants to maintain the protection that life insurance provides.

Portability: an Employee can carry or "port" her/his current Group Life coverage after employment ends. Portability is for an Employee who is leaving her/his job and still wants to maintain the protection that life insurance provides.

CONTACT INFORMATION

Plan	Group Number	Website	Phone Numbers
Harvard Pilgrim	**Best Buy HMO $2,000** Policy # varies by class **Best Buy PPO $2,000** Policy # varies by class	www.harvardpilgrim.org	(888) 333-4742
Delta Dental of MA	**Dental – Low & High Plans**	http://deltadentalma.com/	(617) 886-1234
Mutual of Omaha	**Basic Life / AD&D** **Voluntary Life** **Long Term Disability**	https://www.mutualofomaha.com/	(800) 877-5176
HRC Total Solutions	**Flexible Spending Accounts** **Health Reimbursement Account**	https://employee.hrcts.com/Login.aspx?ReturnUrl=%2f	(603) 647-1147
Hays Advocate	**Email:** Curryadvocate@hayscompanies.com		(844) 714-7621

CURRY COLLEGE

1071 Blue Hills Avenue
Milton, MA 02186
(617) 333 - 0500

www.curry.edu