MINNEAPOLIS
PUBLIC SCHOOLS

Urban Education. Global Citizens.

Benefits at a Glance

2016 Plan Year







Welcome

Welcome to the Minneapolis School District employee benefits program. It is our pleasure to provide you with a copy of the *2016 Employee Benefits Guide*. Its purpose is to acquaint you with the benefits and health care plans offered by the Minneapolis Public School District. We believe this guidebook will assist you in understanding and selecting the benefits most helpful in meeting your individual needs.

You probably know that the District offers an extremely competitive and comprehensive benefits program for benefit eligible employees. It does so to provide employees with additional support as they work towards helping the District achieve its mission and strategic priorities. District employee benefits include medical, dental, vision, life, and long-term disability insurance coverage, along with two retirement plans (one defined benefit and one voluntary defined contribution plan), reimbursement accounts and health savings account options, wellness, and an employee assistance program. Additionally, the District has provisions for paid leave time (vacation and sick), family and medical leave, holidays, and other types of paid and unpaid leave.

We encourage you to keep this guidebook along with your other benefits information, as you may want to refer to it periodically. This guidebook is also available on the Human Resources Department website at http://humanresources.mpls.k12.mn.us/prospective.html.

You should know, however, that coverage or participation in most of the benefits outlined in this guidebook are not automatic. It is extremely important that you familiarize yourself with the various options and enroll in those that best fit your needs. Many of the plans are effective for the entire calendar year. If you are a union employee, you may have certain benefits that are part of your collective bargaining agreement. Please refer to your labor agreement for guidance (available on the Human Resources website at http://humanresources.mpls.k12.mn.us/Collective.html).

As your need for certain employee benefits change, you will have opportunities to change your benefits choices - once per year through annual enrollment in the fall or immediately at the time you experience a qualified work/life event (i.e. marriage, birth/adoption of a child). Depending upon the event, you also may add or drop some benefits. Please refer to the *Eligibility and Enrollment* section of this guidebook for more information.

If you should have any questions, the Human Resources Benefits Department is here to assist you:

Email: Benefits@mpls.k12.mn.us
Phone: 612.668.0560
Fax: 612.668.0535
Mail: 1250 West Broadway Avenue North, Minneapolis MN 55411.

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Your Benefit Choices

Minneapolis Public Schools strives to provide a wide variety of benefits for our employees. Some benefits are provided automatically at no cost while others are available if you choose them. Check the guide below to see which benefits you need to make a successful program designed just for you.

Keep this booklet and all coverage materials easily accessible, so that you may refer to them if necessary.

BENEFIT	CARRIER	WHO PAYS THE COST?	EFFECTIVE DATE
Health Insurance	HealthPartners	MPS & Employee	Date which plan is enrolled in online
Dental Insurance	DELTA DENTAL	MPS & Employee	1st of the month following date which plan is enrolled in online
Vision Insurance	VSP Vision care for life	Employee	
Employee Assistance Programs (EAP)	HealthPartners	MPS	Date employee becomes a permanent benefit eligible employee
	Sun Life Financial		
Group Term Life and AD&D Insurance	Sun Life Financial	MPS	
Long-term Disability Insurance			
Supplemental Term Life Insurance		Employee	Date coverage is approved by Carrier
Long Term Care	newman LONG TERM CARE	Employee	
Flexible Spending Accounts	HealthPartners	MPS & Employee	Date which plan is enrolled in online
Health Savings Account (HSA)	hsabank	MPS & Employee	
403(b) Savings Plan	VALIC	Employee	
457 Savings Plan	MNDCP	Employee	
Defined Benefit Pension Plans	PERA		
	Teachers' Retirement Association		
Compensated Time Off and Holidays		MPS	Refer to CBA
Legal Assistance	LegalShield Worry Less. Live More.	MPS	

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits and applicable Limitations and Exclusions.

EMPLOYEE ELIGIBILITY

For the purpose of benefits eligibility, employees are eligible to receive benefits as long as they are a permanent employee working at least 20 hours per week or have an FTE of 0.5 or more.

Employees covered by a union contract are entitled only to those benefits described in that labor agreement. Please refer to your union contract for details regarding your employee benefits.

All employees are eligible to participate in the *Deferred Compensation Program*, however only permanent benefit eligible employees will receive the District match. Please refer to the *Retirement Summary Plan Description* for details.

Temporary employees are ineligible for District-sponsored benefits**.**

DEPENDENT ELIGIBILITY

If you are an eligible participant, you may also cover your eligible dependents under the health, dental, vision, and supplemental life and AD&D plans. Employees will be required to verify eligibility by providing appropriate documentation to Human Resources' Benefits Staff at time of enrollment. Enrolling ineligible dependents into the District's benefits program is a violation of District policy and will be treated accordingly. Eligible dependents include your:

- Legally Married Spouse (**see below for more information**);
- Domestic Partner (**see below for more information**);
- Dependent Children to the age of 26 including;
  - an Enrollee's natural or legally adopted child;
  - a child for whom the Enrollee or the Enrollee's spouse is the legal guardian;
  - a child covered under a valid qualified medical support order (as the term is defined under Section 609 of the Employer Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against an Enrollee;
  - a stepchild of the Enrollee (that is, the child of the Enrollee's spouse)
  - a grandchild of the Enrollee or an Enrollee's spouse who is a newborn, and resides with and is financially dependent on the covered grandparent. The grandchild must be either under 26 years of age or a disabled dependent;
  - an Enrollee's dependent who is (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (b) chiefly dependent on the Enrollee for support and maintenance.

Legally Married Spouse Coverage: A copy of your marriage license AND one form of dated (within six months) documentation establishing current marital status such as a joint household bill, joint bank/credit account, or jointly filed federal tax return.

Domestic Partner Coverage: A copy of a notarized affidavit of domestic partnership AND two forms of dated (within six months) documentation establishing current partnership status such as: a joint household bill, joint bank/credit account, joint mortgage or lease, front page of both federal tax returns showing current common address (with blacked out financial information), assignment of durable power of attorney, or designation as a beneficiary of life insurance or retirement plan.

ENROLLMENT & CHANGES

New hires and newly benefit eligible employees must enroll within thirty (30) days of their employment start date. Employees who elect to insure their spouse, domestic partner and/or dependents will be required to provide proof of eligibility. Human Resources' Benefits staff will verify eligibility status and assist with the process.

Medical coverage will be effective on the date in which the employee enrolls online. Dental and Vision coverage will be effective the first day pf the following month from the date the employee enrolls online.

For those employees who start in the month of August, their medical, dental and/or vision insurance coverage will begin on September 1st, if enrollment is completed by August 31st. If enrolling on September 1st or later, medical coverage begins the day the employee enrolls online and dental/vision insurance will begin the first day of the following month.

PAYROLL DEDUCTIONS

Deductions for premiums are taken out of twelve (12) paychecks from January through June and then again out of eight (8) paychecks from September through December. Your deductions may differ slightly in the latter part of the year. Employees' deductions for January through June also include the premiums for July and August. The September through December deductions only include four months of premiums.

In accordance with state and federal regulations, health benefit premiums paid towards domestic partner benefits will be deducted on a post-tax basis.

EMPLOYEE SELF SERVICE

You can perform a variety of inquiries and make changes online, such as:

- **View and update address and phone number**
- **View and update emergency contact information**
- **View pay statement**
- **View benefit elections**
- **Check your earnings history**
- **View your W-2**
- **View and change your W-4 elections**
- **View and change your 403(b) deductions**

You can access the ESS system from the District website at https://portal.mpls.k12.mn.us/irj/portal. You will want to login using your username and password. If you forgot your password, or are experiencing technical difficulties, please go to the ESS Help website at http://staff.mpls.k12.mn.us/pages/ESS.aspx.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself and/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 you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). ***This Special Enrollment opportunity is available only if you indicated (or otherwise as required) information regarding you or your dependents' other coverage on your initial enrollment form/waiver.***

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

**You do have up to 60 days to request enrollment after the loss of Medicaid coverage.*

QUALIFYING LIFE EVENTS

The elections that you make during your initial benefits eligibility period, or at the Annual Enrollment, will remain in effect for the next 12 months. During that time, if your life or family statuses change according to the recognized events below, you will be permitted to revise your benefits coverage to accommodate your new situation. You are able to make benefits changes by contacting Human Resources at 612-668-0560.

IRS regulations govern the circumstances through which you may make changes to your benefits, which benefits you can change, and which types of changes are permitted.

- All changes must be consistent with the qualified life event
- Changes must be accompanied by supportive documentation
- In most cases, you cannot change your benefit elections, but you may modify the level of coverage (In other words, you can add or delete dependents, enroll or dis-enroll yourself or dependents, but not switch carriers or plans).
- Any changes in benefit levels must be completed within 30 days of the event

Recognized Qualifying Events:

- Marriage
- Death of spouse
- Divorce/legal separation/annulment
- Spouse gains or loses coverage from another source
- Birth or adoption of child
- Death of dependent child
- Change in dependent eligibility

CHANGING YOUR BENEFITS

Annual Enrollment

Eligible employees who wish to change their benefits during annual enrollment are allowed a window of opportunity in the Fall of every calendar year. Benefit elections made during this period of annual enrollment are effective on January 1, 2016.

Employees who wish to participate in health care or dependent care reimbursement account elections MUST enroll through ESS online EVERY YEAR. In accordance with IRS regulations, those elections must be made every year regardless of whether they change or not.

Adding New Dependents

- Spouse or Stepchildren - you must submit the appropriate enrollment form within thirty (30) days of the date of the marriage to the Human Resources Department. Coverage for your spouse and/or stepchildren will start on the date of marriage.

- Newborns and Children Placed for Adoption – you must submit the appropriate enrollment form within thirty (30) days after the date of birth for newborn child or thirty (30) days of the date of placement for your adopted child. Coverage starts on the date of birth or date of placement.

- Disabled Children or Disabled Dependents – you must submit the appropriate enrollment form within thirty (30) days of the date of eligibility. Coverage starts on the date of eligibility.

If the enrollment form is received after the application period, your spouse and/or dependent must wait until the next annual enrollment to apply for coverage.

Special Enrollment Periods

Special enrollment periods are periods during which eligible employees and dependents may enroll under certain circumstances after the initial thirty (30) days when they were first eligible. The following conditions must be met:

1. Employee or dependent was covered under health insurance coverage at the time coverage was previously offered to the employee or dependent;

2. The employee must complete any required written waiver of coverage and state in writing that, at such time, other health insurance coverage was reason for declining enrollment;

3. The employee's or dependent's coverage is terminated because his/her continuation has been exhausted, they are no longer eligible for the Plan due to a divorce, legal separation, death, termination of employment, reduction in hours, or District's contributions toward coverage were terminated; and

4. The employee or dependent requested enrollment not later than thirty (30) days after the termination of coverage or District's contribution.

MEDICAID and the CHILDREN'S HEALTH PROGRAM (CHIP)

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

If you or your dependents are already enrolled in Medicaid or CHIP you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

For more information on special enrollment rights, you can contact:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

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

Health Insurance

Insurance Carrier: HealthPartners
Phone: (800) 883-2177 or (612) 339-3663
Website: www.healthpartners.com

January to June Pre-tax Deductions Per Paycheck

Group	Plan I		Plan II		Plan III	
	EE	Family	EE	Family	EE	Family
Teachers, ABE	$30.00	$418.68	$0.00	$364.63	$0.00	$324.50
ESP	$64.46	$474.81	$30.27	$386.57	$4.88	$321.04
AFSCME	$39.36	$458.05	$5.18	$369.81	$0.00	$304.28
Janitors	$97.79	$474.81	$63.60	$386.57	$38.21	$321.04
Transportation	$105.12	$463.70	$70.94	$375.46	$45.54	$309.93
Food Services	$105.12	$474.81	$70.94	$386.57	$45.54	$321.04
Principals	$93.68	$391.47	$59.49	$303.23	$34.10	$237.71
MAAS, MACA, AMP	$81.12	$308.14	$46.94	$219.90	$21.54	$154.37
Non-Rep	$42.23	$174.81	$8.05	$86.57	$0.00	$21.04
Trades	$81.12	$419.25	$46.94	$331.01	$21.54	$265.48
Electricians	$144.02	$661.30	$109.83	$573.06	$84.44	$507.54
Machinists	$105.12	$474.81	$70.94	$386.57	$45.54	$321.04
Grounds	$127.35	$693.87	$93.17	$605.63	$67.77	$540.10

September to December Pre-tax Deductions Per Paycheck

Group	Plan I		Plan II		Plan III	
	EE	Family	EE	Family	EE	Family
Teachers, ABE	$30.00	$314.01	$0.00	$273.47	$0.00	$243.37
ESP	$48.34	$356.11	$22.70	$289.93	$3.66	$240.78
AFSCME	$29.52	$343.54	$3.88	$277.36	$0.00	$228.21
Janitors	$73.34	$356.11	$47.70	$289.93	$28.66	$240.78
Transportation	$78.84	$347.77	$53.20	$281.59	$34.16	$232.45
Food Services	$78.84	$356.11	$53.20	$289.93	$34.16	$240.78
Principals	$70.26	$293.61	$44.62	$227.43	$25.58	$178.28
MAAS, MACA, AMP	$60.84	$231.11	$35.20	$164.93	$16.16	$115.78
Non-Rep	$31.68	$131.11	$6.04	$64.93	$0.00	$15.78
Trades	$60.84	$314.44	$35.20	$248.26	$16.16	$199.11
Electricians	$108.02	$495.98	$82.38	$429.80	$63.33	$380.65
Machinists	$78.84	$356.11	$53.20	$289.93	$34.16	$240.78
Grounds	$127.35	$693.87	$93.17	$605.63	$67.77	$540.10

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Total Pre-tax Deductions for 2016

Group	Plan I		Plan II		Plan III	
	EE	Family	EE	Family	EE	Family
Teachers, ABE	$600.00	$7,536.24	$0.00	$6,563.32	$0.00	$5,840.96
ESP	$1,160.24	$8,546.60	$544.84	$6,958.28	$87.84	$5,778.72
AFSCME	$708.48	$8,244.92	$93.20	$6,656.60	$0.00	$5,477.04
Janitors	$1,760.20	$8,546.60	$1,144.80	$6,958.28	$687.80	$5,778.72
Transportation	$1,892.16	$8,346.56	$1,276.88	$6,758.24	$819.76	$5,578.76
Food Services	$1,892.16	$8,546.60	$1,276.88	$6,958.28	$819.76	$5,778.72
Principals	$1,686.24	$7,046.52	$1,070.84	$5,458.20	$613.84	$4,278.76
MAAS, MACA, AMP	$1,460.16	$5,546.56	$844.88	$3,958.24	$387.76	$2,778.68
Non-Rep	$760.20	$3,146.60	$144.92	$1,558.28	$0.00	$378.72
Trades	$1,460.16	$7,546.52	$844.88	$5,958.20	$387.76	$4,778.64
Electricians	$2,592.40	$11,903.44	$1,977.00	$10,315.12	$1,519.92	$9,135.68
Machinists	$1,892.16	$8,546.60	$1,276.88	$6,958.28	$819.76	$5,778.72
Grounds	$2,292.36	$12,489.64	$1,677.08	$10,901.32	$1,219.88	$9,721.84

Medical

Medical coverage helps you and your family access routine and preventive health care at a reasonable cost and protects against the catastrophic costs of major illness or injury.

The Minneapolis Public School Districts' medical program is fully funded. This means that the District purchases an insurance policy with HealthPartners to cover the cost of claims made against its medical programs. HealthPartners also provides third-party administrative services, such as providing access to a network of providers and processing of claims.

The District does not price the plan to make a profit. Employees also pay a portion of the cost through deductibles and coinsurance. The District pays the remainder of the claims costs and administrative costs.

Prescription Drug Facts

Generic Drugs- These drugs are equal to brand name drugs in safety and therapeutic effectiveness and are approved by the U.S. Food and Drug Administration (FDA). The FDA reviews generic drugs to assure they are bio-equivalent to the brand name drug. This means that they contain the identical amount of the same active ingredient, in the same dosage, form and strength. It is absorbed into the bloodstream at the same rate and to the same extent. It is manufactured in compliance with all FDA regulations. Some examples of this would be Ibuprofen, the generic form of Motrin, Ranitidine HCL, the generic form of Zantac and Cimetidine, the generic form of Tagamet. The average retail cost differential between a brand and generic drug is $30.

Brand Name Drugs With a Generic Equivalent- These drugs that have been on the market and due to the expiration of the brand name patent are now available in generic form. Remember before a generic can be available it must meet FDA approval requirements.

Brand Name Drugs Without a Generic Equivalent- Most often these are drugs that are new to the market or drugs for which the manufacturer patent has not expired. The patent must expire before a generic equivalent can be produced, approved by the FDA and marketed. These drugs may be added to the formulary if they meet the selection criteria. An example of this would be *Imitrex.*

Formulary- This is a listing of drugs that have been selected based upon their safety, effectiveness in treatment, uniqueness and cost. The formulary changes on a quarterly basis to keep up with new drugs that are available in the market. The formulary consists of generic drugs, brand name drugs without generic equivalent and brand name drugs with a generic equivalent. For a listing of formulary drugs, look on the Internet at www.healthpartners.com/healthlibrary.

HealthParnters' *Plan For Me*

Website: www.healthpartners.com/planforme

When you're picking a plan it's helpful to know what plan best fits your needs. HealthPartners® Plan for Me℠ makes it easy to compare your plan options so you can pick the right plan for you.

Use Plan for Me ℠ to help you:	
Compare your health plan options	See plan deductibles, premiums and out-of-pocket limits so you can compare the best options for you.
See how your prescriptions are covered	Compare your prescription costs to help you pick the right plan for your budget.
See if your doctor is in the network	Search for your doctor or find a new one to meet your health care needs.
Experience sample plan scenarios	See how each plan covers your various health care expenses so you can pick the best plan for you.

Get started today by visiting:

www.healthpartners.com/planforme

You'll need to enter this information:

- Group number: **25274**
- Site number: **04**
- Effective date (plan start date): **01/01/2016**

HERE'S HOW IT WORKS:

1. Log on using the information to the left.
2. Look at options side-by-side to see how they differ and compare.
3. Easily estimate out-of-pocket costs based on age and gender for you and any dependents you'd be covering. Or pick from a list of common conditions and medical procedures that relate to you and your family.
4. Once you've found a plan option you think will work best, print out a summary of that plan or email one to yourself for future reference.

Keep in mind, Plan for Me ℠ is designed to help you compare the plans your employer is offering. You'll need to review all plan information in the Summary of Benefits and Coverage your employer gave you before you make your final choice. Don't forget, you'll still need to sign up for a plan through your employer's benefit enrollment process.

The *Plan For Me* tool will also request that you provide your current premium amounts, to assist you in calculating your total annual medical costs. For your convenience, we have provided those amounts on the previous page (page 8).

Health Savings Account (HSA)

Account Administrator: HSA Bank
Phone: (800) 357-6246
Website: www.hsabank.com

What is an HDHP-HSA Medical Plan?

An HDHP-HSA is a Medical Plan that combines a high deductible health plan with a savings account that offers you lower premium deductions from your paychecks and an opportunity to set aside pre-tax dollars to pay for future health care expenses. As long as those dollars are used to pay eligible health care expenses, you do not have to pay taxes on those funds. You may also invest your funds in a brokerage account once your account reaches certain levels, and investment earnings on your account grow tax-free.

How does the HSA Plan work?

- Your health plan provides first-dollar coverage for preventive care, such as routine physicals, screening tests, well child care and pre-natal care.
- Other expenses are subject to the medical plan deductible until you have reached the annual out-of-pocket maximum, and then your expenses are covered at 100%.
- When you enroll in the HSA, you will receive two (2) free VISA debit cards that you can use to pay for medical out-of-pocket expenses (e.g., at your doctor's office, at a retail pharmacy, etc.). If your doctor or hospital bills you for any services, you can provide your debit account information to the provider and the amount will be deducted from your debit account balance.
- If you pay your bill directly using another account outside the HSA, you can also obtain a reimbursement from your HSA account direct-deposited to your checking or savings account

Who provides service for my HSA Account?

Your HSA Account is administered by HSA Bank. Headquartered in Milwaukee, Wisconsin, HSA Bank is one of the nation's leading HSA administrators serving more than 700,000 accountholders nationwide.

Where is my HSA Account Invested?

- ***Bank Account:*** contributions are deposited to an interest bearing bank account which is FDIC-insured through Webster Bank, N.A. Your account is credited each month with the interest you've earned based on your daily account balance.
- ***Investment Accounts:*** HSA Bank offers investment options with TD Ameritrade and DEVENIR.
  - TD Ameritrade Self-Directed Brokerage Option: provides you with access to stocks, bonds and thousands of mutual funds. Trading fees may be applied by TD Ameritrade.
  - DEVENIR Mutual Fund Selection Option: you can invest your HSA funds in a pre-selected group of no-load mutual funds covering a range of fund families and asset classes. An annual fee of $24 is deducted from the mutual fund account, pro rata.

How much money can I contribute to a Health Savings Account (HSA)?

If you participate in the Plan Three, you will be eligible to participate in the HSA and contribute up to the annual limits that are established by the federal government. Contributions that are made through payroll deductions will be made pre-tax. Note: benefits are pro-rated for the period of time during which you are covered by an HSA–compliant medical plan):

2016 Calendar Year	Annual Maximum
Employee Only Coverage	$3,350*
Family Coverage	$6,750*
Additional Catch-up Contribution *(Only available if you are age 55 or older)*	$1,000

****Annual Maximums include contributions from all sources: examples would be pre and post-tax contributions.***

How do I make my own contributions to the Health Savings Account?

You can elect to have your HSA contributions deducted from your pay on a before-tax basis, or you can make deposits directly to your HSA account and deduct those contributions from your taxable earnings when you file your taxes. If you choose to make deposits to the HSA outside of payroll deductions, there is a special form you must complete – Form 8889 – when you prepare your taxes.

Unlike traditional plans with a Flexible Spending Account, your unused HSA account balances roll over from year to year (there is no "use it or lose it" requirement). Your account is also portable, meaning that if you retire or leave Minneapolis Public Schools, you can still use your HSA to pay for qualified medical expenses (including COBRA or retiree medical insurance premiums).

Are there any other rules that apply to an HSA?

Because of the tax-favored treatment provided under HSA's, there are some restrictions on participation:

- You must participate in a health plan that meets certain standards (set by the Treasury Department) for minimum deductibles and out-of-pocket maximums. Plan Three offered with the MPS HSA plan meets those minimum standards.
- You cannot be covered under another health plan that would treat the same expenses as eligible for reimbursement. For example, if you are also covered under your spouse's health plan, you are not eligible for the health savings account.
- **If you elect to participate in the MPS HSA, you will not be eligible to participate in the Health Care Flexible Spending Account.** You will however be eligible to participate in the Dependent Care Reimbursement Account.
- If you take a withdrawal from your HSA for a purpose other than to pay for eligible medical expenses, that amount is subject to income taxes, as well as a 20% federal penalty tax.

Participants will receive IRS forms 5498 and 1099 to aid in tax preparation. The participant is responsible for documenting that all withdrawals have been used for qualified medical expenses and they will be liable for state and federal taxes if the expenses were not qualified medical expenses.

Plan I: Well-being Participant	You Pay In-Network	You Pay Out-of-Network
Calendar Year Deductible The in and out-of-network deductibles accumulate separately *Does not include co-pay or coinsurance amounts*	$1,000 Single $2,000 Family	$1,500 Single $3,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$2,750 Single $5,500 Family	$4,750 Single
Lifetime Maximum	Unlimited	$1,000,000
Preventative Health Care (routine physical, eye exam, well-child care, prenatal and postnatal care, immunizations)	You pay nothing	50% after deductible
Convenience Care		
• Retail clinics & e-visits	$15 per visit	50% after deductible
• On-line care *(virtuwell)*	First 3 visits free, then $15 per visit	Not covered
Emergency Care		
• Urgent care Clinic	$30 per visit	
• Hospital Emergency Room	20% after deductible	
• Ambulance	20% after deductible	
Office Visits		
• Benefit Level 1	$30 per visit	50% after deductible
• Benefit Level 2	$55 per visit	
• Benefit Level 3	$80 per visit	
• All Levels - Chiropractic Care	$30 per visit	
Inpatient Hospital Care		
• Benefit Level 1	20% after ded.	50% after deductible
• Benefit Level 2	30% after ded.	
• Benefit Level 3	40% after ded.	
Outpatient Hospital Care		
• Benefit Level 1	20% after ded.	50% after deductible
• Benefit Level 2	30% after ded.	
• Benefit Level 3	40% after ded.	
Prescription Drugs		
Retail Copayment for 30-day supply		
• Generic from formulary	$5 Co-pay	50% after deductible
• Brand from formulary	$40 Co-pay	
• Medications not on formulary	$60 Co-pay	
Specialty	20% up to $200	
Mail Order Copayment for 90-day supply		
• Generic from formulary	$10 Co-pay	Not covered
• Brand from formulary	$80 Co-pay	
• Medications not on formulary	$120 Co-pay	

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits and applicable Limitations and Exclusions.

Plan I: Non Well-being Participant	You Pay In-Network	You Pay Out-of-Network
Calendar Year Deductible The in and out-of-network deductibles accumulate separately *Does not include co-pay or coinsurance amounts*	$1,000 Single $2,000 Family	$1,500 Single $3,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$2,750 Single $5,500 Family	$4,750 Single
Lifetime Maximum	Unlimited	$1,000,000
Preventative Health Care (routine physical, eye exam, well-child care, prenatal and postnatal care, immunizations)	You pay nothing	50% after deductible
Convenience Care		
• Retail clinics & e-visits	$25 per visit	50% after deductible
• On-line care *(virtuwell)*	First 3 visits free, then $25 per visit	Not covered
Emergency Care		
• Urgent care Clinic	$50 per visit	
• Hospital Emergency Room	20% after deductible	
• Ambulance	20% after deductible	
Office Visits		
• Benefit Level 1	$50 per visit	50% after deductible
• Benefit Level 2	$75 per visit	
• Benefit Level 3	$80 per visit	
• All Levels - Chiropractic Care	$50 per visit	
Inpatient Hospital Care		
• Benefit Level 1	20% after ded.	50% after deductible
• Benefit Level 2	30% after ded.	
• Benefit Level 3	40% after ded.	
Outpatient Hospital Care		
• Benefit Level 1	20% after ded.	50% after deductible
• Benefit Level 2	30% after ded.	
• Benefit Level 3	40% after ded.	
Prescription Drugs		
Retail Copayment for 30-day supply		
• Generic from formulary	$5 Co-pay	50% after deductible
• Brand from formulary	$40 Co-pay	
• Medications not on formulary	$60 Co-pay	
Specialty	20% up to $200	
Mail Order Copayment for 90-day supply		
• Generic from formulary	$10 Co-pay	Not covered
• Brand from formulary	$80 Co-pay	
• Medications not on formulary	$120 Co-pay	

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits and applicable Limitations and Exclusions.

Plan II: Well-being Participant	You Pay In-Network	You Pay Out-of-Network
Calendar Year Deductible The in and out-of-network deductibles accumulate separately *Does not include co-pay or coinsurance amounts*	$2,000 Single $4,000 Family	$3,000 Single $6,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$4,250 Single $8,500 Family	$6,750 Single
Lifetime Maximum	Unlimited	$1,000,000
Preventative Health Care (routine physical, eye exam, well-child care, prenatal and postnatal care, immunizations)	You pay nothing	50% after deductible
Convenience Care		
• Retail clinics & e-visits	$15 per visit	50% after deductible
• On-line care *(Virtuwell)*	First 3 visits free, then $15 per visit	Not covered
Emergency Care • Urgent care Clinic • Hospital Emergency Room • Ambulance	$35 per visit 20% after deductible 20% after deductible	
Office Visits • Benefit Level 1 • Benefit Level 2 • Benefit Level 3 • All Levels - Chiropractic Care	$35 per visit $60 per visit $85 per visit $35 per visit	50% after deductible
Inpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after ded. 30% after ded. 40% after ded.	50% after deductible
Outpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after ded. 30% after ded. 40% after ded.	50% after deductible
Prescription Drugs **Retail Copayment for 30-day supply** • Generic from formulary • Brand from formulary • Medications not on formulary **Specialty** **Mail Order Copayment for 90-day supply** • Generic from formulary • Brand from formulary • Medications not on formulary	 $5 Co-pay $40 Co-pay $60 Co-pay 20% up to $200 $10 Co-pay $80 Co-pay $120 Co-pay	50% after deductible Not covered

Plan II: Non-Well-being Participant	You Pay In-Network	You Pay Out-of-Network
Calendar Year Deductible The in and out-of-network deductibles accumulate separately *Does not include co-pay or coinsurance amounts*	$2,000 Single $4,000 Family	$3,000 Single $6,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$4,250 Single $8,500 Family	$6,750 Single
Lifetime Maximum	Unlimited	$1,000,000
Preventative Health Care (routine physical, eye exam, well-child care, prenatal and postnatal care, immunizations)	You pay nothing	50% after deductible
Convenience Care • Retail clinics & e-visits • On-line care *(Virtuwell)*	$25 per visit First 3 visits free, then $25 per visit	50% after deductible Not covered
Emergency Care • Urgent care Clinic • Hospital Emergency Room • Ambulance	$35 per visit 20% after deductible 20% after deductible	
Office Visits • Benefit Level 1 • Benefit Level 2 • Benefit Level 3 • All Levels - Chiropractic Care	$55 per visit $80 per visit $85 per visit $55 per visit	50% after deductible
Inpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after ded. 30% after ded. 40% after ded.	50% after deductible
Outpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after ded. 30% after ded. 40% after ded.	50% after deductible
Prescription Drugs **Retail Copayment for 30-day supply** • Generic from formulary • Brand from formulary • Medications not on formulary **Specialty** **Mail Order Copayment for 90-day supply** • Generic from formulary • Brand from formulary • Medications not on formulary	 $5 Co-pay $40 Co-pay $60 Co-pay 20% up to $200 $10 Co-pay $80 Co-pay $120 Co-pay	 50% after deductible Not covered

Plan III: Well-being Participant	You Pay In-Network	You Pay Out-of-Network
Calendar Year Deductible The in and out-of-network deductibles accumulate separately *Does not include co-pay or coinsurance amounts*	$1,300 Single $3,000 Family	$2,600 Single $5,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$3,000 Single $6,000 Family	$5,000 Single $10,000 Family
Lifetime Maximum	Unlimited	$1,000,000
Preventative Health Care (routine physical, eye exam, well-child care, prenatal and postnatal care, immunizations)	You pay nothing	40% after deductible
Convenience Care • Retail clinics & e-visits • On-line care *(Virtuwell)*	 20% after ded. 20% after ded.	 40% after deductible Not covered
Emergency Care • Urgent care clinic • Hospital Emergency Room • Ambulance	 20% after ded. 20% after deductible 20% after deductible	 40% after deductible
Office Visits • Benefit Level 1 • Benefit Level 2 • Benefit Level 3 • All Levels - Chiropractic Care	20% after deductible	40% after deductible
Inpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after deductible	40% after deductible
Outpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after deductible	40% after deductible
Prescription Drugs **Retail Copayment for 30-day supply** • Medications on the formulary • Medications not on the formulary **Specialty** **Mail Order Copayment for 90-day supply** • Medications on the formulary • Medications not on the formulary	 20% after deductible 30% after deductible 20% up to $200 20% after deductible 30% after deductible	 40% after deductible Not covered

Plan III: Non-Well-being Participant	You Pay In-Network	You Pay Out-of-Network
Calendar Year Deductible The in and out-of-network deductibles accumulate separately *Does not include co-pay or coinsurance amounts*	$1,550 Single $3,500 Family	$2,600 Single $5,000 Family
Calendar Year Out-of-Pocket Maximum (Combined Medical AND Pharmacy)	$3,000 Single $6,000 Family	$5,000 Single $10,000 Family
Lifetime Maximum	Unlimited	$1,000,000
Preventative Health Care (routine physical, eye exam, well-child care, prenatal and postnatal care, immunizations)	You pay nothing	40% after deductible
Convenience Care • Retail clinics & e-visits • On-line care *(Virtuwell)*	 20% after ded. 20% after ded.	 40% after deductible Not covered
Emergency Care • Urgent care clinic • Hospital Emergency Room • Ambulance	 20% after ded. 20% after deductible 20% after deductible	 40% after deductible
Office Visits • Benefit Level 1 • Benefit Level 2 • Benefit Level 3 • All Levels - Chiropractic Care	20% after deductible	40% after deductible
Inpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after deductible	40% after deductible
Outpatient Hospital Care • Benefit Level 1 • Benefit Level 2 • Benefit Level 3	20% after deductible	40% after deductible
Prescription Drugs **Retail Copayment for 30-day supply** • Medications on the formulary • Medications not on the formulary **Specialty** **Mail Order Copayment for 90-day supply** • Medications on the formulary • Medications not on the formulary	 20% after deductible 30% after deductible 20% up to $200 20% after deductible 30% after deductible	 40% after deductible Not covered

Well@Work Clinic – Davis Center

Account Administrator: Health Partners
Phone: (952) 967-7474
Website: www.healthpartners.com

The medical clinic at the Davis Center is a partnership between MPS and HealthPartners that is managed by the Human Resources Department. It provides conveniently located health care to MPS employees and their dependents at no charge. You do not have to have HealthPartners insurance through MPS to use the clinic. All benefits eligible employees and their qualified dependents may utilize the clinic's services.

The clinic will be staffed by a HealthPartners Nurse Practitioner or Physician's Assistant who can provide the following services onsite:

Medical	Lab Tests
- Cold & Flu	- Blood draws
- Seasonal allergies	- Blood pressure
- Sinus infections	- Cholesterol
- Strep throat	- Blood sugar
- Pink eye	
- Ear infections	
- Back pain	
- Sprains	
- Stomach problems	
- Women's health	
- Vaccinations	

Many of the medicines commonly prescribed by the clinic will be available in generic form. This includes antibiotics, anti-inflammatories, blood pressure and cholesterol medications. Specialty and brand name drugs won't be available, but can be filled through your local pharmacy. Narcotic pain medications also won't be available on-site.

Generic medications prescribed by the clinic will be provided to employees at no charge. The program is designed to save time and money by offering common medications on site and is not intended to replace your regular pharmacy.

Before you make your first appointment, be sure to register by calling the appointment center at the number listed below. Most appointments take about 20 minutes. **Visits are by appointment only**.

The clinic is open Monday through Friday, 8:00 AM to 4:30 PM, however the clinic is closed on MPS recognized holidays.

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virtuwell by HealthPartners – Online Care

Account Administrator: HealthPartners
Website: www.virtuwell.com

Do you have the flu? Or a child with pinkeye?

Now there is a way to quickly and conveniently get care for these and over 40 other common conditions. It's called virtuwell, an online clinic that treats everyday illnesses so you – or your kids – can get better faster.

Online Diagnosis and Prescriptions

Developed by HealthPartners, virtuwell is a great option for getting help with simple medical conditions like cold and flu, ear pain and sinus infections. You'll take a quick online interview that checks your history and makes sure your problem isn't serious.

Trusted Advice

With virtuwell, you're helped by nurse practitioners with experience in treating common conditions. They can also write prescriptions. If you have questions during or after your visit, they're always available.

Fast Response

When you finish your interview, a nurse practitioner reviews it in about 30 minutes. Your personalized Treatment Plan notification will come to you by email or text. Then just log on to virtuwell.com to view it. It will include your diagnosis with suggestions to help you get better. If you need a prescription, virtuwell will send it to the pharmacy you choose.

How a virtuwell Visit Works

- A virtuwell.com visit starts with a quick online interview that checks your medical history and makes sure the problem isn't serious.
- Next, a certified nurse practitioner will review your case and write a personalized treatment plan. You'll get an email or text the moment your plan is ready.
- If a prescription is needed, it'll be sent it to a pharmacy of your choice.
- Your satisfaction is guaranteed.

24/7 ONLINE CLINIC
Available via your:

- Computer
- Smartphone
- Tablet

Affordable Care

- **Members in Plan I or II get three virtuwell.com visits free**; it is then only $15 per visit.
- Visits for Members in Plan III (HSA plan) will be subject to deductible and co-insurance.
- **If Virtuwell can't treat you, you don't pay.**

virtuwell is simple to use and always there when you need it. Learn more about virtuwell and find out what it can treat at virtuwell.com.

Dental Insurance

Insurance Carrier: Delta Dental of Minnesota
Phone Local: (651) 406-5916
Phone Toll Free: (800) 553-9536
Website: www.deltadentalmn.com
Network: Premier

NON-GROUNDS	2016 PER PAY CHECK EMPLOYEE COST	
	January - June	September - December
Employee Only Coverage	$5.56	$4.17
Employee + One Coverage	$11.11	$8.33
Employee + Family coverage	$16.67	$12.50

GROUNDS	2016 PER PAY CHECK EMPLOYEE COST	
	January - June	September - December
Employee Only Coverage	$0.00	$0.00
Employee + Family coverage	$22.73	$17.05

Am I able to go to any dentist?

You have the freedom to see any dentist. However, dentists who participate in the Delta Dental PPO or Delta Dental Premier Networks have agreed not to charge more than our maximum allowable amount. This can result in lower out-of-pocket costs. Choosing a dentist in the Delta Dental PPO network may save you even more money. As an added convenience, you never have to file a claim when you use a participating dentist – the dentist files the claim for you.

How do I find a participating dentist?

Finding a participating dentist is easy. Simply visit www.deltadentalmn.org and use the interactive Dentist Search tool, or call Customer Service at (651) 406-5901 or toll-free at 1-800-553-9536.

If I don't sign up as a new hire, can I sign up in the future?

Yes. Employees will be able to elect coverage after their initial new hire enrollment period either during the annual enrollment period or through a qualifying status change.

Dental Summary of Benefits

After you have satisfied the dental deductible, if applicable, your dental program pays the following percentages of the treatment cost, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for Delta Dental PPO dentists, participating dentists and nonparticipating dentists. If you see a nonparticipating dentist, your out-of-pocket expenses may increase. If a Delta Dental PPO dentist provides dental services, the deductible will be waived and the payment percentages may increase and discounts may apply which will result in lower out-of-pocket costs to you.

Unlike medical conditions, which can be unpredictable and catastrophic, most dental problems are preventable. Preventive care, including regular checkups and cleanings, is the key to maintaining good oral health. Problems can be diagnosed early and treated without extensive testing or elaborate and expensive procedures. That keeps the costs of dental care much lower than those of medical care.

TO AVOID ANY MISUNDERSTANDING OF BENEFIT PAYMENT AMOUNTS, ASK YOUR DENTIST ABOUT HIS OR HER PARTICIPATION STATUS WITH DELTA AND DELTA DENTAL PPO PRIOR TO RECEIVING DENTAL CARE. YOU MAY ALSO REQUEST A PRE-ESTIMATE OF BENEFITS BEFORE THE WORK IS PERFORMED.

Dental Benefit Description	Delta Dental PPO (In-Network)	Delta Dental Premier (In-Network)	Non-Participating (Out-of-Network)
Annual Deductible –Per Coverage Year *The deductible does not apply to check-ups, teeth cleanings, or braces.*	$25 per person	$50 per person	
Annual Maximum –Per Coverage Year *All services are subject to the annual maximum benefit and will not be paid if your annual maximum benefit has been reached.*	$1,300		
Lifetime Ortho Plan Maximum – per eligible person	$1,000		
Diagnostic & Preventive Services • Exams and Cleanings (2 per year) • X-rays and fluoride treatments	100%	80%	80% of allowable maximum fee
Basic Services • Emergency treatment for relief of pain, sealants, space maintainers, amalgam restorations (silver filings) and composite resin restorations (white fillings)	80%	80%	80% of allowable maximum fee
Endodontics • Pulpotomies on primary teeth for dependent children • Root canal therapy on permanent teeth	80%	80%	80% of maximum allowable fee
Periodontics • Surgical/nonsurgical periodontics	80%	80%	80% of maximum allowable fee
Oral Surgery • Surgical/nonsurgical extractions, all other oral surgery	80%	80%	80% of maximum allowable fee
Major Restorative Services • Crowns and composite resin restorations (white fillings) on posterior (back) teeth	50%	50%	50% of maximum allowable fee
Prosthetic Repairs and Adjustments • Denture adjustments and repairs, bridge repairs	80%	80%	80% of maximum allowable fee
Prosthetics • Dentures (full and partial), bridges	50%	50%	50% of maximum allowable fee
Orthodontics • Treatment for the prevention/correction of malocclusion, available for dependent children only, age 8 to 19	50%	50%	50% of maximum allowable fee

Dental Benefit Description -GROUNDS ONLY-	Delta Dental PPO (In-Network)	Delta Dental Premier (In-Network)	Non-Participating (Out-of-Network)
Annual Deductible –Per Coverage Year *The deductible does not apply to check-ups, teeth cleanings, or braces.*	**$25 per person**	**$50 per person**	
Annual Maximum –Per Coverage Year *All services are subject to the annual maximum benefit and will not be paid if your annual maximum benefit has been reached.*	**$1,300**		
Lifetime Ortho Plan Maximum – per eligible person	**$1,000**	**$750**	
Diagnostic & Preventive Services • Exams and Cleanings (2 per year) • X-rays and fluoride treatments	100%	80%	80% of allowable maximum fee
Basic Services • Emergency treatment for relief of pain, sealants, space maintainers, amalgam restorations (silver filings) and composite resin restorations (white fillings)	80%	80%	80% of allowable maximum fee
Endodontics • Pulpotomies on primary teeth for dependent children • Root canal therapy on permanent teeth	80%	80%	80% of maximum allowable fee
Periodontics • Surgical/nonsurgical periodontics	80%	80%	80% of maximum allowable fee
Oral Surgery • Surgical/nonsurgical extractions, all other oral surgery	80%	80%	80% of maximum allowable fee
Major Restorative Services • Crowns and composite resin restorations (white fillings) on posterior (back) teeth	50%	50%	50% of maximum allowable fee
Prosthetic Repairs and Adjustments • Denture adjustments and repairs, bridge repairs	80%	80%	80% of maximum allowable fee
Prosthetics • Dentures (full and partial), bridges	50%	50%	50% of maximum allowable fee
Orthodontics • Treatment for the prevention/correction of malocclusion, available for dependent children only, age 8 to 19	50%	50%	50% of maximum allowable fee

Vision Insurance

Insurance Carrier: VSP Vision Care
Phone: (800) 877-7195
Website: www.VSP.com

Standard Plan

STANDARD PLAN – 2016 PER PAY CHECK EMPLOYEE COST JANUARY – JUNE	
Employee Only Coverage	$3.94
Employee + Family Coverage	$10.88

STANDARD PLAN – 2016 PER PAY CHECK EMPLOYEE COST SEPTEMBER - DECEMBER	
Employee Only Coverage	$2.96
Employee + Family Coverage	$8.16

Premier Plan

PREMIER PLAN – 2016 PER PAY CHECK EMPLOYEE COST JANUARY - JUNE	
Employee Only Coverage	$5.58
Employee + Family Coverage	$15.31

PREMIER PLAN – 2016 PER PAY CHECK EMPLOYEE COST SEPTEMBER - DECEMBER	
Employee Only Coverage	$4.18
Employee + Family Coverage	$11.48

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VSP VISION CARE		
Vision	**Standard Plan**	**Premier Plan**
WellVision Exam Focuses on your eye health and overall wellness	**$10 copay every calendar year**	**$10 copay every calendar year**
Prescription Glasses Lenses: *Single vision, lined bifocal, lined trifocal lenses *Polycarbonate lenses for dependent children	**$25 copay every calendar year**	**$25 copay every calendar year**
CAN RECEIVE ALLOWANCE FOR FRAMES OR GLASSES		
Frames: Allowance for wide selection of frames	**$150 every other calendar year and 20% off amount over allowance $80 Costco Allowance**	**$175 every calendar year and 20% off amount over allowance $95 Costco Allowance**
Contacts (instead of glasses)	**$150 every calendar year and 20% off amount over allowance up to $60 copay for contact lense fitting**	**$175 every calendar year and 20% off amount over allowance up to $60 copay for contact lense fitting**

Flexible Spending Accounts

Claims Administrator: HealthPartners
Phone (Local): (952) 883-5000
Phone (Toll Free): (800) 883-2177
Website: www.healthpartners.com
Plan Year: January 1st - December 31st

The Minneapolis Public Schools Health and Dependent Care Flexible Spending Accounts (FSAs) allow you to use tax-free dollars to reimburse yourself for a wide variety of health and/or dependent care expenses that aren't covered through your other benefit plans. The annual amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck pre-tax (before Federal and, in most cases, State and Local income taxes are withdrawn).

Health Care FSA – maximum contribution is $2,550 per plan year

This account reimburses you on a pre-tax basis for eligible out-of-pocket expenses including deductibles, co-pays, co-insurance, certain over the counter drugs and other such expenses not covered by your medical or dental plan.

Dependent Care FSA - maximum contribution is $5,000 per family* per plan year

Expenses for dependent care services for children under age 13, a disabled spouse, or incapacitated parent are eligible for reimbursement from your Dependent Care FSA as long as you incur them while you and your spouse work or attend school full-time.

The maximum Dependent Care contribution is $5,000 per family, per year, as set by the IRS or $2,500.00 if you are married and filing a separate income tax return.

Rules and Regulations

Plan your annual FSA contribution amounts carefully; the election you make when you enroll is binding for the entire plan year (January 1 to December 31) unless you have a qualifying status change. Additionally, the IRS imposes some rules and restrictions on the way you can use FSAs, such as:

- You must incur eligible expenses during the plan year
- If you incur fewer expenses than expected, any money remaining in your Dependent Care FSA and any balance above $500 in your Health Care FSA at the end of the year will be forfeited; you can roll over up to $500 from one plan year to the next for the Health Care FSA only.
- You can't transfer money from one account to another; money in your Health Care FSA can't be used for dependent care expenses, and money in your Dependent Care FSA can't be used for health care expenses.
- You can only make changes to your contribution amounts with a qualified status change and the change being made must be consistent with the qualified event; these include birth or adoption, marriage, divorce, death of a spouse or dependent, change from part-time to full-time or full-time to part-time employment, termination or commencement of spouse's employment, unpaid leave of absence, significant change in health coverage due to spouse's employment.

All claims with dates of service during the plan year must be submitted to HealthPartners by 1 pm CST on March 31st, 2017. Any claim(s) submitted with a date of service after the plan year, or any claim(s) with a date of service during the plan year submitted after March 31st, 2017 will be denied.

This is a brief description only. It is not a Certificate of Coverage. Please see the Group Policy, which alone determines all rights, benefits and applicable Limitations and Exclusions.

How do I get reimbursed for medical and/or dependent care expenses?

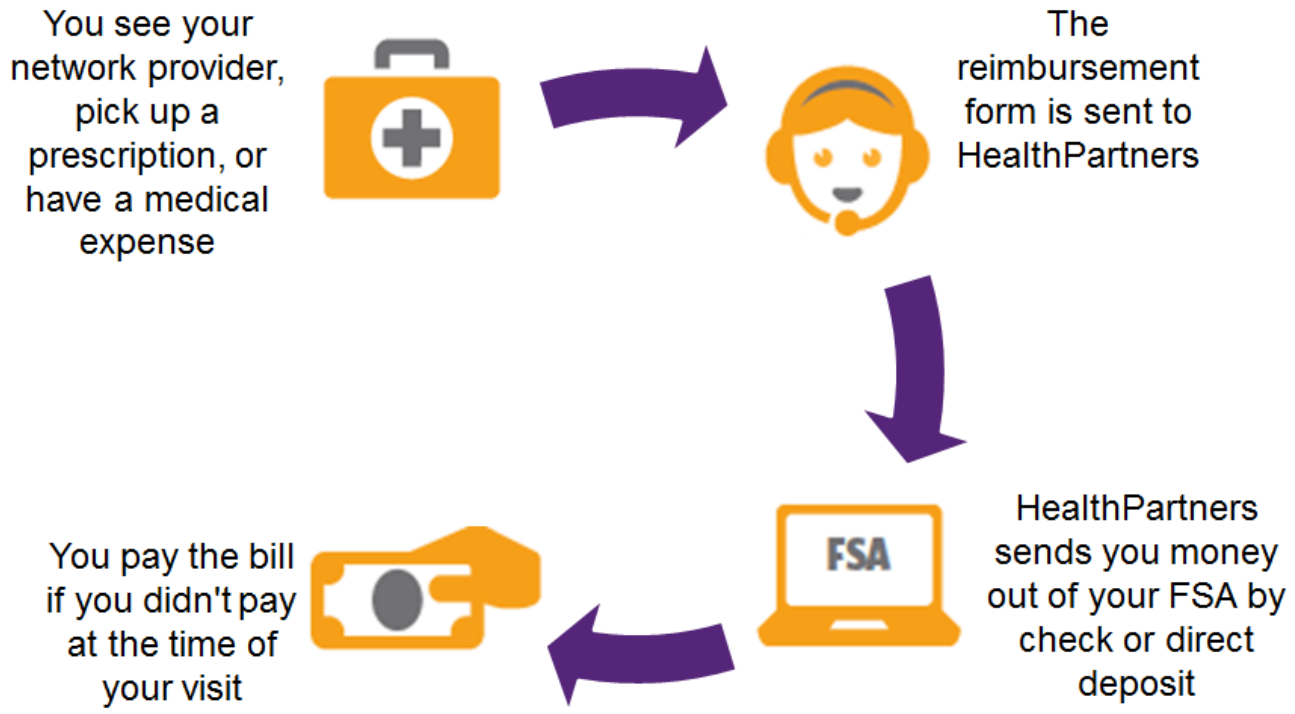
After you incur a health care or dependent care expense, you must file a claim along with verification of the expense. Once your claim has been received and processed, you will be reimbursed by check or direct deposit.

There are several ways to file a claim:

- ***Claims Crossover* (Medical FSA only)***: when enrolled in the claims crossover benefit, if qualified expenses are at a network provider or pharmacy, the claim will automatically be sent to HealthPartners for processing. If there's any payment responsibility from that expense, it will be automatically sent to the health care FSA for reimbursement.
- ***FSA Debit Card:*** as an alternative to the Claims Crossover benefit, you may utilize a FSA debit card that automatically deducts eligible expenses at the point of service. In some cases, claims substantiation may still be required and may be sent by fax or mail to HealthPartners.
- ***Manual Submission:*** claims not sent via crossover or paid with a debit card can be submitted using any of the following methods:
  - *Online:* log onto your account at healthpartners.com and fill out an online claim form. Fax or mail supporting documents with a copy of the online form to HealthPartners at the number or address above.
  - *Fax*: claim forms and documentation can be faxed to HealthPartners at 952-883-5026.
  - *Mail:* claim forms can be mailed to HealthPartners FSA Service Center, Membership Accounting, Mail Stop 21104A, P.O. Box 1309, Minneapolis, MN 55440-1309

****All participants in the Health Care FSA will be automatically enrolled in the Claims Crossover feature. If you would like to opt-out of the Claims Crossover feature you must do so at the time of your initial enrollment.***

How Claims Crossover Works



How Does a Flexible Spending Account Help You Save Money?

If you enroll in one or both of the reimbursement accounts, your elected contributions will be deducted from your pay and will not be subject to federal Income Tax, State Income Tax, or Social Security (FICA) Taxes. When your taxable income is reduced, your taxes are also reduced.

The contributions you designate for flexible spending account (Health Care and Dependent Care) will be credited to a bookkeeping account on your behalf. This account will be used to reimburse you for eligible health care/dependent care expenses for you and your eligible dependents which are not reimbursed by another source, like insurance, another reimbursement plan or a state agency.

The paycheck example provided below will give you an idea of the tax savings provided under the program, for a married person earning $36,000 per year, who elects $1,200 to the health care plan, and $3,600 to the dependent care plan

	Paying your expenses pre-tax using the Flex Spending Account	Paying your expenses after-tax without using the Flex Spending Account
Gross Biweekly Pay	**$1,500.00**	**$1,500.00**
- Health Care FSA	-$50.00	$0
- Dependent Care FSA	-$150.00	$0
= Gross Taxable Earnings	**$1,300.00**	**$1,500.00**
- Federal Income Tax (15%)	-$195.00	-$225.00
- State Income Tax (6%)	-$78.00	-$90.00
- Social Security Tax (7.35%)	-$95.55	-$110.25
- After Tax Health Care Expenses	$0	-$50.00
- After Tax Daycare Expenses	$0	-$150.00
= Net Biweekly Pay	**$931.45**	**$874.75**
Per Paycheck (Net) Savings	**$56.70**	
Yearly Tax Savings	**$1,360.80**	

Basic Life and AD&D

Insurance Carrier: Sun Life Financial
Phone: (800) 247-6875 (Customer Service & Claims)
Website: www.sunlife.com/us

Minneapolis Public Schools pays for basic life insurance for permanent employees working at least 20 hours a week or at least 0.5 FTE. Please refer to your collective bargaining agreement for the basic life insurance amount.

Employee Class	Base Term Life Amount	Base AD&D Amount
Superintendent	2x Basic Annual Earnings*	2x Basic Annual Earnings*
Cabinet Members	$150,000	$150,000
Principals, Assistant Principals & Administrative Contracts	$100,000	$100,000
Administrators	$75,000	$75,000
Teachers, Tutors & Nurses	$50,000	$50,000
All Other Employees	$20,000	$20,000

**Rounded to the next higher $1,000, if not already a multiple of $1,000. Maximum benefit is $750,000.*

This benefit also provides the following additional services:

- **Survivor Financial Counseling Services**
  This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to them. This service is also extended to employees upon the death or terminal illness of their covered spouse.

- **Sun life does not offer portability, only conversion**
  If you retire or leave MPS, you may be able to take your coverage with you in accordance with the terms outlined in the contract

- **Waiver of Premium**
  If you become disabled (as defined by the MPS plan) and are no longer able to work, your premium payments will be waived during the period of disability

- **Accelerated Benefit**
  If you become terminally ill and are not expected to live more than twelve months, you may request up to 50% of your life insurance amount up to 50% of your life insurance amount up to $750,000. without fees or present value adjustments

Supplemental Life and AD&D Insurance

Insurance Carrier: Sun Life Financial
Customer Service: (800) 247-6875 (Customer Service & Claims)
Website: www.sunlife.com/us

	Employee	Spouse	Child[1]
Supplemental Life Coverage: provides a benefit in the event of death			
Schedule	Increments of $10,000	Increments of $5,000	Increments of $2,500
Guaranteed Issue	$150,000	$50,000	$10,000
Overall Benefit Maximum	$250,000	$100,000 *Cannot exceed 50% of the employees election*	$10,000 *Cannot exceed 50% of the employees election*
Age Reduction Schedule	Coverage reduces to 65% of the original amount at age 65, to 40% of the original amount at age 70 and to 20% of the original amount at age 75		N/A

Age*	Rates per $1,000	Supplemental Life Coverage Level					
		Example Monthly Premiums For:					
		$10,000	**$50,000**	**$70,000**	**$100,000**	**$200,000**	**$250,000**
00 – 29	**$0.06**	$0.60	$3.00	$4.20	$6.00	$12.00	$15.00
30 – 34	**$0.08**	$0.80	$4.00	$5.60	$8.00	$16.00	$20.00
35 – 39	**$0.09**	$0.90	$4.50	$6.30	$9.00	$18.00	$22.50
40 – 44	**$0.14**	$1.40	$7.00	$9.80	$14.00	$28.00	$35.00
45 – 49	**$0.25**	$2.50	$12.50	$17.50	$25.00	$50.00	$62.50
50 – 54	**$0.41**	$4.10	$20.50	$28.70	$41.00	$82.00	$102.50
55 – 59	**$0.70**	$7.00	$35.00	$49.00	$70.00	$140.00	$175.00
60 – 64	**$0.77**	$7.70	$38.50	$53.90	$77.00	$154.00	$192.50
65 – 69	**$1.30**	$13.00	$65.00	$91.00	$130.00	$260.00	$325.00
70+	**$2.06**	$20.60	$103.00	$144.20	$206.00	$412.00	$515.00

**Premiums for Spousal Life Insurance are based on the spouses' age at the time of election.*

Dependent Child Coverage Monthly Premium	**$0.308 / $2,500**

Long-term Disability Benefits

Insurance Carrier: Sun Life Financial
Phone: (800) 247-6875 (Customer Service & Claims)
Website: www.sunlife.com/us

Employees in qualifying bargaining units* are automatically enrolled in the MPS Long Term Disability plan, which is paid for by the District. In the event you become disabled, upon approval from the insurance carrier, the policy will provide a monthly benefit, after satisfaction of the elimination period, up to a maximum benefit per month. Check your collective bargaining agreement to determine the coverage and maximum amounts for your group.

Elimination Period:	90 consecutive days of Total Disability
Definition of Total Disability:	During the elimination period and the next 24 months, the Employee, because of injury r sickness, is unable to perform the Material and Substantial Duties of his Own Occupation. After Total or Partial Disability benefits combined have been paid for 24 months, the employee will continue to be Totally Disabled if he is unable to perform with reasonable continuity any Gainful Occupation for which he is or becomes reasonably qualified for by education, training, or experience.
Monthly Benefit:	60% of the employee's covered monthly earnings
Maximum Monthly Benefit:	$2,500
Definition of Covered Monthly Earnings:	The Employee's basic monthly earnings as reported by the Employer immediately prior to the first date Total or Partial Disability begins. Total Monthly Earnings does not include commissions, bonuses, overtime pay or any other extra compensation
***Qualifying Bargaining Units:**	Teachers, Principals, AFSCME, AMP, Non-Representative, MAAS, MACA, Teamsters-Grounds, Teamsters-Drivers

Benefit Duration	
Age at Disability	**Maximum Benefit Period**
>60	To age 65, but not less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

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Additional Benefits Available – Sun Life Financial

Travel Assistance:

If you have a medical emergency while traveling 100 miles or more away from home, you do not have to face it alone. With one phone call you can be connected to Assist America's staff of medically trained, multilingual professionals who can advise you in a medical emergency, 24 hours a day, 7 days a week.

You will be immediately connected to:

- Pre-qualified, English-speaking doctors, hospitals, pharmacies, and dentists anywhere in the world
- medical consultation, evaluation and referral
- Hospital admission guarantee
- Emergency medical evacuation
- Loss Prevention assistance
- Legal and interpreter services

Identity Theft Solutions:

You have the support of a powerful identity theft program through Assist America's Secure-Assist Identity Protection Program. It provides:

- 24 hour, 7 day a week telephone support and step-by-step guidance provided by anti-fraud experts
- An expert case worker who is assigned to you and will help you notify your credit bureaus and file paperwork to correct your credit reports
- Help in cancelling stolen credit cards and reissuing new cards
- Help in notifying police, financial institutions and government agencies

Online Will Preparation

A will is the cornerstone of any estate plan and can protect your assets and loved ones. Through an easy-to-use website, you and your spouse can now create a legally binding will in about 20 minutes. Best of all, it is free of charge!

The process includes:

- Step-by-step guidance on a secure website
- Glossary of legal definitions
- Ability to name an executor to carry out your wishes and a guardian(s) to care for your children
- Ability to create a living will (for an additional fee)

You can access services online:

Online www.estateguidance.com
Promotional Code SLFVAS

Work-Life Balance – Employee Assistance Program

Insurance Carrier: HealthPartners Employee Assistance Program
Phone: (866) 326-7194
Website: www.hpeap.com
Username: *healthpartners*
Password: *mpsk12*

Insurance Carrier: Sun Life Employee Assistance Program
Phone: (800) 460-4374
Website: www.guidanceresources.com
Username: *EAPEssential*

Timely Care When You Need It.

The Employee Assistance / Work-Life Program offers services designed to help employees reduce stress, balance their work and family responsibilities and improve the quality of their lives. The program consists of resources and referral services, counseling and support services, online information and interactive tools. All services are free, confidential, accessible 24 hours a day, 365 days a year, and available to you and all members of your household.

Overview of Services Available to You:

- ***Dedicated Toll Free Crisis Line***
  - 24-hours a day / 7 days a week / 365 days a year
- ***Diagnostic Assessment and Problem Resolution Sessions***
  - Employees and Dependents will receive a total of 3 face-to-face short-term problem resolution sessions per issue.
  - Some common concerns the EAP can help with:
    - Stress, Anxiety, Depression
    - Life transitions
    - Grief & Loss
    - Divorce / Separation
    - Conflict Resolution
    - Substance abuse
    - Work-Life counseling
    - Financial concerns
    - Legal information, Resources and Consultation
- ***Online Work-Life EAP Resources***
  - Hundreds of articles on a variety of topics
  - Self-assessment tools
  - Child care and elder care resources searches
  - Legal forms
  - Financial calculators
  - Monthly work/life webinars

Long Term Care Insurance

Insurance Carrier: Newman Long Term Care Insurance Company
Phone: (612) 454-4400
Website:

Long Term Care Insurance offers a variety of services to individuals unable to care for themselves due to an accident, illness, or effects of aging, and can be for a temporary or permanent basis. It is designed specifically to cover costs associated with extended long-term care.

Benefit	Benefit Details
Benefit Maximum	Up to a maximum $100, or $200 if filing jointly
Eligibility	Employee, spouse, parents, grandparents and in-laws Evidence of good health for new employees is not required if insurance is applied for within the first thirty (30) days of employment
Benefit Cost	Premiums are per person and based upon age and the effective date of coverage. Premiums are paid with after-tax dollars and do not change unless you increase your benefits

The Need for Long Term Care Insurance

Under the age 65, common causes are cancer, complications of surgery, spinal cord injury, brain damage from accidents and strokes, and Multiple Sclerosis. Over the age 65, common causes are diabetes, fractures and falls, emphysema, stroke, influenza and Alzheimer's disease.

403(b) & 457 Tax-Deferred Savings Plan

403(b) Plan Administrator: Valic
Contacts: Dave Koller - North Locations District Office
Cameron Strobel - South Locations Transportation
Phone: (800) 892-5558
Website: www.valic.com/plan-details2234433090

457 Plan Administrator: MNDCP
Contacts: David Wright (612) 964-8094
Kirk Soland (612) 247-1980
Website: www.mndcplan.com

Starting to save early can make a significant difference in reaching your retirement goals. Minneapolis Public Schools Tax-Deferred Savings plans are an easy way to invest pre-tax earnings to build the level of income you will need for a secure financial future. MPS allows employees to participate in a 403(b) and 457 Plan.

Contributions

All contributions are made on a pre-tax basis. This reduces your taxable income at the end of the tax year. All gains are tax deferred until you withdraw them for retirement.

You may contribute to these savings plans at any time, and do not require any type of participation eligibility. These accounts also allow for an MPS match up to an annual dollar amount. That means that MPS will contribute one dollar for every dollar you contribute up to an annual maximum amount. Check your collective bargaining agreement for more information on your group's matching amounts.

The Internal Revenue Code limits the amount that can be contributed in a calendar year. At no time may you go over the elective deferral limit for the year. Employees are responsible for monitoring their contribution limit each year.

The Tax-Deferred Savings arrangement offers eligible employees the opportunity to direct voluntary contributions to one or both recognized MPS carriers, Valic and Minnesota Deferred Compensation Plan.

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Defined Benefit Pension Plans

MPS employees are covered by two (2) Defined Benefit Pension plans:

- Public Employee Retirement Association (PERA)
- Teacher Retirement Association (TRA) – Licensed employees

Contributions are made jointly by MPS and the employee in accordance with formulas established by the respective agency and State law. The plans are administered by the respective agency and funds held and distributed by them.

For more information on the plans and account balances, employees should contact:

Public Employee Retirement Association (PERA)	**www.mnpera.org**
Customer Service	(800) 657-5757
Teacher's Retirement Association (TRA)	**www.minnesotatra.org**
Customer Service	(800) 657-3669

Minnesota 529 College Savings Plan

TIAA CREF Financial Services

The Minnesota 529 Plan is an easy way to help you prepare for your children's college education. These plans are individual investment accounts that offer tax incentives to save for higher education and training. An account can be established for a designated beneficiary and after-tax contributions are then automatically deposited through an automatic deduction from your bank account. When the money is withdrawn for qualified education expenses, there are no state or federal taxes on the earnings of this account.

Other advantages include:

- Choice of schools – Whether your child decides to go to private or public college/University, trade or graduate school, in Minnesota or another state, funds in your account may be used at any eligible educational institution. Your savings can be used for tuition as well as related qualified expenses such as books, fees, certain room and board expenses, and supplies and equipment required for enrollment or attendance.
- Anyone can contribute – Parents, grandparents, relatives and friends at any income level may open an account and contribute.
- You are in control – You maintain control of the funds in the account. Your child or beneficiary cannot spend the money on a non-qualified expense.
- Low minimum contribution – An account may be opened with $25.

For enrollment information go to www.mnsaves.org or call (877) 338-4646

Legal Services

Carrier: LegalSheild
Phone: (612) 454-4400
Website: www.legalshield.com/info/mpls

What is LegalShield?

LegalShield was founded in 1972, with the mission to make equal justice under law a reality for all North Americans. The 3.5 million individuals enrolled as LegalShield members throughout the United States and Canada can talk to a lawyer on any personal legal matter, no matter how trivial or traumatic, all without worrying about high hourly costs. LegalShield has provided identity theft protection since 2003 with Kroll Advisory Solutions, the world's leading company in ID Theft consulting and restoration. We have safeguarded over 1 million members, provided more than 200,000 identity consultations, and helped restore nearly 10,000 individual identities.

The LegalShield® Membership Includes:	
• Legal Advice – personal legal issues • Letters/calls made on your behalf • Contracts & documents reviewed (up to 15 pages) • Residential Loan Document Assistance • Attorneys prepare your Will, your Living Will and your Health Care Power of Attorney • Moving Traffic Violations (available 15 days after enrollment) • Trial Defense including Pre-Trial & Trial	• Uncontested Divorce, Separation, Adoption and/or Name Change Representation (available 90 days after enrollment) • IRS Audit Assistance • 25% Preferred Member Discount (Bankruptcy, Criminal Charges, Other Matters, etc.) • 24/7 Emergency Access for covered situations

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under age 18 for whom the member is legal guardian; never married, dependent children up to age 26 if a full-time college student; and physically or mentally disabled dependent children.

The IDShield℠ Membership Includes:	
Full Service Restoration Complete identity recovery services by Kroll Licensed Private Investigators and our $5 million service guarantee ensure that if your identity is stolen, it will be restored to its pre-theft status.	**Security Monitoring** SSN, credit cards (up to 10), and bank account (up to 10) monitoring, sex offender search, financial activity alerts and quarterly credit score tracking keep you secure from every angle.
Privacy Monitoring Monitoring your name, SSN, date of birth, email address (up to 10), phone numbers (up to 10), driver license & passport numbers, and medical ID numbers (up to 10) provides you with comprehensive identity protection service that leaves nothing to chance.	**Consultation** Your identity protection plan includes 24/7/365 live support for covered emergencies, unlimited counseling, identity alerts, data breach notifications and lost wallet protection

IDShield plans are available at individual or family rates. A family rate covers the member, member's spouse and up to 8 dependents up to the age of 18.

Monthly Rates
(Premiums Paid via Bank Draft/Credit Card)

	LegalShield	IDShield	Combined
Individual Coverage	$14.95	$8.45	$23.40
Family Coverage	$15.95	$15.95	$28.90

This is a general overview and is for illustrative purposes only. Plans and services vary from state to state. See a plan contract for your state of residence for complete terms, coverage, amounts, conditions and exclusions. An individual rate is available for those enrollees who are not married, do not have a domestic partner and do not have minor children or dependents. No family benefits are available to individual plan members. Ask your Independent Associate for details.

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FMLA – The Family and Medical Leave Act of 1993

FMLA entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. MPS uses a 12-month period prior to or after the commencement of leave as the 12-month period.

Employee Eligibility

To be eligible for FMLA benefits, an employee **must:**

1. have worked for MPS for a total of 12 months;
2. have worked at least 1,250 hours over the previous 12 months; and
3. worked at a MPS location in the United States or in any territory or possession of the United States where at least 50 employees are employed by the employer within 75 miles

Leave Entitlement

MPS will grant an eligible employee up to a total of 12 workweeks of **unpaid** leave during any 12-month period for one or more of the following reasons:

- for the birth and care of the newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for an immediate family member (spouse, child or parent) with a serious health condition;
- to take medical leave when the employee is unable to work because of a serious health condition; or
- to care for a relative who is a covered service member with a serious injury or illness

Spouses employed by MPS are jointly entitled to a **combined** total of 12 work-weeks of family leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition.

Leave for birth and care, or placement for adoption or foster care must conclude within 12 months of the birth or placement.

Under some circumstances, employees may take FMLA leave intermittently – which means taking leave in blocks of time, or by reducing their normal weekly or daily work schedule.

- If FMLA leave is for birth and care or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.
- FMLA leave may be taken intermittently whenever medically necessary to care for a seriously ill family member, or because the employee is seriously ill and unable to work.

MPS will require that employees use accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave.

Serious Health Condition

According to the FMLA, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves: (1) inpatient care (i.e., an overnight stay), including any period of incapacity or any subsequent treatment in connection with the inpatient care; or (2) "continuing treatment" by a health care provider which includes any period of incapacity as a result of:

a) a health condition lasting more than three full consecutive days and any subsequent treatment or period of incapacity relating to the same condition that also includes (i) treatment two or more times by or under the supervision of a health care provider; or (ii) one treatment by a health care provider with a continuing regimen of treatment;

b) pregnancy or prenatal care, including severe morning sickness;

c) a chronic serious health condition that continues over an extended period of time, requires periodic visits to a health care provider (at least two annually), and may involve occasional episodes of incapacity;

d) a permanent or long-term condition for which treatment may not be effective, if the employee is under the supervision of a health care provider (but not necessarily receiving active treatment); or

e) any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

In the absence of extenuating circumstances, the first (or only) visit to a health care provider must occur within seven days of the start of the incapacity, and the second visit must occur within 30 days of the start of the incapacity at the request of the medical provider.

Birth, Adoption or Foster Care of Children

FMLA leave for birth or placement for adoption or foster care must conclude within 12 months of the birth or placement. In addition, spouses employed by the same employer are jointly entitled to a combined leave of 12 workweeks of parental leave in the 12-month period for the birth or placement of a child for adoption or foster care.

Intermittent or Reduced Work Schedule Leave.

In certain circumstances, eligible employees may take FMLA leave intermittently (for example, in blocks of time) or by reducing their work schedule. If FMLA leave is to care for a child after the birth or for placement for adoption or foster care, employees may take their FMLA leave intermittently or on a reduced work schedule only with the Agency's permission. If the FMLA leave is because of the employee's serious illness or to care for a seriously ill family member, the employee may take the leave intermittently or on a reduced work schedule if it is medically necessary.

Military Family Leave

Leave During a Qualifying Exigency.

Eligible employees may take up to a total of 12 weeks of FMLA leave during any 12-month period for "any qualifying exigency" for the spouse, child or parent of a family member who is notified of an impending federal call or order to active duty in the armed forces (including the reserves, National Guard and certain retired military) for reasons related to or affected by the family member's call-up or service. Military leave does not extend to family of members of the regular armed forces on active duty status. This type of leave counts toward the employee's 12 week maximum of FMLA leave in a 12 month period.

Military leave may be taken for one or more of the following qualifying exigencies, as set forth in the FMLA:

1. Short Notice Deployment
2. Military Events and Related Activities
3. Childcare and School Activities
4. Financial and Legal Arrangements
5. Counseling
6. Rest and Recuperation
7. Post-deployment Activities
8. Additional Activities as Agreed Upon by the Employer and Employee

Leave for a qualifying exigency may be taken on an intermittent or reduced leave schedule. The Agency may require certification of the need for leave, which may include a copy of the call or order to active duty upon the employee's first request for such leave.

Military Caregiver Leave.

Eligible employees may take up to 26 weeks of total FMLA leave during a single 12-month period for the employee to care for a spouse, child, parent, or next of kin who is a covered armed forces member undergoing medical treatment, recuperation or therapy, is on out-patient status, or is on the temporary disabled retired list for a serious injury or illness incurred in the line of duty which prevents the service member from performing the duties of the service member's office, grade, rank or rating. Leave is not available to a former member of the military on the permanent disability list. Next of kin is defined as the closest blood relative of the injured or recovering service member.

This is the only type of FMLA leave that may extend an employee's leave entitlement beyond 12 weeks to 26 weeks. The 26 week leave limit includes all types of FMLA taken in the applicable 12 month period. Thus, the total leave taken for any purpose during the single 12-month period may not exceed 26 workweeks overall. The 12-month period in which military caregiver leave may be taken begins on the first day the employee takes leave to care for the covered service member and ends 12 months after that date, regardless of the method used by the employer to determine the 12-month period for any other FMLA-qualifying reason.

Military caregiver leave may be taken on an intermittent or reduced leave schedule if medically necessary. The employer may require the employee to obtain a certification from an authorized health care provider of the covered service member.

Notice and Certification

Employees who want to take FMLA leave ordinarily must provide the Agency at least 30 days' notice of the need for leave, if the need for leave is foreseeable. Foreseeable leave includes expected birth, placement for adoption or foster care, planned medical treatment for a serious health condition of an employee or family member, or planned medical treatment for a serious injury or illness of a covered service member. If the employee's need is not foreseeable, the employee should give as much notice as is practicable.

If the employee is seeking FMLA leave due to a FMLA-qualifying reason for which the Agency already provided FMLA leave, the employee must specifically refer to the qualifying reason for leave or the need for FMLA leave. The employee must provide the Agency with enough information to allow the Agency to determine whether FMLA leave applies.

When leave is needed to care for an immediate family member or for the employee's own illness and is for planned medical treatment, the employee must try to schedule treatment in order to minimize disruptions of the Agency's operations.

In addition, employees who need leave for their own or a family member's serious health condition must provide medical certification from a health care provider. The Agency also may require a second, and if necessary, a third opinion (at the Agency 's expense), periodic recertification's of the serious health condition, and, when the leave is a result of the employee's own serious health condition, a fitness for duty report to return to work.

The Agency may delay or deny leave to employees who do not provide proper advance notice of the need for leave or fails to comply with The Agency's written notice/procedural requirements for leaves. The Agency also may delay or deny approval of leave for lack of proper medical certification.

Benefits During FMLA Leave

Employees taking leave under the FMLA are entitled to receive health benefits during the leave at the same level and terms of coverage as if they had been working throughout the leave. If applicable, arrangements will be made for employees to pay their share of health insurance premiums while on leave. If an employee chooses not to return to work from FMLA leave, The Agency may be entitled to recover premiums it paid to maintain health coverage during the leave.

The employee's use of FMLA leave will not result in the loss of any employment benefit that accrued prior to the start of the employee's leave. However, the employee must use any accrued paid time off or other available paid leave before taking unpaid FMLA leave. Your FMLA leave will run concurrently with the use of any paid time-off benefits.

Job Restoration After FMLA Leave

The Agency will reinstate an employee returning from FMLA leave to the same or equivalent position with equivalent pay, benefits, and other employment terms and conditions. However, an employee on FMLA leave does not have any greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the FMLA leave period.

Unlawful Acts by Employers

The FMLA makes it unlawful for any employer (1) to interfere with, restrain, or deny the exercise of any right provided under the FMLA; or (2) discharge or discriminate against any person for opposing any practice made unlawful by the FMLA or for involvement in any proceeding under or related to the FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement which provides greater family or medical leave rights.

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under the Minneapolis Public Schools Group Health Plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description *or* get a copy of the Plan Document from the Plan Administrator.

The Claims Administrator for each plan subject to COBRA Continuation Coverage is as follows:

Medical Plan:	HealthPartners
Dental Plan:	Delta Dental of Minnesota
Vision Plan:	VSP
Health Care Flexible Spending Account:	HealthPartners

The Plan Administrator is Minneapolis Public Schools. COBRA administrative services are outsourced to TASC. For information about your COBRA continuation rights, contact Human Resources at the address shown on the Welcome page, which is the first page of this booklet.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct
3. If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:
    a. Your spouse dies;
    b. Your spouse's hours of employment are reduced;
    c. Your spouse's employment ends for any reason other than his or her gross misconduct;
    d. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
    e. You become divorced or legally separated from your spouse.
4. Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:
    a. The parent-employee dies;
    b. The parent-employee's hours of employment are reduced;
    c. The parent-employee's employment ends for any reason other than his or her gross misconduct;
    d. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
    e. The parents become divorced or legally separated; or
    f. The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), you will receive notice of your continuation rights within 45 days of the date coverage ends.

You Must Give Notice of Some Qualifying Events

For the 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. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. **You must send this notice to the Human Resources Department at the address shown on the Welcome page, which is the first page of this booklet.**

How is COBRA 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. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months. When the qualifying event is the end of employment or the reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. **You must send this notice to the Human Resources Department at the address shown on the Welcome page, which is the first page of this booklet.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and, dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. You must send this notice to the Human Resources Department at the address shown on the Welcome page, which is the first page of this booklet.**

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact MPS at (605) 444-6319 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

Notice of Privacy Practices

For the Group Health Plans Maintained by Minneapolis Public Schools

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.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA. We have prepared this explanation of how the Plan(s) are required to maintain the privacy of your health information and how the Plan(s) may use and disclose your health information. The Plan(s) may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

> Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include case management.
> Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be adjudicating a claim and reimbursing a provider for an office visit.
> Health care operations means such business-related activities as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review. However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

As permitted or required by law. The Plan(s) may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. The Plan(s) permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. The Plan(s) are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. The Plan(s) will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, the Plan(s) will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. The Plan(s) may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. The Plan(s) may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, the Plan(s) may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. The Plan(s) may disclose protected health information to certain employees of The Printer, Inc. for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

The Plan(s) may also create and distribute de-identified health information by removing all references to individually identifiable information. The Plan(s) may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and the Plan(s) are required to honor and abide by that written request, except to the extent that the Plan(s) have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. The Plan(s) are not, however, required to agree to a requested restriction. If the Plan(s) do agree to a restriction, the Plan(s) must abide by it unless you agree in writing to remove it.
- We will agree to your requested restrictions if: (1) except as otherwise required by law, the disclosure is to a health plan for purposes of payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.
- The right to reasonable requests to receive confidential communications of protected health information from the Plan(s) by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of non-routine disclosures of protected health information.
- If your PHI is maintained in an electronic health record, you are entitled to a copy of the information in an electronic format and you may direct us, in a clear and specific manner, to transmit such copy to a designated entity or person.
- If your PHI is maintained in an electronic health record, the accounting will reflect disclosures for the purposes of treatment, payment and health care operations.
- You have the right to be notified in the event that we (or our business associates) discover a breach involving your PHI that is unsecured.

The Plan(s) have the obligation to provide and you have the right to obtain a paper copy of this notice from the Plan(s) at least every three years. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

The Plan(s) are required to abide by the terms of the Notice of Privacy Practices currently in effect. The Plan(s) reserve the right to change the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that is maintained. The Plan(s) will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office for Civil Rights, about violations of the provisions

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

When key parts of the new health care law took effect in 2014, there was 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 MPS.

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 under the Marketplace begins November 1, 2015 for coverage starting on January 1, 2016.

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 that does not meet certain standards. The savings on your premiums that you are eligible for depends upon 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 means certain standards. If the cost of a plan from your employer that would cover you (and not only any other members of your family) is more than 9.56% 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.

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

If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you will lose the employer contribution 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?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Your employer CANNOT supply any information or guidance in regard to Marketplace benefits. Visit www.healthcare.gov for more information, including an application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Carrier Contact Information

Vendor	Benefit	Telephone Number	Website
HealthPartners	Health Insurance	800-883-2177 866-398-9119 Española	www.healthpartners.com
	Flexible Spending Accounts	(952) 883-5000 800-883-2177	
	CareLine Service (Nurse Line)	800-551-0859	www.healthpartners.com/healthlibrary
Delta Dental of MN	Dental Insurance	(651) 406-5916 800-553-9536	www.deltadentalmn.com
HSA	HSA Bank	800-357-6246	www.hsabank.com
VSP	Vision Insurance	800-877-7195	www.VSP.com
Sun Life Financial	Life Insurance	800-247-6875	www.sunlife.com/us
	Long Term Disability		
Newman	Long Term Care Insurance	(612) 454-4400	www.newmanlongtermcare.com
VALIC	403(b) Savings Plan	800-892-5558	www.valic.com
MNDCP	457 Savings Plan	(612) 964-8094 (612) 247-1980	www.mndcplan.com
MN Public Employee Retirement Association (MNPERA)	Defined Benefit Pension Plans	800-657-5757	www.mnpera.org
Teachers' Retirement Association (TRA)		800-657-3669	www.minnesotatra.org
Minnesota Office of Higher Education	529 College Savings Plan	877-338-4646	www.mnsaves.org
HealthPartners Employee Assistance Program	Employee Assistance Program	866-326-7194	www.hpeap.com
Sun Life Employee Assistance Program		800-460-4374	www.guidanceresources.com
Legal Shield	Legal Assistance & Identity Protection	800-654-7757	www.legalshield.com/info/mpls