

MOORE COLLEGE OF ART & DESIGN

Staff

Open enrollment is your opportunity to learn more about your benefit options for the 2025 plan year. Please keep in mind that this is the only time of year that you can make changes to your benefit election unless you experience a change in family status. Valid family status changes include: marriage, divorce, or legal separation, birth or adoption of a child, death of a dependent, a change in your spouse's employment, or you or your spouse take a leave of absence.

For the plan year beginning 11/01/2025, Moore College of Art & Design will continue to receive medical network services and prescription benefits through Independence Blue Cross.

Annual Election Forms and Flexible Spending/Dependent Care Account Election Form are due no later than Friday, September 19, 2025; otherwise, your enrollment may be delayed.

Open Enrollment (September 08, 2025 through September 19, 2025)

Moore is proud of the comprehensive benefits we offer you and your family. We encourage you to read more about them in this newsletter as well as the additional information within the enrollment packets available for each benefit program.

All full time employees working 30 hours or more per week are eligible for all benefits on the 1st of the month following 30 days of employment.

Medical will be offered through IBC, and Dental, Life and Disability coverage will continue to be offered through Guardian.

Thank you for all of your hard work and commitment to Moore College of Art & Design.

A LOOK AT YOUR BENEFIT CHOICES

IBC Health Plan Options

We will offer two medical plan options. Under both options, you will have access to IBC's extensive network of providers and hospitals.

IBC HBT HMO 20/40

The IBC HBT HMO 20/40 gives you access to IBC's Keystone network of providers. The IBC HBT HMO 20/40 requires you to select a primary care provider (PCP). Coverage is available when your care is provided or referred by your Keystone HMO PCP. Your Keystone HMO PCP may also refer you to other Keystone HMO providers for care, if needed. IBC's Keystone network is a local network that covers the Philadelphia 5-county area. This plan does not offer an out-of-network benefit.

To search for providers in the Keystone HMO network, please access IBC's provider search link at www.ibx.com.

IBC HBT PPO 20/40

The IBC HBT PPO 20/40 gives you access to IBC's Personal Choice network of providers. The IBC HBT PPO 20/40 does not require you to elect a primary care physician. Personal Choice has no referral requirement, and lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. Personal Choice is a national network. This plan also allows you to visit physicians outside the network.

To search for providers in the Personal Choice network, please access IBC's provider search link at www.ibx.com.

Emergency Coverage

You are always covered in the case of an emergency - no matter where you are. Please seek care from the closest emergency room. You do not need to contact IBC first. An emergency room copayment will apply for emergency services. The Emergency Room copay will be waived if you are admitted.

PREScription DRUG COVERAGE

The Prescription Drug benefit will continue to be administered by Independence Blue Cross.

The IBC Prescription plan is a 3-tier Formulary Prescription Plan which consists of a “Preferred” Drug List. The Preferred Drug List is a list that includes a selection of generic and brand name prescription medications. These medications have been approved by the FDA as safe and effective and are considered cost-effective. To see if your medication is on the preferred list, visit www.ibxpress.com.

Maintenance Medications

With IBC, you will have the option of filling your long-term maintenance medications at any in-network pharmacy or through the mail order program. Receiving a long-term fill for your maintenance medications provides you with the benefit of paying 2x the co-pay for a 90 day supply of your medication.

You can contact the IBC customer team at 1-833-444-2583 if you have any questions about the long-term fill options for maintenance medications.

VISION BENEFITS

Both medical plan options include a \$100 vision benefit through VBA. The VBA vision benefit offers routine eye care covered at \$25 co-pay and \$100 of reimbursement toward frames, lenses, and contacts. Benefits are maximized by using VBA vision providers that are located throughout the area.

To search for providers in VBA’s network, please access the provider search link at www.vbaplans.com.

PER PAY (12) MEDICAL/DENTAL CONTRIBUTIONS

11/01/2025-10/31/2026

	<u>IBC HMO 20/40</u>	<u>IBC PPO 20/40</u>	<u>Guardian</u>
Employee	\$149.23	\$249.63	\$0.00
Employee & Spouse	\$1,286.63	\$1,532.63	\$53.68
Parent/Child(ren)	\$816.03	\$1,001.73	\$55.21
Family	\$1,757.33	\$2,063.53	\$108.84

A SUMMARY OF YOUR MEDICAL OPTIONS

The following is a brief summary of each of your medical plan options. Keep in mind that some provisions may change as a result of state legislation review. Some restrictions may also apply. For specific information about the coverage details including limitations, exclusions and other plan requirements, please visit your IBC member portal at www.ibx.com.

	HBT HMO 20/40
Network	Local
Deductible	N/A
Referrals	Yes
PCP Copay	\$20
Specialist Copay	\$40
Inpatient Hospital Copay	\$150 per day, 5 day max
Outpatient Hospital Copay	\$75
PT/OT	\$40, 30 visits per year
Emergency Room	\$150
Urgent Care Copay	\$50
Prescription Copay	\$20/\$40/\$60

	HBT PPO 20/40
Network	National
Deductible	LIMITED DEDUCTIBLE, \$2,000/\$4,000
Referrals	No
PCP Copay	\$20
Specialist Copay	\$40
Inpatient Hospital Copay	After deductible, \$150 per day, 5 day max
Outpatient Hospital Copay	After deductible, \$75
PT/OT	\$40, 30 visits per year
Emergency Room Copay	\$150
Urgent Care Copay	\$50
Durable Medical Equipment	50%, after deductible
Prescription Copay	\$20/\$40/\$60

IBC Find A Provider

In order to locate an IBC provider, you can go to your IBC member portal at www.ibxpress.com. You have the option to find a Provider by name, location or specialty. You must pick Plan Preference in order to locate a provider. Pick either Keystone HMO/POS/Direct POS or Personal Choice PPO.

Enrollment Process

All employees must submit their completed Annual Election Form and Flexible Spending/Dependent Care Account Election Form by Friday, September 19, 2025; otherwise, your enrollment may be delayed.

All forms must be returned to the Human Resources mailbox in the Business office to the attention of Rachel Phillips.

If You Waive Medical Coverage

Moore College believes it is important for all employees to be protected from the high cost of health care. However, you do have the option to waive medical coverage. This option may be a good choice if you have coverage through another plan - such as through your spouse's employer.

If you are enrolled in a spouse's benefit plan, and he/she loses coverage due to a layoff, termination or plan cancellation, you may enroll in the Moore College Benefits Plan within 31 days of the loss of other coverage. In this case you will need to contact Human Resources who will assist you. If you wait longer than 31 days from the loss of other coverage, you will be able to enroll next annual open enrollment period.

GUARDIAN DENTAL PLAN

The Guardian dental plan offers a high level of coverage when you use providers in the Guardian dental care network. The plan also encourages good dental health by paying the full cost of preventive care benefits. In-network and out-of-network, the deductible is waived for preventive care benefits. The chart below shows how expenses are covered under the plan. The per pay cost to participate in the dental plan is included in the cost of the medical benefit. All eligible FT employees working 30 hours or more are eligible to participate on the 1st of month following date of hire.

<u>Plan Feature</u>	<u>In-Network</u>	<u>Out-of-Network</u>
Annual Deductible	\$50 Individual/ \$150 Family	\$50 Individual / \$150 Family
Preventive Care Services	Plan pays 100%	Plan pays 100%
Basic Services	Plan pays 100% after the deductible	Plan pays 80% after the deductible
Major Services	Plan pays 60% after the deductible	Plan pays 50% after the deductible
Orthodontic Services	Plan pays 50% after the deductible	Plan pays 50% after the deductible
UCR Payment Level	Guardian fee schedule	Guardian fee schedule
Annual Dental Maximum	\$1,500	\$1,000
Orthodontia Lifetime Maximum	\$1,000	\$1,000

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE (GUARDIAN LIFE)

Your Life and AD&D insurance provider is Guardian Life, and there are no changes being made to the life program. This will provide your family with additional financial protection should you die while working for Moore College. AD&D insurance is also included, and provides an additional level of protection to your beneficiary or you if you die or are seriously injured in an accident.

Moore College automatically provides both of these valuable coverages to you at no cost. Although there are no enrollment forms to complete, you are encouraged to update your beneficiary designations.

DISABILITY BENEFITS (GUARDIAN LIFE)

If you are unable to work as a result of an illness or injury, Moore College provides you with a measure of financial protection.

LONG-TERM DISABILITY - The LTD plan works in conjunction with the STD plan to provide you with income throughout your entire qualified disability period. If you are still disabled and unable to return to work after 90 days of disability (“elimination period”) the Moore College LTD plan will pay a monthly benefit of 60% of your pre-disability earnings to a maximum monthly benefit of \$7,500.

OTHER EMPLOYEE BENEFITS

Medical Reimbursement Plan - Moore College will continue to provide a Medical Reimbursement plan where you can submit receipts for office visit and RX copays, and other non-covered medical or dental service receipts to HR for reimbursement of up to \$250 per plan year & hospital copays up to \$500 per plan year.

Guardian Life offers an EAP Plan - The Human Management Services Employee Assistance Plan (EAP) is provided at no cost to you. This is a confidential support service designed especially to help you and your family with everyday life issues. This is a company paid benefit.

Flexible Spending Account (FSA) - Used to pay for out of pocket medical, dental and vision expenses with pretax dollars. You may contribute up to \$3,300 per year. For the plan year beginning November 1, 2024 you will have the option of rolling over up to \$660 of unused FSA funds into the next plan year. You may also contribute to a dependent care up to \$5,000 per year.

2025 PLAN NUMBERS & CONTACT INFORMATION

**IBC Premier Customer
Service Team**
1-833-444-BLUE

IBC Home Page
www.ibx.com

IBC Find A Provider
www.ibx.com

Infinisource
FSA Administration
866-370-3040

COBRA Administration
800-594-6957
www.infinisource.net/Employee

Guardian Dental
Plan # 394328
Customer Service Center
888-278-4542
www.guardianlife.com

Guardian Life, AD&D and Disability
Plan # 394328
Customer Service Center
888-278-4542
www.guardianlife.com

Guardian EAP Program
800-386-7055
www.ibhworklife.com

Moore College reserves the right to amend or modify the benefit offerings to employees at any time. This newsletter explains some of the provisions of the benefit plans being offered for the 2025 plan year. This newsletter is intended to provide an overview of the benefit plans; it is not the official plan document. If there are any disputes over plan provisions, the official plan documents will govern.

MOORE COLLEGE OF ART & DESIGN

2025 Legal Notices

HIPAA Special Enrollment Rights

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, 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 Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

New dependent by marriage, birth, adoption, or placement for adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources.

Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Moore College of Art & Design group health plan. Individuals may request enrollment for such children for 31 days from the date of notice. For more information contact Human Resources.

Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve

symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 215-965-4025 for more information.

Patient Protection Notice

For children, you may designate a pediatrician as the primary care provider. In addition, you do not need prior authorization from your insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the insurance carrier directly via their website or Customer Service.

Notice of Lifetime Limits

The lifetime limit on the dollar value of benefits under the Moore College of Art & Design group health plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 31 days from the date of this notice to request enrollment. For more information contact Human Resources.

Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

Moore College of Art & Design's Group Health Plan (the "Plan") is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices (the "Notice") applies to the medical, prescription and coverage offered through the Plan.

Protected health information is individually identifiable health information that the Plan or its business associates maintain or transmit in any form or medium, including verbal conversations and written or electronic information. Individually identifiable health information is information that identifies you, or could reasonably be used to identify you, and that relates to your past, present or future (a) physical or mental health, (b) provision of health care, or (c) payment for such health care.

The Plan's Duties Regarding This Notice

The Plan must give you this Notice to explain the uses and disclosures of your protected health information, to advise you of your rights with respect to your protected health information, and to explain the Plan's legal duties and privacy practices with respect to your protected health information.

The Plan is required to abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and make the new provisions applicable to all protected health information that it maintains. In the event the Plan changes this Notice in a significant manner, the Plan will distribute a revised notice.

The Plan is meeting its obligation by delivering this Notice to you. This Notice is effective April 14, 2004.

How Your Protected Health Information May Be Used or Disclosed For Treatment, Payment, and Health Care Operations

The confidentiality of your protected health information is very important to us. The Plan is able to use or disclose your protected health information for treatment, payment, and health care operations as explained below. Other uses and disclosures of your protected health information are explained in later sections of this Notice.

Treatment

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers. For example, the Plan may disclose, for treatment purposes, protected health information to a health care provider such as a physician, pharmacist, or dentist involved in your care.

Payment

The Plan may use or disclose your protected health information for purposes relating to payment. Payment includes activities such as:

- Determining eligibility for coverage,
- Obtaining premium payments for the coverage,
- Performing utilization review of services (including pre-certification or preauthorization),
- Coordinating benefits with other health plans,
- Applying for reimbursement under a reinsurance contract,
- Reviewing your claim for health care services, and
- Making a determination as to whether the claim is a covered benefit and is payable by the Plan.

For example, you or your health care provider may submit your claim to the Plan for payment. This claim will contain information that identifies you, and may include the date the service took place, the diagnosis, the treatment provided, and the charges. The Plan uses this information to evaluate the medical necessity of the treatment and to determine its payment obligation under the terms of the Plan.

Also, if you are covered by another health plan, such as through your spouse's employer, the Plan may disclose your claim information to the other plan to determine which plan has primary payment responsibility and to coordinate any benefits due.

Health Care Operations

The Plan may use or disclose protected health information for the management and oversight of its health care operations. Health care operations include many activities such as:

- Activities that relate to quality and accreditation (including quality assessment and improvement, assessment of outcomes, accreditation by independent organizations, and review of qualifications of health care professionals);
- Cost, underwriting, and contract placements (including determining the current and projected costs of the Plan, cost-management reviews, obtaining premium quotes, and activities relating to the creation, renewal, or replacement of a health insurance contract or reinsurance contract);
- Medical review and care coordination (including contacting Plan members or health care professionals with information about treatment, review (such as for claim appeals), case management, and other care coordination); and
- Legal oversight (including legal services provided to the Plan, auditing, and fraud and abuse detection).

The Plan may use your protected health information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

An example of medical review is the Plan's formal process to respond to claim appeals. Upon appeal, your relevant protected health information such as the treatment provided and your diagnosis will be gathered and reviewed by persons (including, if appropriate, a health care professional) other than the person who made the initial decision. If necessary, the Plan may also contact your health care provider for additional information regarding your appealed claim.

Other Information

The Plan will take reasonable steps and apply safeguards to limit the permitted or required uses and disclosures of your protected health information to the minimum amount necessary to accomplish the task. With these protections in place, a use or disclosure that is incidental to a permitted or required use or disclosure is allowed.

If a state law has more privacy protections than the federal law, called the Health Insurance Portability and Accountability Act (HIPAA), that governs privacy, then the Plan will abide by the state law in those instances. State laws may permit minors to obtain certain medical care without a parent's permission or knowledge and the Plan will follow those state laws as applicable.

The descriptions listed above do not include every possible use or disclosure that is permitted or required by law. The descriptions given are only intended to provide you with information about the various ways that the Plan may use or disclose your protected health information and to give you some examples.

Other Permitted or Required Uses and Disclosures

Other than treatment, payment, and health care operations, the Plan is permitted or required by law to use or disclose your protected health information in other ways described below.

To You or Certain Other Individuals

Your own protected health information may be disclosed to you or to your personal representative who is an individual, under applicable law, authorized to make health care decisions on your behalf. For example, a parent is generally the personal representative of a minor child.

The Plan may disclose your protected health information to a family member, other relative, close personal friend or other person identified by you. The protected health information that is disclosed must be directly relevant to the family member or other person's involvement with your health care or payment for your health care. The requirements are that you must be present or available prior to the use or disclosure and (a) agree, (b) have the opportunity to object, or (c) the Plan may determine, based on the circumstances and its professional judgment, to make the disclosure.

Unless you object, the Plan may confirm eligibility status (coverage under the Plan) and claim status information (limited to confirmation that the claim was received and paid or not paid) to a family member who calls with knowledge of the claim. You may specifically request that the Plan not disclose this eligibility status and claim status information by contacting the Privacy Officer.

If you are not present or are incapacitated, the Plan may use its professional judgment to determine whether the disclosure of protected health information is in your best interests. If the Plan makes this determination, it may disclose only your protected health information that is directly relevant to the individual's involvement with your health care.

The Plan may, in certain situations, use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person involved in your care of your location or condition.

To Business Associates

The Plan works with different organizations that perform a variety of services on its behalf. These organizations, or Business Associates, perform specific functions and services for the Plan. Examples of functions include claim processing, utilization review, plan administration, and data analysis. Services include consulting, legal, financial, and management activities.

The Plan may disclose protected health information to its Business Associates for the permitted functions or services, but only if the Plan receives assurances through a written contract or agreement that the Business Associate will properly safeguard the information.

To the Plan Sponsor

Protected health information may be disclosed to the plan sponsor for plan administrative functions. Before doing so, the terms of the Plan must establish, in accordance with the privacy regulations, the permitted and required uses or disclosures of the information and protections for the information.

Summary Health Information used for certain purposes and information about who is participating in the Plan may be disclosed to the plan sponsor without any special Plan provisions. Summary Health Information is claims information from which individual identifiers have been removed, except for the five-digit zip code.

In A Limited Data Set

A limited data set contains protected health information from which direct identifiers such as name and social security number have been removed, but indirect identifiers such as date of service have been kept. Information in a limited data set may be used or disclosed for research, public health, or health care operations. The information may be disclosed only if the Plan has entered into an agreement with the recipient that establishes its permitted uses or disclosures.

As Required by Law and for Public Benefit

Protected health information may be:

- Used or disclosed as required by law and in compliance with the requirements of the law, including disclosures to the Secretary of Health and Human Services for the purpose of determining compliance with the privacy standards;
- Disclosed to an authorized public health authority for specified reasons such as to prevent or control disease, injury, or disability; to report child abuse or neglect; to report the safety or effectiveness of FDA-related products such as medication; and to notify a person at risk of contracting or spreading a communicable disease;
- Disclosed to an authorized government authority if the disclosure is about victims of abuse, neglect, or domestic violence;
- Disclosed to authorized health oversight agencies for activities such as audits, investigations, inspections, and licensure requirements necessary for oversight of the health care system and various government benefit programs;
- Disclosed for judicial and administrative proceedings such as responses to court orders and court ordered warrants, to subpoenas issued, to discovery requests, or other lawful processes;
- Disclosed to a law enforcement official for a law enforcement purpose;
- Disclosed to coroners or medical examiners for purposes of identifying a deceased individual and to funeral directors to carry out their duties;
- Used or disclosed to an organ and tissue procuring or transplanting organization to facilitate donation and transplantation;
- Used or disclosed for research purposes if certain requirements are met such as approval by an Institutional Review Board or a Privacy Board;
- Used or disclosed as necessary to prevent or lessen a serious or imminent threat to the health and safety of a person or the public;
- Disclosed to comply with workers' compensation or other similar laws; and
- Disclosed to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

For Specialized Government Functions

Protected health information may be disclosed to federal officials for national security reasons. Protected health information may be used or disclosed to military authorities about Armed Forces personnel for certain purposes. The Plan may release protected health information to a correctional institution for provision of health care to the individual or for the health and safety of the individual or others.

Other Uses and Disclosures Only in Accordance with Your Authorization

Other than the uses or disclosures of your protected health information that are permitted or required by law, the Plan may not use or disclose your protected health information unless you authorize the Plan to do so by completing a written authorization. You may revoke your authorization at any time to stop future uses or disclosures; however, the revocation will not apply to the extent that the Plan has already made uses or disclosures in reliance on your authorization. Your revocation will also not be effective to the extent that the authorization was given as a condition of obtaining insurance coverage if another law gives the insurer the right to contest a claim under the policy or the right to contest the policy itself.

Your Individual Rights Regarding Your Protected Health Information

You have certain rights with respect to your protected health information, as described in detail below. You may exercise your rights by submitting a written request that specifies the right(s) you wish to exercise. Requests should be sent to the Contact Person for the Plan; contact information is provided at the end of this Notice.

Right to Request Restrictions

You have the right to request restrictions on certain uses or disclosures of your protected health information for the purposes of treatment, payment, or health care operations. The Plan is not required to agree to any restriction that you request. You will be notified if your request is accepted or denied.

Right to Receive Confidential Communications

You have the right to request receipt of confidential communications of your protected health information from the Plan by reasonable alternative means or at an alternative location. The Plan is not required to honor your request unless you state that the disclosure of all or part of the information could endanger you.

Right to Inspect and Copy

You have the right to inspect and copy your protected health information that is contained in a "designated record set", that is, enrollment, payment, claims determination, case or medical management records, or records that are used to make decisions about you and that are maintained by the Plan. The Plan may charge you for the reasonable costs associated with your request. There are some exceptions to your right to inspect and copy, such as:

- Psychotherapy notes,
- Information compiled in anticipation of a civil, criminal, or administrative action or proceeding, and
- Situations in which a licensed health care professional determines that releasing the information may have a harmful effect on you or another individual.

Right to Request an Amendment

If you believe that protected health information about you that is contained in a "designated record set" is inaccurate or incomplete, you have the right to request that it be amended. Your request must be in writing and you must provide a reason to support your request.

The Plan may deny your request for an amendment if your request is not in writing or if you do not provide a reason for your request. Your request will also be denied if the Plan determines that:

- The information was not created by the Plan (unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on your request),
- The information is not part of the "designated record set", • Access to the information is restricted by law, or
- The information is accurate and complete.

If your request is denied, you will receive written notification of the denial explaining the basis for the denial and a description of your rights.

Right to an Accounting of Disclosures

You have the right to receive a listing of, or an accounting of, disclosures of your protected health information made by the Plan. Certain disclosures do not have to be included in this accounting, including the following:

- Those made for treatment, payment, or health care operations,
- Those made pursuant to your written authorization,
- Those made to you,
- Those that are incidental to otherwise permitted or required disclosures,
- Those made as part of a limited data set,
- Disclosures to individuals involved in your care, and
- Disclosures for certain security or intelligence reasons and to certain law enforcement officials.

If you request an accounting of disclosures of your protected health information, you will need to specify the dates you want the accounting to cover. The accounting period can not exceed six years prior to the date of the request and it can not cover a period prior to April 14, 2004. You are entitled to one free accounting in any 12-month period. The Plan may charge for any additional accountings you request within the same 12-month period. The Plan will notify you in advance of any charges.

Right to Receive a Paper Copy

Even if you have agreed to receive this Notice electronically, you have the right to request and receive a paper copy of this Notice from the Plan.

Complaints

If you are concerned that your privacy rights have been violated, you may submit a complaint to the Plan by contacting the Contact Person for the Plan. The complaint must be in writing and provide a description of why you think your privacy rights were violated. No retaliatory actions will be taken against you for filing a complaint.

You may also file a complaint with the Secretary of Health and Human Services at:

Office for Civil Rights

U.S. Department of Health and Human Services

801 Market Street, Suite 9300

Philadelphia, PA 19107-3134

Customer Response Center: (800) 368-1019

Fax: (202) 619-3818

TDD: (800) 537-7697

Email: ocrmail@hhs.gov

Contact Information

Please contact the Contact Person for the Plan in order to:

- Obtain a paper copy or another copy of this Notice;
- Ask questions about this Notice or the Plan's practices regarding protected health information,
- File a complaint,
- Request that disclosure of eligibility status or claim status not be provided to a family member,
- Obtain an Authorization form, or
- Make a request for individual rights as described above.

The phone number is: (215) 965-4025

The address is:

Rachel Phillips

HIPAA Compliance Officer, Benefits Administrator

Moore College of Art & Design
20th Street & The Parkway
Philadelphia, PA 19103