**MCPHERSON COLLEGE**

**FLEXIBLE BENEFITS**

**SUMMARY PLAN DESCRIPTION**

**JANUARY 1, 2019**

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**MCPHERSON COLLEGE**

**MCPHERSON COLLEGE FLEXIBLE BENEFITS PLAN SUMMARY PLAN DESCRIPTION**

**1.** **INTRODUCTION**

This Summary Plan Description is designed to explain some of the more important terms and provisions of the employee benefit coverages available under the McPherson College Flexible Benefits Plan (the "Plan") and the operation of certain pre-tax elections under the Plan Sponsor's Code Section 125 cafeteria plan (the "Cafeteria Plan"). This is only a summary of the Plan and the Cafeteria Plan and the benefits available under the Plan and the Cafeteria Plan. It may omit details which may be of importance to you in a given situation. If there is any conflict between the Summary Plan Description and the formal plan documents, the terms and conditions of the plan documents will control. The Plan Administrator has full power to administer the coverage described herein, including without limitation, the power to make discretionary interpretations regarding the terms and provisions of any plan and to make factual findings with respect to any issue arising under any plan, its interpretation to be final and conclusive on all persons.

**1.1** **Benefit Descriptions.** This document should be attached to the benefit summaries, certificates of coverage, benefit description booklets, summary plan descriptions, and other similar descriptions (hereinafter "Benefit Descriptions") that have been provided to you to describe the various benefits available under the Plan. If you have lost or misplaced one or more of your Benefit Descriptions, a replacement will be furnished without cost to you upon request to the Plan Administrator. This document, along with such Benefit Descriptions for each of the coverages available under the Plan, constitutes the Summary Plan Description for the Plan. If there is any conflict between the terms of the Benefit Descriptions and this document, the terms of this document will control. Also, see Benefits Descriptions on pg. 18.

If you have any questions or wish to see the formal Plan documents, please contact the Plan

Administrator.

**1.2** **Notice Under Newborns’ and Mothers’ Health Protection Act of 1996.** Group health plans and health insurance issuers offering group insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

**1.3** **Notice Under Women’s Health and Cancer Rights Act of 1998.** Federal law provides that group health plans and health insurance issuers providing health insurance coverage in connection with group health plans must provide certain medical and surgical benefits with respect to a mastectomy. If you are a participant in the plan, or a beneficiary of the plan, and you receive benefits in connection with a mastectomy and you elect breast reconstruction in connection with that mastectomy, the plan must provide coverage for: reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and, physical complications of all stages of mastectomy including lymphedemas. The above coverage is subject to any deductibles and co-insurance provisions contained within the plan.

**1.4** **No Right to Employment.** No plan maintained by McPherson College, Inc. or any affiliate is intended to create any contractual right of employment, and nothing contained therein or in this summary plan description shall be construed as a guarantee of employment for any specific period of time or for any specific type of work.

**1.5** **Reservation of Rights.** McPherson College, Inc. reserves all rights to make changes at any time in the benefits, costs, and other provisions relative to any benefit plan, including, but not limited to, retiree medical provisions (if any). Those changes could include the complete termination of benefits for all individuals or certain groups of individuals. No employee, spouse, or dependent will acquire any vested (non-forfeitable) right to have benefits or other provisions of the plan remain unmodified or in effect. In addition, your employer reserves all rights to make changes at any time in the costs or contributions relative to any benefit plan or option, notwithstanding any actual or alleged agreement, document, or other communication to the contrary.

**1.6 How the plan is funded.** The plan is funded through both employee and employer contributions.

**1.7 Procedures for allocating and designating administrative duties to a TPA or committee.** The plan sponsor, the HR director, or the CFO, will allocate and designate administrative duties to any TPA of the health and welfare plans.

**2**. **PLAN ADMINISTRATION**

**2.1 Name of Plan and Plan Number.**

McPherson College Flexible Benefits Plan- Plan Number 501

**2.2 Name and Address of Plan Sponsor.**

McPherson College, Inc.

1600 E. Euclid, PO Box 1402

McPherson, Kansas 67460

A complete list of other employers sponsoring the plan (if any) may be obtained by participants and beneficiaries upon written request to the Plan Administrator.

**2.3 Employer Identification Number**

48-0543736

**2.4** **Plan Administrator.**

McPherson College, Inc.

1600 E. Euclid, PO Box 1402

McPherson, Kansas 67460

 (800) 365-7402

**2.5** **Plan Administration.** The Plan is administered by McPherson College, Inc., which is the "plan administrator" for the Plan. The following organizations also provide administrative services to the Plan, including review and payment of claims:

Insurance and Administrative Services

Blue Cross Blue Shield of Kansas (Health Insurance)

1133 SW Topeka Blvd. Topeka, KS 66629-0001

800-432-3990

Blue Cross Blue Shield of Kansas (Dental Insurance)

1133 SW Topeka Blvd. Topeka, KS 66629-0001

800-432-3990

 OneAmerica® Companies

 P.O. Box 368

 Indianapolis, IN 46206

 Office: 800-553-5318

 Fax: 888-285-1565

 Claims:

 Life: 800-553-3522

 Disability: 866.258.8744

 AFLAC

 Accident, Critical Illness, Hospital Indemnity

 Benefits Advisor representing AFLAC since 2012
 **Cell: 316-554-4990** | Fax: 316-462-0667

 *7920 W Kellogg #103 - Wichita, KS 67209*

 saida\_sosa@us.aflac.com | [www.aflac.com](https://urldefense.proofpoint.com/v2/url?u=http-3A__www.aflac.com&d=DwMFaQ&c=9x2CBciYENyP4Yz0z8xbkw&r=Y7gMEx41n65pG_tcAU013AFNjUNougaRMqvpG-24wCQ&m=lGfQGByjeOgQ0OranceXglKtajMVgfUcoj-F9Gh-fr0&s=qkvAV1Q5Vqcy-A_xnKqgz7BdGGMN_qF5wCc8ytqHmj8&e=)

 InfoArmor Employee Protection Solutions

 7001 N. Scottsdale Road, Suite 2020

 Scottsdale, AZ 85253

 480-302-6711

 Surency Vision

 1619 N. Waterfront Parkway

 P.O. Box 789773

 Wichita, KS 67278-9773

 888-316-5986

**Administrative Services** **Only**

Maestro Health (Health and Dependent Care FSA, H.S.A., COBRA)

 Maestro Health

 P.O. Box 2370

 Matthews, NC 28106

 888-488-5054

 questions@maestrohealth.com

 msave.maestrohealth.com

**2.6** **COBRA Administration.** The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") enable employees to continue group health plan coverage for certain periods of time. In order to preserve certain important rights under COBRA and/or USERRA, you may be required to provide certain notices to the Plan Administrator or COBRA Administrator(s) within specified times as provided by applicable law and Plan rules. (See the "Continuation Coverage" section of this Summary Plan Description). Unless you are notified otherwise, the Plan Administrator is the COBRA Administrator with respect to group health coverages available under the Plan, and all notices or information regarding COBRA coverage required to be given to the Plan Administrator or COBRA Administrator must be given to the Plan Administrator.

**2.7** **Agent for Service of Legal Process.**

McPherson College

Attn: Casey Law

Wise and Reber, LC

120 W Kansas Ave

McPherson, KS 67460

Service of legal process may also be made upon the Plan Administrator.

**2.8** **Plan Year**. The Plan operates on a 12-month period commencing January 1. In general, accounting is done as of the last day of the plan year.

**2.9** A complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries.

**3.** **ELIGIBILITY AND ENROLLMENT**

**3.1** **Eligibility**. Generally, for the purpose of voluntary benefits, employees working at least half-time (1040 hours annually) in a benefits-eligible position are eligible for benefits in most circumstances. The long term disability benefit is provided for eligible employees working at least three quarter time (1560 hours annually) and an eligible employee who works at least half-time (1080 hours) is eligible for the $10,000 group term life insurance policy and who agree and elect in the manner established by the Plan Administrator to reduce their compensation for the purposes of payment of their share of the costs of coverages elected under the Plan, and who satisfy all other conditions established by the Plan and the Benefit Descriptions are eligible to participate in the selected coverages under the Plan, so long as they enroll within the time limitations established by the Plan Administrator.

**3.2** **Continuing Eligibility.** Generally, participation in selected coverages under the Plan will continue until the earliest of: (i) the date such coverages are no longer offered under the Plan; (ii) the date on which the Plan terminates; or (iii) the date coverage terminates under the Plan and/or the Benefit Descriptions.

If a participant is on an approved leave of absence, coverage may be continued for the period (if any) set forth in the Benefit Description(s). To continue coverage, participants must continue to pay their share of any required contribution for such coverage.

**3.3** **Eligibility When Re-Employed**. If you quit working after becoming eligible to participate and return to work during the same plan year, special rules may apply to your pre-tax elections made under the Cafeteria Plan. In some cases you may not be allowed to make a new election and will be required to continue your election in place at the time you left employment, subject to recognized changes in status occurring during your absence.

**3.4** **Eligibility for Children of Employees.** Children of employees are allowed to stay on their parent’s health insurance plans until they turn 26 years old.

**3.5** **Qualified Medical Support Orders** A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health coverage to the children of a parent-employee who is divorced, separated, or never married when ordered to do so by state authorities. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

**3.6 Mental Health Parity**. Mental health issues will not be discriminated against and will be treated with the same care as physical health issues.

**3.7 Enrollment Procedures.** When you become eligible to participate in one or more available coverages under the Plan, you may request that the Plan Administrator provide you with enrollment information. A new participant who fails to make an election for any available coverages on or before the last day of the enrollment period will be deemed to have elected not to participate in such coverages under the Plan. The following rules also apply:

(a) There may be an annual re-enrollment of all eligible employees during the enrollment period established by the Plan Administrator. During the open-enrollment period, you will have the opportunity to decide to what extent you want to participate in available coverages under the Plan for the upcoming plan year. The election you make during this time period will be effective for the next plan year.

(b) An employee who has previously elected to participate in any available coverages under the Plan but fails to return a new enrollment form for any subsequent plan year will be deemed to have elected not to participate in such coverage(s) for the subsequent plan year.

**3.8** **Irrevocability of Election.** Any election you make under the Cafeteria Plan cannot be changed by you during the plan year unless such change is permitted under the Cafeteria Plan. Any revocation or change of election made by you must be made in writing and must be proximate in time to the occurrence of the circumstances giving rise to the revocation or change. Any new election generally will be prospectively effective as of the first day of the month following receipt of timely notice.

**3.9** **Certain Changes in Elections.** Notwithstanding the general rule that elections under the Cafeteria Plan are irrevocable, changes under the Cafeteria Plan generally are permitted in accordance with the following but are not included to:

(a) You may be allowed to revoke your election and make a new election if you have a change in status and your election change is consistent with your change in status. Permissible status changes include the following:

(1) Events that change your legal marital status including marriage, death of a spouse, divorce, legal separation, or annulment.

(2) Events that change the number of your dependents including birth, death, adoption, or placement for adoption.

(3) Any of the following events that change your employment status or that of your spouse or dependent: termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, a change in worksite or a change in employment status with the consequence that the individual becomes or ceases to be eligible to participate in a cafeteria plan or other employee plan benefit of such person.

(4) Events that cause your dependent to satisfy or cease to satisfy the requirements for coverage including attainment of a specified age, changes in student status, or other similar circumstance.

(5) A change in the place of residence or worksite of you or your spouse or dependent.

(6) Any other change or revocation which the Plan Administrator determines will allow a change or revocation of an election during the plan year under the regulations or rulings of the Internal Revenue Service.

(b) In addition to the foregoing status changes, the following changes will also be allowed:

(1) In the case of a plan subject to the Health Insurance Portability and Accountability Act of 1996 you may be allowed to revoke an election for coverage under a group health insurance plan during a period of coverage and make a new election that corresponds with the special enrollment rights provided in Code Section 980l(f).

(2) A conforming election under a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health insurance coverage for your child or for a foster child who is your dependent (the foregoing includes an election to provide coverage for the child if the order requires coverage for the child under your plan and cancellation of coverage for the child if the order requires the spouse or -former spouse or other individual to provide coverage for the child and that coverage is in fact provided).

(3) If you or your spouse or dependent is enrolled in an accident or health plan of the employer and become enrolled under Medicare Part A or Part B of Title XVIII of the Social Security Act or Title XIX of the Social Security Act (other than coverage consisting solely of benefits described in Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines)) you may make a prospective election to cancel or reduce coverage for that individual.

(4) If you or your spouse or dependent loses coverage under Medicare or Medicaid, a prospective election may be made to commence or increase coverage of that individual.

(c) You may also be allowed to revoke a benefit election agreement for the balance of a plan year and make a new prospective election change if both the revocation and new election change is on account of and corresponds to an election change made under another employer's plan if (I) the other cafeteria plan or qualified benefit plan permits participants to make an election change under applicable IRS rules, or (ii) the plan year of this plan is different from the period of coverage under the other cafeteria plan or other qualified benefits plan.

(d) Also, if the cost of qualified benefits significantly increase or decrease during the plan year, the Plan Administrator may allow you to make a corresponding change in your election. Further, if you or your spouse or dependent experience a significant curtailment of coverage, the Plan Administrator may allow you to make certain prospective changes in your election.

**Caution: Your ability to obtain or otherwise modify coverages under some of the above rules may be limited by the rules and requirements of the applicable plan and/or any insurance carrier or HMO providing underwriting and/or benefits under such plan. You should refer to such rules and requirements prior to choosing to eliminate or otherwise modify any coverage for yourself and/or an affected spouse or dependent.**

(e) To insure that special nondiscrimination rules governing the Cafeteria Plan are satisfied, the Plan Administrator may take whatever action is necessary to assure compliance with these rules. This action may include modifying or reducing your salary reduction election.

**4. CONTINUATION COVERAGE**

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") enables employees that experience a "qualifying event" to continue group health plan coverage for 18, 29, or 36 months depending upon the nature of the "qualifying event."

COBRA continuation coverage can become available to you and to other members of your family who are covered under a group health plan when you or your covered family members would otherwise lose your group health coverage. This section of your Summary Plan Description explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enro11ees.

**Description of COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of group health insurance coverage when coverage would otherwise end because of an event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under a group health 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. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**Qualifying Events**

If you are an employee, you will become a qualified beneficiary if you lose group health plan coverage because either one of the following qualifying events happens:

(a) Your hours of employment are reduced, or

(b) Your employment ends for any reason other than your gross misconduct.

If you are a spouse of an employee, you will become a qualified beneficiary if you lose group health plan coverage 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 (under Part A, Part B, or both); or

(e) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose group health plan coverage 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 (under Patti 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer and that bankruptcy results in the loss of coverage of any retired employee covered under a group health plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under a group health plan.

**When COBRA Continuation is Available**

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrator has been timely 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, commencement of a proceeding in bankruptcy with respect to *type* Employer, or the employee's becoming enrolled in Medicare (under Part A, Part B, or both), the Employer must notify the Administrator of the qualifying event within 30 days of any of these events.

**A Qualified Beneficiary 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), a qualified beneficiary must provide written notice of the qualifying event to the Administrator within 60 days after the qualifying event occurs (or, if later, the date coverage is lost as a result of the qualifying event), using the group health plan's notice procedures. If written notice of the qualifying event is not provided to the Administrator within this 60- day period, a spouse or dependent child that would otherwise lose group health plan coverage will not be given the opportunity to continue coverage.

**How COBRA Continuation Coverage is provided**

Once the Administrator receives a timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to the qualified beneficiaries who are recognized by the group health plan as being entitled to elect COBRA continuation coverage with respect to the qualifying event. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

A qualified beneficiary must elect COBRA continuation coverage within 60 days after the date notice of the right to elect COBRA continuation coverage is provided to the qualified beneficiary. If a qualified beneficiary does not elect continuation coverage within the 60-day election period, the qualified beneficiary will lose his or her right to elect continuation coverage.

The Trade Act of 2002 created a second 60-day election period for certain individuals that become eligible for trade adjustment assistance pursuant to the Trade Act of 1974 ("TAA-eligible individuals"). In general, if a TAA-eligible individual loses health benefits coverage as a result of becoming a TAA­ eligible individual (a "TAA-related loss of coverage") but does not elect COBRA continuation coverage within the general 60-day COBRA election period, the TAA-eligible individual may elect COBRA continuation coverage during the 60-day period beginning on the first day of the month in which he or she is determined to be a TAA-eligible individual, so long as the election is made no later than 6 months after the date of the TAA-related loss of coverage. More information about the Trade Act of 2002 is available at [www.doleta.gov/tradeact/2002act\_index.asp.](http://www.doleta.gov/tradeact/2002act_index.asp)

**Length of COBRA Continuation Coverage**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming enrolled in Medicare (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child under the group health plan, COBRA continuation coverage may last for up to a total of 36 months after the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment and the employee became enrolled in Medicare less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee may last for up to 36 months after the date of enrollment in Medicare. For example, if a covered employee becomes enrolled in 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 enrollment, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months after the date of the qualifying event. 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 any qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and a qualified beneficiary provides timely written notice of the disability to the COBRA Administrator, all qualified beneficiaries receiving COBRA continuation coverage with respect to the same covered employee may be entitled to get up to 11 additional months of COBRA continuation coverage, for a total maximum of up to 29 months after the date of the qualifying event. The SSA's determination of disability must occur either before or during the first 60 days after the date of the qualifying event, and the disability must last at least until the end of the first 18 months after the date of the qualifying event. In general, a qualified beneficiary giving notice of a disability must provide written notice of the SSA’s determination to the COBRA Administrator within 60 days after the latest of (i) the date of the SSA’s determination, (ii) the date of the qualifying event, or (iii) the date the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event. In all events, a qualified beneficiary must give notice of a disability before the end of the first 18 months after the date of the qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Each qualified beneficiary who has elected continuation coverage with respect to the same covered employee will be entitled to the 11-month disability extension if one of them qualifies. If the disabled qualified beneficiary is determined by the SSA to no longer be disabled, written notice of that fact must be given within 30 days after the SSA's determination using the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. Continuation coverage will cease for all qualified beneficiaries on the first day of the month that is 30 days after the date the SSA determines that the qualified beneficiary is no longer disabled. If timely written notice is not given that the qualified beneficiary is no longer disabled, coverage for all qualified beneficiaries may be retroactively cancelled and restitution to the group health plan may be required.

*Second Qualifying Event Extension of 18-Month Period of Continuation Coverage*

If, while receiving 18 months of COBRA continuation converge, a qualified beneficiary experiences another qualifying event that would have caused the qualified beneficiary to lose group health plan coverage if the first qualifying event had not occurred, the qualified beneficiary may get up to 18 additional months of COBRA continuation coverage, for a maximum of up to 36 months, if timely written notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the spouse and any dependent children getting COBRA if the employee or former employee dies, becomes enrolled in Medicare (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the group health plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the group health plan had the first qualifying event not occurred. In all of these cases, timely written notice of the second qualifying event must be given within 60 days after the date of the second qualifying event. The qualified beneficiary must follow the notice procedures specified below (see "Notice Procedures"). Notice must be given to the COBRA Administrator. If the notice procedures are not followed or timely written notice is not provided, there will be no extension of COBRA continuation coverage.

Notwithstanding the foregoing provisions, COBRA continuation coverage will not be made available to any qualified beneficiary under a plan constituting a health care spending account plan for any plan year after the end of the plan year in which a qualifying event occurs if the following conditions are satisfied: (i) the plan is a health care spending account plan and excepted from compliance under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and (ii) the annual premium payment for COBRA continuation coverage equals or exceeds the maximum benefit available under the plan for the plan year.

**Notice Procedures**

Any notice you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must deliver your written notice to the Administrator or COBRA Administrator, as applicable, at the addresses listed at the beginning of this Summary Plan Description. If you mail your notice, it must be postmarked not later than the last day of the required notice period.

(a) The name of the group health plan.

(b) The name and address of the employee covered under the group health plan.

(c) The name(s) and address(es) of the qualified beneficiary(ies).

(d) If the notice is a notice of a qualifying event or second qualifying event, the name of the qualifying event and the date it happened.

If the qualifying event is divorce or legal separation, the notice also must include a copy of the divorce decree or decree of legal separation. A notice of disability also must include the name of the disabled qualified beneficiary and a copy of the SSA’s determination. If a qualified beneficiary is determined by the SSA to no longer be disabled, the notice of such determination also should include a copy of the SSA's determination.

Notice of a qualifying event or disability determination must be given using the group health plan's form. A copy of the necessary form may be obtained without charge by contacting the Administrator or COBRA Administrator.

**Electing Continuation Coverage**

To elect continuation coverage, you must complete the group health plan's election form and furnish it according to the directions of the form and the notice procedures specified above (see "Notice Procedures"). A copy of the required election form may be obtained from the Administrator or COBRA Administrator at no charge. Failure to make a timely written election will result in loss of the right to elect continuation coverage under the group health plan.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A covered employee or a qualified beneficiary that is (or was) the spouse of the covered employee may elect COBRA continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event. In addition, a parent or legal guardian may elect COBRA continuation coverage on behalf of a minor child.

In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Additional information about whether to elect COBRA continuation coverage is available in Notice 98-

12, which was prepared by the Internal Revenue Service and the Department of Labor and is available on the internet at [www.dol.gov/ebsa.](http://www.dol.gov/ebsa) You also may contact the Administrator to obtain a copy of Notice 98-

12.

**Cost of Continuation Coverage**

Generally, each qualified beneficiary is required to pay the entire cost of continuation coverage. The

amount a qualified beneficiary will be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. You should contact the Administrator or COBRA Administrator for the required payment for continuation coverage.

Other coverage options may cost less. For example, you may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

**Health Information Portability and Accountability Act of 1996**

Covered entities under HIPAA are health care clearinghouses, certain health care providers, and health plans. A "group health plan" is one type of health plan and is a covered entity (except for self-administered plans with fewer than 50 participants). The group health plan is considered to be a separate legal entity from the employer or other parties that sponsor the group health plan. Neither employers nor other group health plan sponsors are defined as covered entities under HIPAA.

Thus, the Privacy Rule does not directly regulate employers or other plan sponsors that are not HIPAA covered entities. However, the Privacy Rule does control the conditions under which the group health plan can share protected health information with the employer or plan sponsor when the information is necessary for the plan sponsor to perform certain administrative functions on behalf of the group health plan. See [45 CFR 164.504(f)](https://www.gpo.gov/fdsys/pkg/CFR-2003-title45-vol1/xml/CFR-2003-title45-vol1-sec164-504.xml). Among these conditions is receipt of a certification from the employer or plan sponsor that the health information will be protected as prescribed by the rule and will not be used for employment-related actions.

The covered group health plan must comply with Privacy Rule requirements, though these requirements will be limited when the group health plan is fully insured.

**What is the Health Insurance Marketplace?**

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at [www.healthcare.gov.](http://www.healthcare.gov/)

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

**When can I enroll in Marketplace coverage?**

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.healthcare.gov.](http://www.healthcare.gov/)

**If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace or vice versa?**

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful. If you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to

COBRA continuation coverage under any circumstances.

**Can I enroll in another group health plan?**

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

 **What factors should I consider when choosing coverage options?**

When considering your options for health coverage, you may want to think about:

(a) **Premiums.** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.

(b) **Provider Networks.** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

(c) **Drug Formularies**. If you're currently taking medication, a change in your health coverage may affect your costs for medication - and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

(d) **Severance Payments.** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time.

(e) **Service Areas.** Some plans limit their benefits to specific service or coverage areas - so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

(f) **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

 **Payment for Continuation Coverage**

If you elect continuation coverage, you do not have to send any payment with the election form, but you will not be covered under the group health plan until you make timely payment. You must make your first payment for continuation coverage not later than 45 days after the date of your election. (The date of your election is the date the election form is postmarked, if mailed.) If you do not make your first payment for continuation coverage in full within this 45-day period, you will lose all COBRA continuation coverage rights under the group health plan.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent month of coverage. Although periodic payments are due on the applicable due date, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If you do not make your payment on the applicable due date, however, the group health plan may elect to suspend your coverage until payment is made, with coverage reinstated retroactively if payment is made within the grace period. If your coverage is suspended, any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to COBRA continuation coverage under the group health plan.

You are responsible for making sure your payment amounts are correct. You may contact the Administrator or COBRA Administrator to confirm the correct amount of your payments. Your payments for continuation coverage must be sent to the COBRA Administrator listed at the beginning of this Summary Plan Description.

**Conversion Rights**

If a qualified beneficiary’s COBRA continuation coverage ends because the qualified beneficiary has reached the end of the maximum coverage period described above (see "Length of COBRA Continuation Coverage"), a conversion insurance option may be available. In general, a qualified beneficiary may have the right to convert group health plan coverage to an individual policy of group health insurance if the qualified beneficiary applies promptly under the terms and conditions of the conversion provisions (if any) contained in the group health plan. For more information concerning conversion policies, please contact the COBRA Administrator.

**Early Cessation of COBRA Continuation Coverage**

COBRA continuation coverage will be terminated prior to the expiration date of the continuation period otherwise applicable (see "Length of COBRA Continuation Coverage" above) under the following circumstances:

(a) The employer (including any affiliate of the employer) ceases to provide any group health plan to any employee;

(b) Any required premium is not paid in full on time;

(c) A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition (other than an exclusion or limitation that does not apply to, or is satisfied by, such beneficiary by reason of chapter 100 of title 26, part 7 of subtitle B of ERISA);

(d) A qualified beneficiary becomes enrolled in Medicare (under Part A, Part B, or both)

after electing COBRA continuation coverage; or

(e) If a qualified beneficiary is receiving extended disability coverage, upon a final determination under Title II or XVI of the Social Security Act that the disabled qualified

beneficiary is no longer disabled, in which case coverage will end the month that begins more than 30 days following the date of such determination.

Continuation coverage may also be terminated for any reason the group health plan would terminate coverage of a participant or dependent not receiving continuation coverage (such as fraud).

**Other Coverage Options besides COBRA**

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

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

**Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator (or Plan Administrator, if there is no separate COBRA Administrator). For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa.](http://www.dol.gov/ebsa) (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit [www.healthcare.gov.](http://www.healthcare.gov/)

**Address Changes and Records**

You should let the Administrator and COBRA Administrator, as applicable, know about any changes in the addresses of participants or beneficiaries under the group health plan that are, or may become, qualified beneficiaries under the group health plan. You should also keep a copy, for your records, of any notices you provide.

**5.** **CLAIMS**

**5.1** **Claims for Benefits**. To obtain benefits from an insurer, HMO, or self-funded arrangement you must follow the claims procedures under the applicable insurance policy or HMO contract, or self-funded arrangement. Such procedures may require you to complete, sign, and submit a written claim on the insurer's, HMO's, or Plan Administrator's claim form. Forms are available from the insurer, HMO, or Plan Administrator, as applicable. The insurer, HMO, or Plan Administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. If the insurer, HMO, or Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reasons(s) for the denial.

**5.2** **Denial of Claim.** If your claim is denied, you may appeal to the insurer, HMO, or Plan Administrator for a review of the denied claim. The insurer, HMO, or Plan Administrator will decide the claim appeal in accordance with its reasonable claim procedures, as required by ERISA. If you fail to appeal on time, you may lose the right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). For more information and details regarding claims procedures for the various coverages available under the Plan, other than the flexible spending account options, you should refer to the applicable claims procedures in the attached Benefit Descriptions.

**6.** **GENERAL INFORMATION**

**6.1** **Plan Amendment.** McPherson College, Inc. reserves the right to amend any plan, or any coverage available under any plan, in any manner, at will, and at any time, including, but not limited to, retiree medical coverage (if any) offered under any plan. No one will acquire any vested (non-forfeitable) right to have benefits, costs, or other plan provisions remain unmodified or in effect.

**6.2** **Plan Termination.** McPherson College, Inc. specifically reserves the right to terminate any plan, or any coverage available under any plan, in whole or in part, at will, and at any time.

**6.3** **Erroneous Payments.** If you, or your dependent or any other person, receives any amount of benefits that the Plan Administrator in its sole discretion later determines that you were not entitled to receive under the terms of any plan, you are required to make reimbursement to the plan. In addition, the Plan Administrator has the right to offset any future claims for benefits against amounts that you were not otherwise entitled to receive.

**6.4** **Fraud or Misrepresentation.** If any person obtains coverage and/or benefits or other payments under the Plan by reason of any direct or indirect act of fraud or misrepresentation (including fraud or misrepresentation by omission), as determined by the Plan Administrator in its sole discretion, such individual will be required to make restitution to, and/or pay any direct or indirect fees, expenses, costs, losses, or other damages suffered by, the Plan and/or the employer by reason of such act of fraud or misrepresentation in such amount or amounts as may be determined by the Plan Administrator, in its sole discretion. The Plan Administrator also may take such other and further action with respect to such individual as it deems necessary or appropriate, including, but not limited to, retroactively terminating such individual's participation in the Plan (in whole or in part).

**6.5** **Additional Questions.** This Summary Plan Description is a summary of provisions and cannot answer all questions which might arise. Please contact the Plan Administrator about any questions you might have.

**6.6 Additional Information.** Copies of the following items may be obtained from the Plan

Administrator or the insurance carrier:

(a) The plan procedures governing qualified medical child support orders (there is no charge for this document);

(b) A list of any provider networks; and

(c) The current premium cost.

**7.** **STATEMENT OF ERISA RIGHTS**

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

**Receive Information about Your Plan and Benefits**

Examine without charge at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under such plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to

24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Under current law, health insurance companies can’t refuse to cover you or charge your more just because you have a “pre-existing condition” – that is, a health problem you had before the date that new health coverage starts. These rules went into effect for plan years beginning on or after January 1, 2014.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents for the latest annual report from a plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse a plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. In all cases, however, you may not file suit in federal court unless and until you have exhausted any and all administrative remedies and review procedures available to you by law or under the terms of the Plan. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**8.** **BENEFIT DESCRIPTIONS**

The Benefit Descriptions provide additional information regarding the specific terms and provisions of the coverages available to you under the Plan. You are encouraged to carefully review the Benefit Description in its entirety. You should pay particular attention to the limitations and exclusions described in the Benefit Descriptions, and any required conditions precedent to receiving benefits (e.g., prior authorization), before incurring any claim for benefits. In addition, coverage may be reduced or unavailable for goods or services obtained out of network.

The following benefits are available to employees of McPherson College through Blue Cross Blue Shield of Kansas:

* Medical
* Dental
* Vision
* Life
* Voluntary life
* Short-term disability,
* Long-term disability
* Accident
* Critical illness including cancer
* Hospital indemnity
* FSA
* Health Savings Account (HSA)
* Cobra

Email the Director of Human Resources for more information:

stocklib@mcpherson.edu