Earlham
COLLEGE

Earlham College

January 1, 2020 – December 31, 2020 Benefit Summary

Earlham COLLEGE

Table of Contents

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Benefits Overview

The College's goal is to provide you with the most comprehensive benefit package possible while balancing our fiscal commitments and obligations.

Benefits Offered

- Medical Insurance
- Dental Insurance
- Employer Paid Life and Accidental Death & Dismemberment (AD&D) Insurance
- Supplemental Life and AD&D Insurance
- Vision Insurance
- Flexible Spending Account (FSA)
- Health Savings Account (HSA)
- Employer-Paid Long-Term Disability
- Employee Assistance Program

Who Is Eligible?

Benefits are available to all full-time employees and their dependents who meet specific eligibility requirements. The plan allows coverage for an employee's legal spouse, domestic partner and/or child(ren), including biological, adopted, or stepchildren, covered from birth to the end of the month they turn age 26. If your spouse/partner is eligible for group coverage under his/her employer's health plan, they are not eligible for Medical benefits under the Earlham plan.

Active eligible employees, regardless of age, are eligible for benefits under the College's Health Plan.

Important Contact Information

If you would like to find an in-network provider, or ask detailed questions about your benefits, you may contact the insurance companies/service provider directly.

Benefit	Administrator	Phone	Website/email
Medical	UMR	800.207.3172	www.UMR.com
Prescription	RxBenefits	800.334.8134	www.rxbenefits.com
Dental	Delta Dental	800.524.0149	www.deltadentalin.com
Vision	VSP	800.877.7195	www.vsp.com
Life and AD&D, Supplemental Life and AD&D	Symetra	800.796.3872	www.symetra.com
Flexible Spending Account (FSA)	BPC	800.355.2350	www.bpcinc.com
Employee Assistance Program (EAP)	LifeWorks	888.319.7819	www.guidanceresrouces.com

Qualifying Events

Changing your benefits during the year

With the Cafeteria Plan, including employee contributions on a pretax basis and the FSA, it is important that you make your elections during your enrollment period carefully because you can only make changes during the year if you have a qualified life event according to IRS regulations listed below.

Changes to your benefits can be made if preceded by a documented qualified life event and they are made within 31 days of the event. Your change must be consistent with your life event/status change. Listed below are some events that qualify for a change in coverage. For a complete list, please reference your Cafeteria Plan document.

- Marriage
- Divorce or legal separation
- Birth or placement for adoption of a child
- Ineligibility of a dependent
- Loss of other coverage
- Change in your employment status or that of your spouse
- A court order
- Entitlement to Medicare or Medicaid

If you experience one of these events and want to change your benefits, you must make the change within 31 days after the event occurs. Contact Human Resources for details to ensure the change is made correctly. If you miss the window for making a change, you will need to wait until the next open enrollment period to make a change.

Medical Insurance

The Who's Who for Earlham College's Medical Plans

- **UMR is the claims administrator for the medical plans.** They determine if you and your dependents are eligible for benefits and process your claims. Contact UMR for questions concerning eligibility, benefits, or status of claim payments. Customer Service can be reached at **800.207.3172**.
- **RxBenefits is the administrator of your pharmacy benefits**. Member Services is available to assist members with any questions or concerns regarding their pharmacy benefits, such as: benefit details, claims status, pharmacy network, coverage determination/inquiries, mail and specialty scripts, and pharmacy information and can be reached at 800.334.8134.

Terms You Should Know

Deductible: The amount you pay for covered health care expenses before your insurance starts to pay. For example, with a $2,000 calendar year deductible, you pay the first $2,000 of covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example), after you have paid your calendar year deductible.

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Medicare/Retirement

Medicare and Group Health Plan Coverage

When you reach age 65 and you are retired, you have a number of important decisions to make. These may include whether to enroll in Medicare Part B, join a Medicare Prescription Drug Plan, buy a Medigap policy, and/or keep employer or retiree coverage. Understanding your choices may help you avoid paying more than you need to for Medicare Part B and other insurance, and get the coverage that's best for you. You can visit **www.medicare.gov** and select "Compare Medicare Prescription Drug Plans" and "Compare Health Plans and Medigap Policies in Your Area." You can also call your State Health Insurance Assistance Program. To get their telephone number, call **1.800.MEDICARE** (800.633.4227). TTY users should call **877.486.2048**.

Medicare Part B benefits are optional and are available to all beneficiaries when they become entitled to Medicare Part A. Medicare Part B may be purchased by most persons age 65 and over. Although participation in Medicare Part B is optional, the College's health plans will pay as if Medicare Part B has been elected when Medicare is primary. See chart below to determine when Medicare is primary. **Failure to purchase Medicare Part B when Medicare is primary will drastically affect an individual's ability to recover any costs incurred for physician services and other Medicare Part B covered items.**

Medicare Part D (prescriptions)

Those eligible for Medicare are provided a letter of creditable coverage by the College. The letter states that the prescription drug program currently provided by the College's Healthcare Plan meets or exceeds Medicare Part D. Medicare participants are advised that they may select the College's prescription drug plan instead of Medicare Part D. The purpose of the letter is to allow Medicare eligible persons to join Medicare Part D at a later date, if they choose, without paying a late entrant "penalty." This letter will be provided annually each fall.

Who Pays First?			
If You	**Situation**	**Pays First**	**Pays Second**
Are 65 or older and covered by a group health plan because you or your spouse is still working	Entitled to Medicare	Group Health Plan	Medicare
	The employer has 20 or more employees		
Have an employer group health plan after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree Coverage

Medical Plans Comparison

Earlham COLLEGE

UMR Healthcare Plan Administrator

UMR continues to be our healthcare provider. As always, you can go to their website **www.umr.com** to learn more.

	High Deductible Health Plan		Traditional PPO	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Individual Deductible[1]	$2,800	$5,600	$750	$2,500
Family Deductible[1]	$5,600	$11,200	$1,500	$5,000
Coinsurance Level	100%	70%	90%	70%
Individual Out-of-Pocket Limit (Including deductible)[1]	$3,800	$11,200	$2,500	$5,000
Family Out-of-Pocket Limit (Including deductible)[1]	$7,600	$22,400	$5,000	$10,000
Covered Services	100%*	70%*	90%*	70%
Hospital				
Inpatient Services	100%*	70%*	90%*	70%*
Outpatient Services	100%*	70%*	90%*	70%*
Emergency Room	100%*		$100*	
Physician				
Inpatient Surgery	100%*	70%*	90%*	70%*
Outpatient Surgery	100%*	70%*	90%*	70%*
Primary Care Office Visits	100%*	70%*	90%*	70%*
Specialist Office Visits	100%*	70%*	90%*	70%*
Preventive Services[2]	100%	70%*	100%	70%*
Virtual Visits	Up to $49 copay	70%*	Up to $49 copay	70%*
Other				
X-ray and Lab	100%*	70%*	90%*	70%*
Therapy: Occupational, Physical or Speech (annual 20-visit limit)	100%*	70%*	90%*	70%*
Prescription Drugs	**RxBenefits**		**RxBenefits**	
Retail Pharmacy (30-day supply)	$10 Tier 1* / $30 Tier 2* / $60 Tier 3* / 25%* up to $200 per fill		$10 Tier 1 / $25 Tier 2 / $40 Tier 3	
Mail Order (90-day supply)	$10 Tier 1* / $75 Tier 2* / $180 Tier 3*		$20 Tier 1 / $50 Tier 2 / $80 Tier 3	
Prescription Out-of-Pocket Limit (Retail 30-Day / Mail Order 90-Day)	Integrated with Medical		$4,100 / $8,200	

***Subject to deductible and coinsurance.**

1. Deductibles are based on calendar year.
2. As defined by the US Preventive Services Task Force.

Note: The comparisons are outlines of the benefit schedules. This exhibit in no way replaces the plan document of coverage, which outlines all the plan provisions and legally governs the operation of the plans.

Dental Insurance

Earlham College Dental Plan

Earlham has contracted with Delta Dental to be the claims administrator of dental benefits for you and your family.

Dental Benefits		
Administered by Delta Dental	**High Plan**	**Low Plan**
	Plan Pays	**Plan Pays**
Individual Deductible	$50	None
Family Deductible	$150	None
Calendar Year Maximum	$2,000	$750 per person per calendar year
Orthodontia Lifetime Maximum	$1,500	Not covered
Benefit Waiting Periods for Late Enrollees	None	None
Preventive Care		
Routine Oral Exams – 1 every 6 months	100% deductible waived	100% deductible waived
Cleaning and Polishing – 1 every 6 months	100% deductible waived	100% deductible waived
Topical Fluoride (Under age 14)– 1 every 12 months	100% deductible waived	100% deductible waived
Bitewing X-rays – every 12 months	100% deductible waived	100% deductible waived
Space Maintainers (under age 16)	100% deductible waived	100% deductible waived
Sealants (Under age 6)	100% deductible waived	100% deductible waived
Basic Care		
Emergency Palliative Treatment	80% after deductible	50% after deductible
Minor Restorative / Filings, Crown Repair	80% after deductible	50% after deductible
Simple extractions	80% after deductible	50% after deductible
Complex Oral Surgery	80% after deductible	Not covered
Endodontic (Root Canal Therapy)	80% after deductible	Not covered
Periodontal Maintenance	80% after deductible	50% after deductible
Periodontal Services (including Surgery)	80% after deductible	Not covered
Crowns / Inlays / Onlays	80% after deductible	Not covered
Restorative Services	80% after deductible	50% after deductible
Major Care		
Prosthodontics (Bridgework / Implants / Dentures	80% after deductible	Not covered
General Anesthesia	80% after deductible	Not covered
Implant Services	80% after deductible	Not covered
Orthodontia to Age 19		
Evaluation and Treatment	50%; no deductible	Not covered
Orthodontia Lifetime Maximum	$1,500	N/A

*Deductibles are calendar year.
**Preventive care not subject to deductible.

When you use a Delta Dental PPO or Premier Network Provider you will receive a discount for services. All other providers will be subject to Reasonable & Customary Fees, and you may be balance billed. Log onto **www.deltadental.com** to register and find participating providers.

Vision Program

VSP Vision Benefit

Earlham College and VSP provide you with an affordable eye care plan. Please see the chart to the right for details.

Personalized Care. VSP doctors take the time to get to know you and your eyes. They'll look for vision problems and signs of other health conditions too.

Doctor Network. You'll find the VSP choice provider who's right for you at **www.vsp.com** or by calling **800.877.7195.** VSP doctors offer flexible hours, a variety of office settings, and eyewear choices you'll love.

Value and Savings. You'll get great savings on your eye exam and eyewear, and discounts on laser vision correction.

A VSP Vision ID card will not be provided. All you need to do is let your vision provider know that you are a VSP member and they will take care of the rest.

Dental Benefits		
	In-Network	**Out-of-Network**
WellVision Eye Exam (once every 12 months)	$10 Exam copay applies	Up to $45 reimbursement
Eyeglass Frames (once every 24 months)	$25 Materials copay applies; Copay up to $130 frame allowance	Up to $70 reimbursement
Eyeglass Lenses (once every 12 months)	$25 Materials copay applies	
Standard Plastic Single Vision Lenses	Included	Up to $30 reimbursement
Standard Plastic Bifocal Lenses	Included	Up to $50 reimbursement
Standard Plastic Trifocal Lenses	Included	Up to $65 reimbursement
Lenticular Lenses	Included	Up to $100 reimbursement
Polycarbonate Lenses for Children Under Age 19	Included	
Eyeglass Lens Enhancements		
Standard Progressive Lenses	$55	No allowance on lens enhancements when obtained out-of-network
Premium Progressive Lenses	$95 – $105	
Custom Progressive Lenses	$150 – $175	
Average Savings of 20%-25% on Other Lens Enhancements	$70	
Contact Lenses Instead of Glasses		
Elective Conventional Lenses	Included in copay up to $130 allowance	$105 allowance
Elective Disposable	$130 allowance	$105 allowance
Non-Elective Contact Lenses	Covered in full	$210 allowance

Receive an extra $20 to spend on featured frame brands. Login to www.vsp.com/specialoffers to learn more about the savings.

Life Insurance and AD&D

Life Insurance and AD&D

Earlham pays 100% of your basic life and AD&D insurance premiums. Basic Life and AD&D benefits reduce 35% at age 65; 50% at age 70; 25% at age 75.

Full-time employees working at least 30 hours per week for 36 weeks per year	$50,000
Part-time employees working at least 20 hours per week for 36 weeks per year (After 1 year of service)	$25,000

Voluntary Life and AD&D Insurance

You can purchase additional life and AD&D insurance for yourself, your spouse and your children. When you and your spouse enroll for Voluntary Life you will automatically be enrolled for matching AD&D.

For Employees: Choice of $10,000 increments not to exceed 5 times your basic annual earnings or $500,000.
Guarantee Issue: $150,000

For Spouse: Choice of $5,000 increments not to exceed 50% of employee's election or $100,000. You must enroll for Voluntary Life and AD&D to add coverage for your spouse.
Guarantee Issue: $25,000

For Children: Choice of $5,000 or $10,000 for children age from 6 months to age 26. Children 14 days to 6 months limited to $250. You must enroll for Voluntary Life and AD&D to add coverage for your child(ren).

Enroll Online. You will see the cost for coverage based on your age and your selection of voluntary life coverage.

- Timely applicants enter within 30-days of eligibility date. Guarantee Issue applies.
- Premiums for your spouse are based on your age.
- Guarantee Issue requirements do not apply to late applicants or members increasing benefits as Evidence of Insurability is required.
- Premiums are banded in 5-year increments and will automatically adjust on your birth-date.
- No age reductions
- Benefits terminate at retirement. Portability and Conversion Privilege are available upon termination.

Flexible Spending Account

Earlham College has chosen to sponsor a Flexible Spending account, of "Flex Plan" as one of your insurance benefits. Flex is an IRS-approved method of paying for your 'out-of-pocket' expenses for health, dental, vision and qualified Over the Counter expenses with pre-tax dollars.

Earlham's flexible spending plan is administered by BPC: **(www.bpcinc.com)**.

Register at **www.pbcinc.com/participants/home**. Once registered you can safely and securely submit claims for reimbursement or manage your flexible spending account.

Download the BPC Benefits Mobile App for iPhone, iPad, iPod Touch and Android at the App Store or on Google Play.

- BPC has tools to help you manage your flex account including: A Video Library to learn more about the advantages of Flex Accounts.
- Tools and Calculators to assist in how much you should contribute Flex Account and how much tax saving you will have based on your annual election.

Healthcare Flexible Spending Account

A healthcare flexible spending account can be used to pay for out-of-pocket medical, dental, vision, and hearing expenses not covered by insurance. The 2019 IRS maximum plan year election is $2,600.

Dependent Care Flexible Spending Program

A dependent care flexible spending account allows you to be reimbursed for qualified child care and dependent care expenses using pretax dollars. If you are married and file a joint return, the annual IRS limit is $5,000. If you are married and file separate returns or you are single, you can elect $2,500 for the plan year. To qualify for the dependent care flexible spending account, you and your spouse must be employed, or your spouse must be a full-time student.

Eligible Dependents

- Children under age 13 who are claimed as a dependent for tax purposes
- Disabled spouse or disabled dependent of any age

Long-Term Disability, EAP

Long-Term Disability

Monthly Benefit	60% of Pre-Disability Earnings
Maximum Monthly Benefit	$4,000
Minimum Monthly Benefit	$100
More than 3 Year of Employment	Flat 10% Pension Benefit Included
2-3 Years of Employment	Flat 5% Pension Benefit Included
Benefit Begin	181st day after Disability
Benefit Duration	Social Security Retirement Age (if disabled prior to age 60)
Definition of Total Disability: Inability to perform each of the main duties of your own occupation due to injury or sickness.	
Definition of Earnings: Base gross pay excluding commission, awards or bonuses, overtime, grants or other compensation.	
Preexisting Condition Clause: Sickness or injury diagnosed or treated within 3 months of your effective date are excluded until insured by the plan for 12 months.	

Employee Assistance Program (EAP)

Administered by LifeWorks

Problems are just a part of daily life. In addition to your benefits insured by MetLife, you and your household members will have access to an Employee Assistance Program. This program includes:

Consultations and Support including up to 5 personal and confidential consultations with a licenses clinician. You can choose between in person sessions or telephonic consultations. Please call 888.319.7819 anytime to speak with a clinician.

Work and Life Services including consultations for Legal Services, Financial Services, Childcare and Eldercare Assistance and Identity Theft Recovery Services, Daily Living Services.

Website and Mobile App that features a wide range of tools and information.

Log onto: **www.guidanceresources.com**.

www.guidanceresources.com
Site Password: SYMETRA

Glossary of Health Insurance and Medical Terms

Earlham COLLEGE

Allowed Amount. Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing. When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider should not balance bill you.

Beneficiary. The person(s) you name to receive certain benefits (such as life insurance) upon your death.

Brand Name Drug: Medications are marketed under a trademark-protected name and are often available from only one manufacturer.

Coinsurance. The percentage of covered medical or dental expenses that you must pay. For example, if your plan pays 80%, you must pay the remaining 20%.

Copayment. A fixed amount you pay for a covered healthcare service, usually at the time of service.

Deductible. The amount of medical or dental expenses you must pay each year before your plan begins paying benefits.

Emergency Medical Condition. An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Evidence of Insurability (EOI). An application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

Explanation of Benefits (EOB). The document you receive from the insurance company after your claim is filed and processed. The EOB shows how much of the expense the plan covered and how much you may be expected to pay.

Formulary Brand Name Drug: A list of prescribed medications that are preferred by your plan because they are safe, effective alternatives to other generics or brands that may be more expensive. The formulary has a wide selection of generic and brand-name medications.

HIPAA (Health Insurance Portability and Accountability Act of 1996). A federal law that addresses the privacy of patient health information. The "privacy" regulations give patients greater access to their own medical records and more control over how their personal health information is used. Also, the law defines the obligations of health care providers and health plans to protect patient records.

Hospitalization. Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care. Care in a hospital that doesn't require an overnight stay.

In-Network Provider. The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Maximum Annual Benefit. The maximum amount the plan pays for specific services (such as dental or chiropractic) for a covered individual, each plan year.

Medically Necessary. Services and supplies that the insurance company determines to be consistent with generally accepted practices for the diagnosis of an illness or injury, or the medical care of a diagnosed illness or injury. Only medically necessary services and supplies are covered by the plan.

Out-of-Network Provider. The facilities, providers and suppliers who don't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-Pocket Limit. Is the most you have to pay for covered medical expenses in a year. Once you've reached the out-of-pocket maximum, the plan pays 100% of eligible expenses for the remainder of the plan year. This limit never includes your premium, balance-billed charges or charges the plan doesn't cover.

Plan. A benefit your employer, or other group sponsor provides to you to pay for your healthcare services.

Plan Year. The period of time in which plan coverage and records are based. For the College's plan, it is the calendar year. (For example, the annual deductible, annual out-of-pocket maximum, and maximum annual benefit all apply to expenses incurred during the plan year.)

Preauthorization. A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification.

Premium. The amount you pay for your health care coverage and other benefits, through payroll deductions.

Primary Care Physician. A physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. The following types of providers are PCPs: family practitioners, general practitioners, pediatricians, internal medicine, and gynecologists.

Specialist. A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care. Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Voluntary Benefits. Optional benefit plans sponsored by the employer, but fully paid for by employees who elect coverage. These benefits are generally available at special group rates or discounts, making them more cost-effective than employees could obtain on their own.

Waiver of Premium. Rider or provision included in the life insurance policy exempting the insured from paying premiums after insured has been disabled for a specified period of time.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **866.444.EBSA (3272).**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711
FLORIDA – Medicaid
http://flmedicaidtplrecovery.com/hipp 877.357.3268

GEORGIA – Medicaid
https://medicaid.georgia.gov/ health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid http://www.indianamedicaid.com | 800.403.0864
IOWA – Medicaid
http://dhs.iowa.gov/Hawki 800.257.8563
KANSAS – Medicaid
http://www.kdheks.gov/hcf 785.296.3512
KENTUCKY – Medicaid
http://chfs.ky.gov 800.635.2570
LOUISIANA – Medicaid
http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 888.695.2447
MAINE – Medicaid
http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
http://www.mass.gov/eohhs/gov/departments/masshealth 800.862.4840
MINNESOTA – Medicaid
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll-Free:800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075

PENNSYLVANIA – Medicaid
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm 800.692.7462
RHODE ISLAND – Medicaid
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
Medicaid: http://www.coverva.org/programs_premium_assistance.cfm 800.432.5924 CHIP: http://www.coverva.org/programs_premium_assistance.cfm 855.242.8282
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022, ext. 15473
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf 800.362.3002
WYOMING – Medicaid
https://wyequalitycare.acs-inc.com/ 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 12/31/19)

Women's Health & Cancer Rights Act

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

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physician complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, call Blue Cross Blue Shield of Illinois.

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 3.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **877.696.6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

HIPAA Special Enrollment Rights

Initial Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the College's Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan—your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

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 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 employer 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).

Loss of Coverage 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 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 a state children's health insurance program.

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.

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 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.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your plan administrator.

Michelle's Law

Michelle's Law requires group health plans to provide continued coverage for certain dependents who are covered under Earlham College group health plan as a student if they lose their student status because they take a medically necessary leave of absence from school. This continuation of coverage is described below.

If your dependent is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your dependent may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your dependent was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges, universities, some trade schools and certain other post-secondary institutions).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the dependent at the institution, that:

- begins while the dependent is suffering from a serious illness or injury,
- is medically necessary, and
- causes the dependent to lose student status for purposes of coverage under the plan.

The coverage provided to dependents during any period of continued coverage:

- is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
- stays the same as if your dependent had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed under the plan during this one-year period, the plan will provide the changed coverage for the dependent for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for these dependents.

If you believe your dependent is eligible for this continued coverage, the dependent's treating physician must provide a written certification to the plan stating that your dependent is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA Continuation Coverage

If your dependent is eligible for Michelle's Law's continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage under COBRA may be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Questions?

If you have any questions regarding the information in this notice or your dependent's right to Michelle's Law's continued coverage, or if you would like a copy of your Summary Plan Description (which contains important information about plan benefits, eligibility, exclusions, and limitations), you should contact your Benefits Administrator at **765.983.1619**.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting