Earlham
COLLEGE

Earlham College

January 1, 2023 - December 31, 2023 Benefit Summary

Earlham COLLEGE

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Benefits Overview

Earlham COLLEGE

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
- Vision Insurance
- Employer Paid Life and Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D Insurance
- Flexible Spending Account (FSA)
- Employer-Paid Long-Term Disability
- Employee Assistance Program (EAP)

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
Teladoc	First Stop Health	888.691.7967	www.fshealth.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, Voluntary Life and AD&D Long Term Disability (LTD)	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.guidanceresources.com

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Advocate Center

Ask Your Advocate

Helping you make the most of your healthcare benefits.

Gallagher

Insurance | Risk Management | Consulting

Gallagher is ready to help you get the most from your benefit programs by providing an advocate at no cost to assist you with:

- **Explanation of benefits.** Is it unclear to you what the insurance covered on a particular claim and what is your responsibility?
- **Prescription/pharmacy problems.** Is the pharmacy telling you that your medication is not covered or charging you full price? Do you need help getting an authorization on a medication?
- **Benefits questions.** Are you unsure if the insurance will pay for a certain procedure?
- **Claim issues.** Did you receive a bill from a doctor but don't know why?
- **Difficult situations.** Are you having difficulty getting a referral? Has the insurance carrier denied a procedure and you want to appeal their decision?

You have a Team of Advocates ready to handle any situation in a discreet and confidential manner.

CONTACT INFORMATION

Earlham College Advocate Center
Toll Free (833) 233-2953
bac.earlham@ajg.com

Hours of Operation:
Monday - Friday 7:00 a.m. – 6:00 p.m. CST

Qualifying Events

Earlham COLLEGE

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.

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Medical

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

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%*		90%*	
Physician				
Inpatient Surgery	100%*	70%*	90%*	70%*
Outpatient Surgery	100%*	70%*	90%*	70%*
Primary Care Office Visits (includes Telehealth)	100%*	70%*	90%*	70%*
Specialist Office Visits	100%*	70%*	90%*	70%*
Preventive Services[2]	100%	70%*	100%	70%*
Telemedicine - OC24health (General Medicine/Dermatology)	100%*	100%*	90%*	90%*
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*	Not covered	$10 Tier 1 / $25 Tier 2 / $40 Tier 3	Not covered
Retail Pharmacy (90-day supply)	$10 Tier 1* / $75 Tier 2* / $180 Tier 3*	Not covered	$20 Tier 1 / $50 Tier 2 / $80 Tier 3	Not covered
Mail Order Extended Supply (90-day supply)	$10 Tier 1* / $75 Tier 2* / $180 Tier 3*	Not covered	$20 Tier 1 / $50 Tier 2 / $80 Tier 3	Not covered
Specialty Medications (30-day supply)	25% w/$200 max	Not covered	$10 Tier 1 / $25 Tier 2 / $40 Tier 3	Not covered
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.

Home delivery really delivers

Millions of people enjoy the convenience of home delivery for medicines they take on a regular basis. Your plan recommends home delivery from the Express Scripts Pharmacy℠. It's easy to get started, your medicine is delivered right to your door about eight days after your prescription is received and delivery is free.
That's why home delivery is preferred by your plan.

Here's how you can get started with home delivery

ePrescribe
Ask your doctor to send your prescription electronically to the Express Scripts Pharmacy

Call the number on the back of your card
Talk with a prescription plan specialist

Log-in
1. Log-in at express-scripts.com
2. Scroll down to 'Transfer to Home Delivery' section, select the medicines you want to refill to Home Delivery
3. Check out

Register at express-scripts.com and you can:

- Transfer medicines to home delivery
- Refill and renew prescriptions
- Track your home delivery order status
- View claims, balances and prescription history
- Manage account settings and payment methods

Join the millions of Americans who already enjoy the safety and convenience of home delivery from the Express Scripts Pharmacy.

If you have any questions about home delivery from the Express Scripts Pharmacy or your prescription benefit, please call the number on your member ID card.

EXPRESS SCRIPTS®

Express Scripts manages your prescription benefit for your employer, health plan or benefit fund.

tria HEALTH

WANT TO UNDERSTAND?

Is there a way to save money on the medications I take?

I'm taking all my medications - why do I still not feel good?

Do I really need to take all those medications?

TRIA HEALTH IS FOR YOU IF...

Healthcare and insurance is confusing and difficult, especially if you take a lot of medications and have chronic conditions. Tria Health is a free and confidential benefit that will support you in managing your health, medications and healthcare budget. Talk to a pharmacist over the phone and receive the personalized care you deserve.

Who Should Participate?

Tria Health's Pharmacy Advocate Program is available for employees and/or dependents on Independent Colleges Indiana Benefits Consortium's insurance. Tria Health is recommended for members who have any of the following conditions:

- Diabetes
- Heart Disease
- High Cholesterol
- High Blood Pressure
- Mental Health
- Asthma/COPD
- Osteoporosis
- Migraines

Earn up to $175 by Participating!

By completing your first consultation with a Tria pharmacist, you will receive a $75 gift card then $50 thereafter. Members can qualify to receive up to $175 within a 12-month period.

Free Diabetes & Blood Pressure Devices

Select participants with diabetes and/or high blood pressure will have access to a FREE blood glucose meter and testing supplies and/or a blood pressure monitor for easy monitoring at home. All readings will be monitored by a clinician and can easily be shared with any physician.

Why Participate?

Did you know that approximately 50% of patients do not take their medications as prescribed?[1] Tria Health provides pharmacist-led consultations. Using their knowledge of medications, pharmacists understand how to achieve maximum benefit, minimal side effects and to avoid drug interactions. Your Tria Health pharmacist can help:

- Make sure your medications are working as intended.
- Help you save money - Tria saves patients an average $250 per year![2]
- Answer any questions you have about your health.
- Coordinate care with your doctor(s) - Over 95% of recommendations made by Tria Health were accepted by an individual's physician.[2]

How to Make an Appointment

Call 1.888.799.8742 or visit www.triahealth.com/schedule

*Limited to pharmacist consultations only.

1. Medication adherence: WHO cares? - PubMed (nih.gov)
2. Tria Health BOB & Patient Satisfaction Survey

Adult screenings and immunizations

General screening guidelines

Heart disease and cancer are the two leading causes of death in the United States, and the risks of developing a significant health condition rise significantly with age.

Your family health history can also make you predisposed to certain diseases. So it's important to understand your risk factors and receive appropriate screenings to head off potential problems when they are most treatable. Early detection could save your life.

Recommended tests are based on your age, gender and overall risk factors. The guidelines here are a general reference only. Always discuss your particular health care needs with your physician.

Tests for women

	18-39	40-49	50-64	65 +
Mammogram*		Discuss with your doctor or nurse	Every two years through age 74; talk to your health care provider about need for screening after age 74	
Cervical cancer (Pelvic exam/pap smear)	At least every three years after age 21 or if you have been sexually active for three years	At least every three years		Ask your health care provider if you need testing
Bone mineral density (osteoporosis)			Ask your health care provider if you are at risk for osteoporosis	Receive test after age 65; talk to your health care provider about repeat testing
Blood pressure	At least every two years; or annually if your blood pressure is higher than 120/80			
Cholesterol		Regular screenings 40-75 years. Ask your health care provider for recommended frequency		
Obesity/BMI	Regular screenings; a BMI of 25 to 29.9 is considered overweight, and a BMI of 30 and above is considered obese			
Diabetes (fasting plasma glucose test recommended)	Screening for pre-diabetes and type 2 diabetes for adults ages 35 to 70 years who are overweight or obese with no symptoms of diabetes			
Colorectal cancer			Fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 and continuing until age 75	

* The U.S. Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women age 40 and older.

UMR
A UnitedHealthcare Company

Tests for men

Age range	18-39	40-49	50-64	65 +
Blood pressure	At least every two years; or annually if your blood pressure is higher than 120/80			
Cholesterol		Regular screenings 40-75 years. Ask your health care provider for recommended frequency		
Obesity/BMI	Regular screenings; a BMI of 25 to 29.9 is considered overweight, and a BMI of 30 and above is considered obese			
Diabetes (fasting plasma glucose test recommended)	Screening for pre-diabetes and type 2 diabetes for adults ages 35 to 70 years who are overweight or obese with no symptoms of diabetes			
Colorectal cancer			Fecal occult blood testing, sigmoidoscopy, or colonoscopy beginning at age 45 and continuing until age 75	
Prostate cancer			Talk to your doctor about the risks and benefits of screening*	

* The U.S. Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of prostate cancer screening in men younger than age 75. Given the uncertainties and controversy surrounding prostate cancer screening in men younger than 75, a clinician should not order the PSA test without first discussing with the patient.

Immunization guidelines

Vaccinations work to help your body learn to fight off disease and build immunity to future exposure. Traditional vaccines mimic a natural infection by introducing dead or weakened versions of the germs that trigger a specific illness. Your immune system can clear these germs from your body, without experiencing common symptoms and complications, and it will "remember" how to protect your body from germs it has encountered before. For additional information on immunizations, visit **cdc.gov/vaccines**.

Age range	19-26	27-49	50-59	60-64	65 +
Tetanus/diptheria (Td/Tdap)	One-time dose of Tdap, then Td booster every 10 years				Td booster every 10 years
Influenza (flu)	One dose annually				
Pneumococcal vaccine (pneumonia)	One or two doses recommended if risk factor present, based on medical, occupational or lifestyle indications				One dose
Shingles			RZV (recombinant zoster vaccine) Two doses. This is the preferred vaccine.	ZVL (Zoster vaccine live) One dose	
Varicella (chicken pox)	Two doses for those who have never had chicken pox or who lack evidence of immunity				
Human papillomavirus (HPV)	Gardasil4 to age 26	Three doses for those who lack evidence of immunity*			
	Gardasil9 to age 45				* Not to be given during pregnancy
MMR (Measles, Mumps, Rubella)	One or two doses up to age 55 for those who lack evidence of immunity			One dose	
Meningococcal, Hepatitis A, Hepatitis B	Recommended for those with certain risk factors due to health, job or lifestyle, or who did not receive the vaccine as a child				

Sources: Recommended Adult Immunization Schedule 2018, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; The Guide to Clinical Preventive Services 2010-2014, Recommendations of the U.S. Preventive Services Task Force; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

Telehealth vs. Telemedicine

Which is which?

Telehealth is …

Telehealth is a general term used to describe clinical services provided to patients through electronic communications not through a vendor. This can be patient-to-physician or physician-to-physician.

Examples:

- Patient is consulting with a specialist that is out of their geographical area
- Patient has a virtual visit with their PCP

Telehealth is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage your health care.

Telemedicine is …

Telemedicine vendor/virtual visit are general terms used to describe clinical services provided to patients via electronic communications through a **vendor**.

Examples:

- Teladoc®
- Doctor on Demand

The program provides telephone and online video consultations with a physician and serves patients of all ages.

Earlham College's telemedicine vendor is **First Stop Health.**

UMR
A UnitedHealthcare Company

first stop health®

Care you will love. | (888) 691-7867 | fshealth.com

Care At Your Fingertips, 24/7

Telemedicine and Virtual Counseling from Independent Colleges of Indiana.

You now have access to doctors and counselors via phone or video with telemedicine and virtual counseling. Both services are provided to medically enrolled employees and their covered dependents for free.

Talk to a doctor 24/7

Get treatment within minutes for minor injuries, illnesses, and prescriptions.

- Cough & Sore Throat
- Infection (Sinus, Ear, UTI, etc.)
- Skin Rash
- Muscle/Joint Pain
- Medication Refill*

*Doctors can write prescriptions when needed. Prescription costs are applicable to your medical plan.

Talk to a counselor

Sometimes, you just need someone to talk to. Get short-term counseling to work through:

- Anxiety
- Depression
- Marital/Relationship
- Substance Use
- Work/Life Stress

Visits occur on your time! Get support via phone or video anytime between 8 a.m. to 8 p.m. Monday-Friday.

"Always cordial, caring, and very upbeat! Thank you for making us feel better mentally as well as physically!" – Helen from Ohio

Get the app

Download on the App Store | GET IT ON Google Play

Use Last 4 SSN to log in.

Dental

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Dental Plan

Delta Dental of Indiana is the claims administrator of dental benefits for Earlham College.

	Low Plan			High Plan		
Covered Services	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist***	**PPO Dentist**	**Premier Dentist**	**Non-Participating Dentist***
Annual Calendar Year Deductible (Individual/Family)	None	None	None	$50 / $150	$50 / $150	$50 / $150
Annual Calendar Year Benefit Maximum	$750 per person	$750 per person	$750 per person	$2,000 per person	$2,000 per person	$2,000 per person
Diagnostic & Preventive Services (cleanings, exams, x-rays, sealants)	100%	100%	100%	100%**	100%**	100%**
Basic Services (fillings, root canal therapy, oral surgery, extractions, relines, repairs)	50%	50%	50%	80%	80%	80%
Major Services (crowns, bridges, implants and dentures)	Not covered	Not covered	Not covered	80%	80%	80%
Ortho Services Eligibility - Dependent children up age 19						
Braces	Not covered	Not covered	Not covered	50%	50%	50%
Orthodontia Benefit Maximum	Not covered	Not covered	Not covered	$1,500	$1,500	$1,500

When you use a Delta Dental PPO or Premier Network Provider you will receive a discount for services.

*When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her dentist about treatment.
- Fluoride treatments are payable once per calendar year for people age 13 and under.
- Space maintainers are payable once per area per lifetime for people age 15 and under.
- Bitewing X-rays are payable once per calendar year and full mouth X-rays (which include bitewing X-rays) are payable once in any five-year period.
- Sealants are payable once per tooth per lifetime for first and second permanent molars for people age 15 and under. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Porcelain and resin facings on crowns are optional treatment on posterior teeth.
- Crowns, on lays and substructures are payable once per tooth in any seven-year period.
- Full and partial dentures are payable once in any seven-year period.
- Bridges are payable once in any seven-year period.
- Implants are payable once per tooth in any seven-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any seven-year period. Services related to crowns over implants are Covered Services.

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Vision

Vision Plan

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.

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

Vision 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

Health Savings Account

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How does it work?

By enrolling in the High Deductible Health Plan (HDHP), you will have access to a Health Savings Account, which allows you to save money tax-free to pay eligible medical expenses*. Enrolling in an HSA provides two major advantages to employees:

- You pay no Federal income or Social Security taxes on your contributions to the HSA, and
- Any unused portion left at the end of the year will roll over to the next year and new contributions for the following year will be added.

HSA Limits for 2023

For 2023, the maximum HSA contribution limits are:

- $3,850 for single coverage (Earlham College contributes $1,000; Employee maximum contribution is $2,850)
- $7,750 for all other coverage tiers (Earlham College contributes $2,000; Employee maximum contribution is $5,750)

Employees aged 55 and older may contribute an additional "catch-up" contribution of $1,000 per year.

HSA vs. FSA

	HSA	FSA
Do funds carry over year-to-year?	All funds carry over and never expire	An annual maximum (historically $500) will carry over year-to-year
Does it roll over when you terminate or retire?	Yes	No
Can be used only for qualified medical, dental and vision expenses?	Yes, until retirement age when funds can be used for anything	Yes
Contributions are pre-tax?	Yes	Yes
Funds are immediately available when you enroll (or at the start of the plan year)?	No	Yes
Are investment options available?	Yes	No
Can you change your contributions mid-year?	Yes, up to the annual maximum	Not typically, unless you experience a qualifying even such as marriage or birth of a child

*Includes doctor fees, hospital bills, chiropractor visits, prescription drugs, psychiatrist / psychologist, dental care, vision care, therapy, pregnancy tests, and acupuncture. See the IRS website for a complete listing.

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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 2023 IRS maximum plan year election is $3,050.

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

Life Insurance and AD&D

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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.

Supplemental Life Options

- **Employee:** Increments of $10,000 up to $500,000, but not to exceed 5x annual earnings.
- **Spouse:** Increments of $5,000 up to $100,000, but not to exceed 50% of Employee's amount.
- **Child(ren):** Birth to six months: $100
  Six months to 26 years: Increments of $1,000 up to $10,000.

*Employee must be enrolled before they can enroll for Spouse and/or Child coverage.

Guaranteed Issue – Applies when newly eligible

- **Employee coverage** enrolled for within 31 days of when they are first eligible: may enroll up to $150,000 without providing Evidence of Insurability.
- **Spouse coverage** enrolled for within 31 days of when they are first eligible: may enroll up to $25,000, without providing Evidence of Insurability.
- **Child(ren) coverage:** may enroll without Evidence of Insurability, even as late entrants.

Evidence of Insurability (EOI) is required when:

- Enrolling as a new hire and requesting more than $150,000 for Employee supplemental life coverage, or more than $25,000 for Spouse supplemental life coverage.
- Enrolling for any amount of new or increased supplemental life coverage outside of the new hire period.
- Enrolling outside of the new hire period for Voluntary Long Term Disability..

Earlham COLLEGE

Long-Term Disability, EAP

Long-Term Disability

Earlham pays 100% of your Long Term Disability insurance premium.

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)

Problems are just a part of daily life. In addition to your benefits insured by Symetra, 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.

www.guidanceresources.com
Site Password: SYMETRA

Employee Premiums

Medical, Dental, and Vision 2023 Rates

	Monthly Deduction
Medical Plan - UMR High Deductible Health Plan	
Employee	1.65% of gross pay, pre-tax
Employee and Spouse	5.55% of gross pay, pre-tax
Employee and Child(ren)	2.60% of gross pay, pre-tax
Family	6.25% of gross pay, pre-tax
Earlham Family (married couple employees)	2.10% of gross pay, pre-tax (each employee)
Medical Plan - UMR Traditional PPO Plan	
Employee	1.65% of gross pay, pre-tax
Employee and Spouse	5.55% of gross pay, pre-tax
Employee and Child(ren)	2.60% of gross pay, pre-tax
Family	6.25% of gross pay, pre-tax
Earlham Family (married couple employees)	2.10% of gross pay, pre-tax (each employee)
Dental Plan - Delta Dental High Plan	
Employee	$44.95
Employee and Spouse	$91.58
Employee and Child(ren)	$97.55
Family	$153.97
Dental Plan - Delta Dental Low Plan	
Employee	$12.53
Employee and Spouse	$25.52
Employee and Child(ren)	$33.29
Family	$50.11
Vision Plan - Vision Service Plan (VSP)	
Employee	$7.77
Employee and Spouse	$13.08
Employee and Child(ren)	$13.34
Family	$21.51

Employee Paid Life/AD&D Insurance Rates for 2023 Premiums

Per $1,000 of Benefits	Monthly	
Age	Employee Rate	Spouse Rate*
15-24	$0.043	$0.043
25-29	$0.043	$0.043
30-34	$0.056	$0.056
35-39	$0.071	$0.071
40-44	$0.096	$0.096
45-49	$0.147	$0.147
50-54	$0.230	$0.230
55-59	$0.392	$0.392
60-64	$0.591	$0.591
65-69	$0.949	$0.949
70-74	$1.793	$1.793
75+	$1.793	$1.793

Accidental Death and Dismemberment

Per $1,000 of Benefits	$0.017

*Spouse rate is based on employee's age

To calculate your cost:

Dollar amount you wish to purchase	$_____
Divide by 1000	$_____
Multiply by	$_____ (enter the rate from above chart)
Your estimated monthly cost=	$_____

Dependent Child Life
$1,000 of Coverage Monthly Rate
$0.240

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.

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).

Important Notices

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, 2022. 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: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676 | Email: hipp@dhcs.ca.gov
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 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment: https://www.maine.gov/dhhs/ofi/applications-forms 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 617.886.8102
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/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 | Email: HHSHIPPProgram@mt.gov
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/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 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
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
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
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2022, 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 1/31/2023)

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. 20211, 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.

Important Notice from Earlham College About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Earlham College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Earlham College has determined that the prescription drug coverage offered by the Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Earlham College coverage will not be affected. For those individuals who elect Part D coverage, coverage under the entity's plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Earlham College coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Earlham College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Earlham College changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1.800.MEDICARE (1.800.633.4227)**. TTY users should call **1.877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1.800.772.1213** (TTY **1.800.325.0778**).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender:	Earlham College
Contact:	Human Resources
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Phone Number:	765.983.1628

This benefit summary prepared by

Gallagher

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