



2025 Benefit Guide

January 1, 2025 – December 31, 2025

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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.

Welcome

The health and financial security of you and your family is important to us. Earlham College is proud to offer you competitive, comprehensive benefits that enhance the lives of you and your family. These benefits are intended to protect your well-being and financial health. You have the flexibility to select the plans that best meet your needs and the opportunity to elect additional benefits that protect you and your family and balance your life outside of work.

Benefits Overview

- » Medical Insurance
- » Dental Insurance
- » Vision Insurance
- » Employer Paid Life and Accidental Death & Dismemberment (AD&D) Insurance
- » Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance
- » Flexible Spending Account (FSA)
- » Employer-Paid Long-Term Disability
- » Employee Assistance Program (EAP)
- » Voluntary Accident Insurance
- » Voluntary Critical Illness Insurance
- » Voluntary Hospital Indemnity Insurance

Who Is Eligible?

Benefits are available to all employees and their dependents who meet the following specific eligibility requirements:

- » **Full-time:** Position that is scheduled 30 or more hours per week, and for 36 or more weeks per year
- » **Part-time:** Position scheduled 20 or more hours per week, and for 36 or more weeks per year
- » **Limited Part-time:** Position scheduled less than 20 hours per week, and/or for less than 36 weeks per year

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.

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
Telemedicine	First Stop Health	888.691.7967	www.fshealth.com
Prescription	RxBenefits	800.334.8134	www.rxbenefits.com
Dental	UnitedHealthcare	877.844.4999	https://member.uhc.com/myuhc
Vision	VSP	800.877.7195	www.vsp.com
Life and AD&D, Voluntary Life and AD&D Long-Term Disability (LTD)	Guardian	Life: 800.525.4542 LTD: 800.538.4583	www.guardianlife.com
Flexible Spending Account (FSA)	Chard Snyder	800.982.7715	www.chard-snyder.com
Employee Assistance Program (EAP)	Guardian / Guidance Resources	855.239.0743	www.guidanceresources.com
Voluntary Accident, Voluntary Critical Illness and Voluntary Hospital Indemnity	Guardian	800.541.7846	www.guardianlife.com

Benefit Advocate Center

Ask Your Advocate

Helping you make the most of your
healthcare benefits.



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

The services provided by an Advocate do not ensure or guarantee benefits. Applicable plan documents containing information regarding all terms, conditions and exclusions of coverages shall govern Consulting and insurance brokerage services to be provided by Gallagher Benefit Services, Inc. and/or its affiliate Gallagher Benefit Services (Canada) Group Inc. Gallagher Benefit Services, Inc. is a licensed insurance agency that does business in California as "Gallagher Benefit Services of California Insurance Services" and in Massachusetts as "Gallagher Benefit Insurance Services." Neither Arthur J. Gallagher & Co., nor its affiliates provide accounting, legal or tax advice.

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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

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](tel: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](tel: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



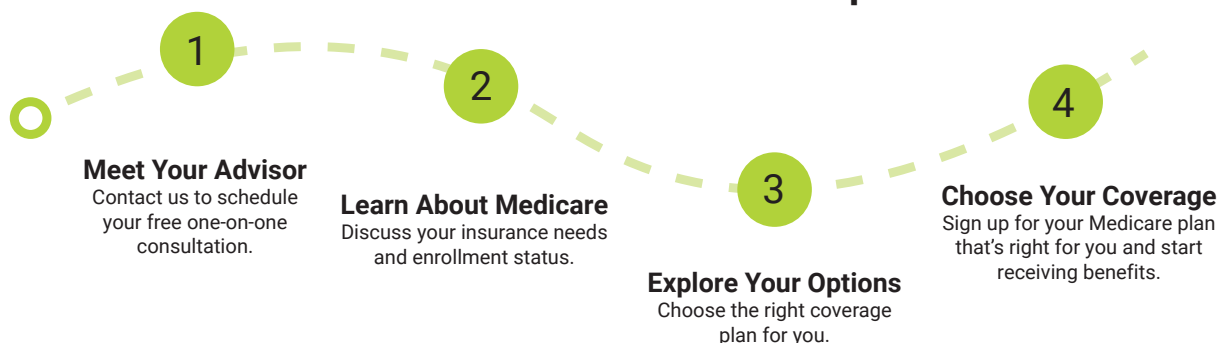


We're LIG Solutions, Your New Medicare Advisors!

Offering a no-cost consulting service to Medicare eligible employees and retirees to review coverage options.



Find The Best Plan In 4 Steps



Let's Find The Right Coverage For Your Needs.

Employer-Sponsored Coverage

Health coverage that's offered through you or spouses employer. Usually offered to active staff of the company, Federal laws allow you to extend employer coverage from 18-36 months after employment.

Original Medicare: Parts A & B

The most essential element of Medicare, Part A covers inpatient care and skilled nursing facilities. Part B focuses on outpatient and preventative services.

Medicare Part C

Also known as the Medicare Advantage Plan, Part C combines the coverage of other Parts of Medicare in a comprehensive, privately-offered package.

Medicare Part D

Medicare Part D covers prescription drugs, giving you peace of mind about your medication expenses.

Medicare Supplement

Medicare supplements are insurance plans that fill the gaps in your Medicare coverage – like co-payments, coinsurance, and deductibles.



Plans are Ready for Review!

LIG Solutions' dedicated staff is here to educate and answer all questions around your coverage options.



We do not offer every plan available in your area. Currently we represent 7 organizations which offer over 200 products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.

Contact LIG Solutions' Medicare Enrollment Team:
Partner.LIGSolutions.com/Medicare
(866) 210-0639

UMR Healthcare Plan Administrator

UMR continues to be our healthcare provider and Earlham College offers 2 plans. As always, you can go to their website www.umar.com to learn more.

	HDHP HSA		Traditional PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual Deductible ¹	\$3,500	\$7,000	\$1,450	\$3,200
Family Deductible ¹	\$7,000	\$14,000	\$2,900	\$6,400
Coinsurance Level	100%	70%	90%	70%
Individual Out-of-Pocket Limit (includes deductible) ¹	\$5,000	\$10,000	\$3,500	\$7,000
Family Out-of-Pocket Limit (includes deductible) ¹	\$12,000	\$24,000	\$7,000	\$14,000
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				
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.

¹Deductibles are based on calendar year.

²As 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.



Registering with Express Scripts

Online access to savings and convenience

Manage your medicines anywhere, any time with express-scripts.com and the Express Scripts® mobile app

Register now so you can experience:

- **More savings.**
Compare prices of medicines at multiple pharmacies. Get free standard shipping¹ from the Express Scripts PharmacySM.
- **More convenience.**
Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.
- **More confidence.**
Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.
- **More flexibility.**
Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.

Get Started Today!

Registering is safe and simple. Your information is secure and confidential. Please have your member ID number or SSN available.

- Go to express-scripts.com and select **Register**, or download the **Express Scripts mobile app** for free from your mobile device's app store and select **Register**.
- Complete the information requested, including personal information and member ID number or Social Security number (SSN). Create your username and password, along with security information in case you ever forget your password.
- Click **Register now** and you're registered.
- To set preferences,² select **Communication Preferences** from the menu under **Account**, then scroll to **Communication** and **Viewing Preferences**. Click **Edit preferences**. Preferences can only be selected via the member website.

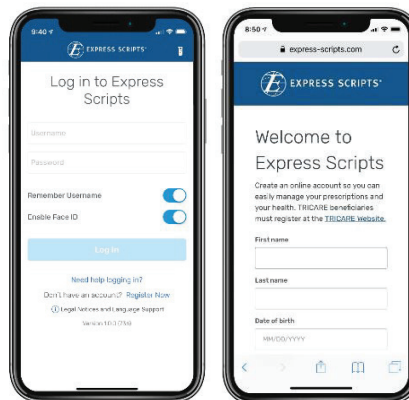
Members who have **touch or facial ID authentication** on their mobile devices can enable it to log in to their Express Scripts account on the mobile app, if desired.

¹ Standard shipping costs are included as part of your prescription plan benefit.

² Preferences include the option to share your prescription information with other adult members of your household (aged 18+) covered under your prescription drug plan.

- All covered adults (aged 18+) in the household need to register separately.
- When you grant permission to share your prescription information with other registered household members, they can view your information, place orders on your behalf and more.

The Express Scripts mobile app is available for iPhone®, iPad®, and Android™ mobile devices.

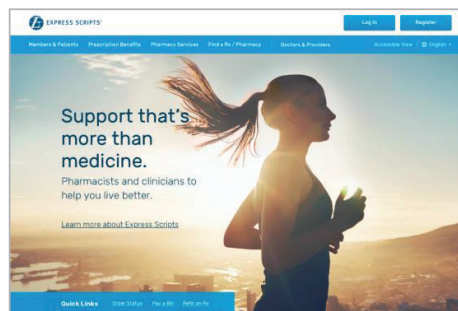


Getting Started with Home Delivery from the Express Scripts PharmacySM

Online access to savings and convenience

Whether you are viewing the member website or using the Express Scripts[®] mobile app,¹ you can easily manage your home delivery prescriptions:

- Check order status
- Refill and renew prescriptions
- Check prices and coverage
- Find convenient pharmacies
- View your Rx claims and balances
- Pay your balance using a variety of payment options
- View our therapeutic resource centers for information
- And much more



To access the member website ...

Log in to express-scripts.com (Register if it is your first visit. Just have your member ID or SSN handy.)

If you have a NEW prescription ...

Get started by contacting your doctor to request a 90-day prescription that he or she can e-prescribe directly to Express Scripts

Or print a form by selecting “Forms & Cards” from the menu under “Benefits.” Print a mail order form and follow the mailing instructions.

Or call us and we'll contact your doctor for you.

Please allow 10 to 14 days for your first prescription order to be shipped.

Forms & cards

To mail in a prescription your doctor has already written:

1 Print a mail order form by [clicking here](#)

2 Mail your prescription(s) along with completed form to the address provided on the mail order form

If you already have a prescription ...

Check Order Status online or using our app to view details and track shipping.

Transfer retail prescriptions to home delivery. Just click **Add to Cart** for eligible prescriptions and check out. We'll contact your provider on your behalf and take care of the rest. Check **Order Status** to track your order.

Recent Order Status			
Toprol XL 200 mg tablet 200 mg, brand View details	Rx #: 123-	Chris	Go to full order status Address Verification Required
Harvoni 90-400 mg tablet 90 mg - 400 mg, brand View details	Accredo Rx #: 297-44	Shipped on XX/XX/XXXX Tracking # 937482011e4600649231480	

Prescriptions You Can Order Today			
Find a prescription not listed below View Rx Archive			
Chris			
Omeprazole dr 10 mg capsule 10 mg, generic View details	Rx #: 123 90-day supply 2 refills remaining	Refill past due You may be running low on this medication	<input checked="" type="checkbox"/> Prescription in cart

Refill and Renew Prescriptions for yourself and your family while online or while using our app. Just click **Add to Cart** for eligible prescriptions and check out. We'll contact your provider on your behalf, if renewals are included, and take care of the rest.

¹ You can search for “Express Scripts” in your app store and download it for free. Then register, if first visit, or log in.
© 2019 Express Scripts. All Rights Reserved. Express Scripts and the “E” Logo are trademarks of Express Scripts Strategic Development, Inc.



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

Get all your answers **quick** and **easy** @ umr.com

Make umr.com your first stop

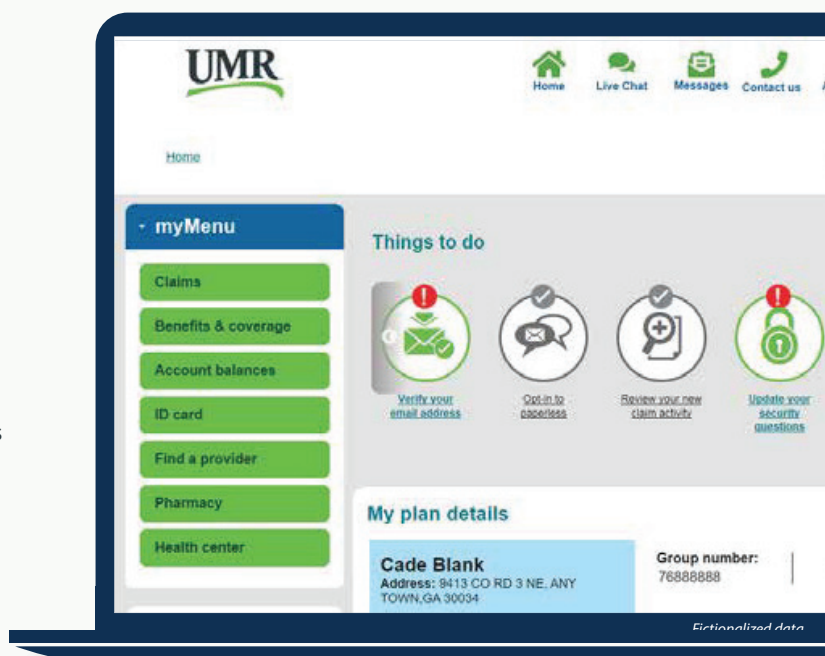
You want managing your health care to be fast and easy, right? You got it. At umr.com, you'll find everything you want to know – and need to do – as soon as you log in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

- View **Things to do**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

Note: The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.



The **UMR app** is another way we're reimagining health care to work for you.

We have a smarter, simpler, faster way to manage your health care benefits, right from the palm of your hand.

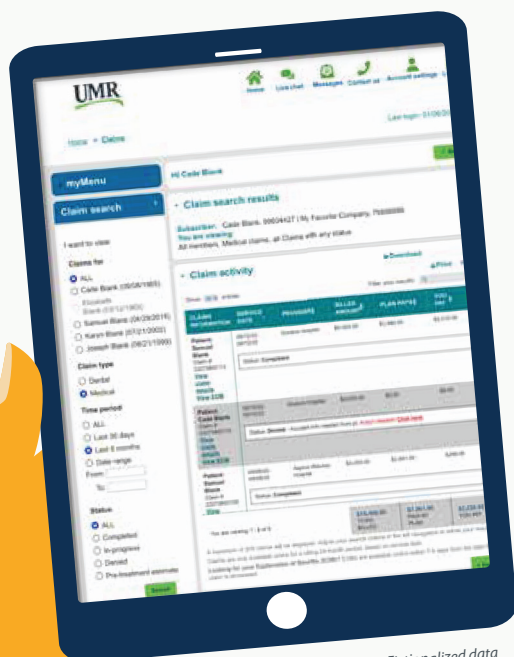
With just a tap, you can:

- Access your digital ID card
- View your plan details on-demand – anytime, anywhere
- Find out if there is a co-pay for your upcoming appointment
- Chat, call or message UMR's member support team

Stay connected to your health care and download the UMR app today!

Simply scan the QR code to the left or visit your app store to get started.





Fictionalized data

You don't need a Ph.D. to understand your benefits

We've made it easy to find the top things people want to know. Choose **Benefits & coverage** from **myMenu** to find out:

- What health care services are covered?
- What's the cost difference between an in-network and out-of-network service?
- What's your deductible, and are you close to reaching it?
- Is there a co-payment for your office visit? If so, how much?

Buried in paperwork? A single click lets you track all your claims

Check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, click **view claim details** or **view EOB**. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure e-mail any time you have a new EOB. If you're not ready to give up paper completely, you can print out copies from our claims center.

Don't be surprised by unexpected costs

- Know the price you'll pay ahead of time. Search treatments or procedures in the **Health cost estimator**.
- Get your in-network discount. Use **Find a provider** to look up doctors and facilities near you.

©2023 United HealthCare Services, Inc. UM0106-2PG 0123 UA (FS0737)
This content is provided for information only and is not to be considered medical advice. All decisions about medical care should be made by the doctor and patient. Always refer to the plan document for specific benefit coverage or call the toll-free member phone number on the back of your health plan ID card. UMR operates in accordance with medical privacy standards established by applicable federal and state laws. The screen shots shown are for illustrative purposes and use fictional data only.



A UnitedHealthcare Company

Looking for a health care provider?

Compare quality and costs before you go

The next time you're in the market for a new doctor or are wondering how much you'll pay for a possible medical procedure, visit **umr.com** first. Your online services make it easy to look up UnitedHealthcare network providers and health care facilities and find cost estimates for different services – all in one place.

You'll get the information you need to make the right choices for you and your family and know what to expect before making an appointment.

Stay in-network

With **umr.com**, you have anytime access to a searchable directory of UnitedHealthcare network providers in your area. Choosing a doctor or facility in the network ensures your benefits are paid at the highest level, so you can expect to pay less out of your own pocket. And when you go to a network provider for preventive services, there's typically no cost to you.



START SHOPPING TODAY

Log in to **umr.com** and select Find a provider.

Then choose View providers to search for medical providers. Or log in and look for the health cost estimator shopping cart icon to get started.

Find Health Care by Category



People

Doctors, medical groups, and other professionals by specialty



Places

Hospitals, clinics, labs, imaging centers, medical suppliers



Services and Treatments

Providers for office visits, tests, treatments, surgeries



Care by Condition

Find care for common concerns



Cost Estimates

Treatment for common conditions

You can narrow your search to primary care providers or look up physicians by specialty. Then select a physician from your search results to learn more about where they went to school, where they practice and how to schedule an appointment.

Check for quality

The two blue hearts next to a doctor's name tells you they are a Premium Care Provider who has been reviewed by UnitedHealthcare and meets quality standards for delivering cost-effective care.

You may also see star ratings for customer satisfaction based on reviews from previous patients.

Understand the costs

Different providers may charge different amounts for the services they offer. Your search results will give you a range of the average costs for preventive care or medical procedures in your area. And the individual provider listings show whose costs are below, above, or meet the local average.

If a procedure typically includes multiple steps of treatment, you can review the total cost and your estimated out-of-pocket cost for each step. So you'll know what to expect, from start to finish.

Your estimated out-of-pocket costs are personalized to you, based on your own benefit plan's deductible, annual out-of-pocket max, co-pay, co-insurance and how much you've paid toward your deductible.

Abcd, Michael E, DO
Family Practice, Urgent Care Medicine

123 Any Street
Any City, WA 55555
12.2 Miles Away | Get Directions

(555) 555-5555 Home
711 pm

Additional Locations (0)

Premium Care Physician

Accepting All Patients

In-Network Provider

★★★★★ 14 Reviews

You May Own
\$176
Monthly Average Cost

United Healthcare

Doctor's office visit, long - 99214 (CPT)
Cost range in your area: \$87 - \$114

In network Compare out of network

Jack's estimated cost

Your estimated out-of-pocket cost **\$25**
Below Average Cost

Total cost before coverage \$83
Your health plan pays \$58
You may pay \$25

Costs included in this estimate
How do these providers and facilities choose? | Learn more

1. Doctor's office visit, long [Change doctor](#)

Provider	Estimated Total Cost	Your Estimated Cost
Michael E. Abcd, DO Internal Medicine	\$83	\$25 <small>Below Average</small>

Additional Information

[Learn more about this procedure](#)

[Explanation of Costs](#)

Your current plan summary

Jack's in-network deductible
\$800 of \$800 spent

Jack's in-network out-of-pocket maximum
\$13,112 of \$13,112 spent



A UnitedHealthcare Company

YOUR PLAN ADVISOR

Ready to connect – and guide you to the answers you seek



Health care in the modern world calls for a sensitive, personal approach to service – one that’s built on real relationships and trust.

Which is why Plan Advisor delivers an experience that’s beyond traditional models of member support. Our advisors partner with you so you feel more confident in the decisions you make about your health, and comforted by the steps you’re taking to get there.

Because we all need a person we can rely on.
Let your Plan Advisor be yours.

Connecting you to the care you need

Whether your question is common or complex, we make it easier for you to get answers by ensuring you have the information you need.

Keeping it real

Your plan advisor is an actual person who’s focused on serving you, equipped with knowledge and options to support and anticipate your unique needs and goals.

We’re in it with you

If you need something that’s out of our reach, we’ll connect you to the resources you need – and we’ll even stay on the call as long as you need.



Plan Advisor

Your personal guide to all things health care



Dedicated to
YOU

To connect with your Plan Advisor, call the number on the back of your member ID card.



**VISIT US ANYTIME
ONLINE AT UMR.COM**

Sign up for online services and get quick and easy access to your claims and benefit information.

With **umr.com**, you can:

- ▶ Look up network providers
- ▶ Check your claims activity
- ▶ Review your financial activity
- ▶ Find tools for improving your health

You can even log in on the go with your smart phone or mobile device.



We're ready when you are

Here are some of the ways we can help:

Finding the right fit is important. We can help

Finding the right provider can feel daunting. We'll match you to high-quality health care providers and the highest level of benefits – right where you live – to avoid paying more than you need to. We can schedule appointments with providers, and identify possible health screenings or preventive care.

Know your coverage – and costs

Navigating health care can be tricky, which is why no question is a bad one. Your plan advisor is ready to go over your benefit details with you, or connect you to the right person to find the answer you need, so you won't be caught by surprise.

We'll help you:

- Look into a recent medical claim to make sure it was paid correctly
- Check to see what your out-of-pocket costs are for services
- See how much you have paid – and how much you have left – of your individual or family deductible
- Understand reward programs available to you
- Discover what services are available to you based on your plan

Let's talk

Our plan advisors are available weekdays from 7:30 a.m. to 5:00 p.m. Central Time at 800-207-3172.



A UnitedHealthcare Company



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



Mammogram*

Cervical cancer (Pelvic exam/pap smear)

Bone mineral density (osteoporosis)

Blood pressure

Cholesterol

Obesity/BMI

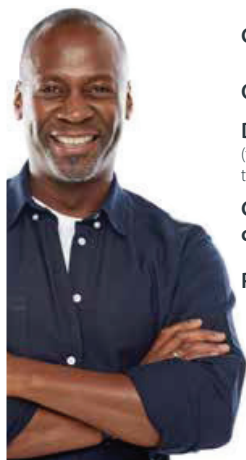
Diabetes (fasting plasma glucose test recommended)

Colorectal cancer

	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.

Tests for men


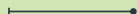






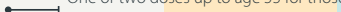





Age range	18-39	40-49	50-64	65 +
Blood pressure	At least every two years; or annually if your blood pressure is higher than 120/80			
Cholesterol		Regular screenings 40-75 years. Ask your health care provider for recommended frequency		
Obesity/BMI	Regular screenings; a BMI of 25 to 29.9 is considered 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](https://www.cdc.gov/vaccines).

Age range	19-26	27-49	50-59	60-64	65 +
Tetanus/diphtheria (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*		* Not to be given during pregnancy	
	 Gardasil9 to age 45				
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.

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 ↓



Use Last 4 SSN to log in.

Dental Insurance

Administered by UnitedHealthcare

UnitedHealthcare is the new claims administrator of dental benefits for Earlham College.

	Low Plan		High Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible (Individual / Family)	None	None	\$50 / \$150	\$50 / \$150
Annual Calendar Year Benefit Maximum	\$750 per person	\$750 per person	\$2,000 per person	\$2,000 per person
Diagnostic and Preventive Services (cleanings / exams / x-rays / sealants / fluoride treatment / space maintainers)	100%	100%	100%	100%
Basic Services				
Emergency Treatment / General Services	50% after deductible	50% after deductible	80% after deductible	80% after deductible
Minor Restorative / Fillings, Crown Repair	50% after deductible	50% after deductible	80% after deductible	80% after deductible
Simple Extractions	50% after deductible	50% after deductible	80% after deductible	80% after deductible
Complex Oral Surgery	Not covered	Not covered	80% after deductible	80% after deductible
Endodontics	Not covered	Not covered	80% after deductible	80% after deductible
Periodontics	50% after deductible	50% after deductible	80% after deductible	80% after deductible
Restorative Services	Not covered	Not covered	80% after deductible	80% after deductible
Major Services (inlays / onlays / crowns / implants / dentures / bridgework)	Not covered	Not covered	80% after deductible	80% after deductible
ORTHODONTIA SERVICES (COVERED TO AGE 19)				
Braces	Not covered	Not covered	50%	50%
Orthodontia Benefit Maximum	Not covered	Not covered	\$1,500	\$1,500

- Oral exams and cleanings are payable 2 times in 12 months.
- 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.



Vision Insurance

Administered by VSP

Earlham College provides 2 affordable eye care plans under VSP.

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.

	Core Plan		Buy Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
WellVision Eye Exam (once every 12 months)	\$10 Exam copay applies	Up to \$45 reimbursement	\$10 Exam copay applies	Up to \$45 reimbursement
Eyeglass Frames	(once every 24 months) \$25 Materials copay applies; Copay up to \$130 frame allowance (\$150 featured brand allowance); 20% savings for frames on amounts over allowance	Up to \$70 reimbursement	(once every 12 months) \$25 Materials copay applies; Copay up to \$130 frame allowance (\$150 featured brand allowance); 20% savings for frames on amounts over allowance	Up to \$70 reimbursement
Eyeglass Lenses (once every 12 months)				
VSP® EasyOptions	N/A		Choice of One Upgrade (\$230 Frame Allowance OR Anti-Reflective Coating OR Photochromic Lenses OR Premium Progressive Lenses)	
VSP LightCare™	N/A		Visit a VSP network doctor and choose either prescription eyewear coverage, or use your frame and lens allowance toward ready-to-wear: • non-prescription sunglasses or • non-prescription blue light filtering glasses	
Standard Plastic Single Vision Lenses	Included	Up to \$30 reimbursement	Included	Up to \$30 reimbursement
Standard Plastic Bifocal Lenses	Included	Up to \$50 reimbursement	Included	Up to \$50 reimbursement
Standard Plastic Trifocal Lenses	Included	Up to \$65 reimbursement	Included	Up to \$65 reimbursement
Lenticular Lenses	Included	Up to \$100 reimbursement	Included	Up to \$100 reimbursement
Standard Progressive Lenses	Included	Up to \$50 reimbursement	Included	Up to \$50 reimbursement
EYEGLASS LENSES ENHANCEMENTS				
Premium Progressive Lenses	\$95 – \$105	No allowance on lens enhancements when obtained out-of-network	\$95 – \$105	No allowance on lens enhancements when obtained out-of-network
Custom Progressive Lenses	\$150 – \$175		\$150 – \$175	

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

	Core Plan		Buy Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
CONTACT LENSES INSTEAD OF GLASSES				
Elective Contact Lenses	Included in copay up to \$130 allowance	\$105 allowance	Included in copay up to \$130 allowance	\$105 allowance
Non-Elective Contact Lenses	Covered in full after copay	\$210 allowance	Covered in full after copay	\$210 allowance

EXTRA SAVINGS:

- » 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
- » \$39 max copay on routine retinal screening
- » **Laser Vision Correction** - Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.



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

A Vision Plan With A Personalized Twist



You and your eyes are unique, so your vision coverage should be too. With VSP® EasyOptions, it's easy and affordable to personalize your benefits.

Personalized Coverage for All

Everyone on your plan gets the comprehensive vision coverage you expect, like eye exams, glasses, and savings on lens upgrades. Plus, with VSP EasyOptions, you get to choose your coverage from a variety of covered upgrades during your in-network doctor's visit.

Here's
How It
Works:



Create an account on **vsp.com**.



Schedule an eye exam with a VSP network doctor.



Choose an upgrade at your doctor's visit.

Meet the Smiths.

See how they personalized their coverage.



Mom chose anti-glare lenses to help reduce glare and eye strain.

Jada chose light-reactive lenses that are dark outdoors and clear indoors.

Dad chose progressive lenses to help him see near and far.

Choose Your Upgrade

\$230 Frame Allowance
OR
Anti-glare Lenses
OR
Progressive Lenses
OR
Light-reactive Lenses

Check your member benefits summary for plan details.
Visit **vsp.com** or call **800.877.7195**.

Put your eyes at ease with VSP LightCare

Why UV and Blue Light Coverage?

Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health.

With VSP LightCare™, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor. Sunglasses or blue light filtering glasses may be just what you're looking for.

KEEP YOUR EYES PROTECTED OUTDOORS AND IN:

Always wear sunglasses outdoors. Protect your eyes from the sun's ultraviolet rays that can damage your corneas and cause eye-related diseases like cataracts. 100% UVA and UVB protection is the best choice for your sunglasses.² Wear blue light filtering glasses indoors to combat digital eye strain. Digital screens and fluorescent lighting emit blue light that can contribute headaches, blurred vision, and sore eyes—all possible symptoms of digital eye strain.

PROVIDER CHOICES YOU WANT

The VSP Premier Program includes thousands of **private practice doctors** and more than 700 **Visionworks® retail locations** nationwide.



Prefer to shop online?

At **eyeconic.com®**, you'll be shopping at the preferred online retailer for VSP members where you can connect and use your benefits.³



Your VSP LightCare
Coverage with a
VSP Network Doctor*

Eye Exam

A fully covered comprehensive WellVision Exam®.¹

Eyewear

Visit a VSP network doctor and choose either prescription eyewear coverage, or use your frame and lens allowance toward ready-to-wear:

- non-prescription sunglasses *or*
- non-prescription blue light filtering glasses

*Register and log in to **vsp.com** to review your benefit information. Based on applicable laws; benefits may vary by location.

Questions? vsp.com | 800.877.7195

1. Less any applicable copay 2. Tips for Choosing the Best Sunglasses, American Academy of Ophthalmology, June 2021 3. To find out whether your employer participates in Eyeconic®, log in to **vsp.com** to check your vision benefits.

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VSP LightCare is a trademark of Vision Service Plan.
All other brands or marks are the property of their respective owners. 103187 VCCM

Classification: Public

Health Savings Account

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 2025

For 2025, the maximum HSA contribution limits are:

- » \$4,300 for single coverage (Earlham College contributes \$1,000; Employee maximum contribution is \$3,150)
 - » \$8,550 for all other coverage tiers (Earlham College contributes \$2,000; Employee maximum contribution is \$6,300)
- 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 event 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.



Flexible Spending Account

Earlham College sponsors a Flexible Spending Account (FSA). An FSA 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 FSA plan is administered by Chard Snyder: (www.chard-snyder.com).

Once registered you can safely and securely submit claims for reimbursement or manage your flexible spending account.

Download the Chard-Snyder Mobile App for iPhone, iPad, iPod Touch and Android at the App Store or on Google Play.

- » Chard-Snyder 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 2025 IRS maximum plan year election is \$3,200. Contributions and carry-over amounts are subject to change based on IRS guidelines.

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 and Accidental Death & Dismemberment (AD&D) Insurance

Provided by Guardian

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 and 50% at age 70.

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 Accidental Death & Dismemberment (AD&D) Insurance

Provided by Guardian

You can purchase additional life and AD&D insurance for yourself, your spouse and your children.

Voluntary 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 14 days: \$100
14 days 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 \$200,000 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** is not applicable to Evidence of Insurability.

Evidence of Insurability (EOI) is required when:

- » Enrolling as a new hire and requesting more than \$200,000 for Employee voluntary life coverage, or more than \$25,000 for Spouse voluntary life coverage.
- » Enrolling for any amount of new or increased voluntary life coverage outside of the new hire period.



Long-Term Disability

Provided by Guardian

Earlham pays 100% of your Long-Term Disability insurance premium for employees with more than 1 year of Service.

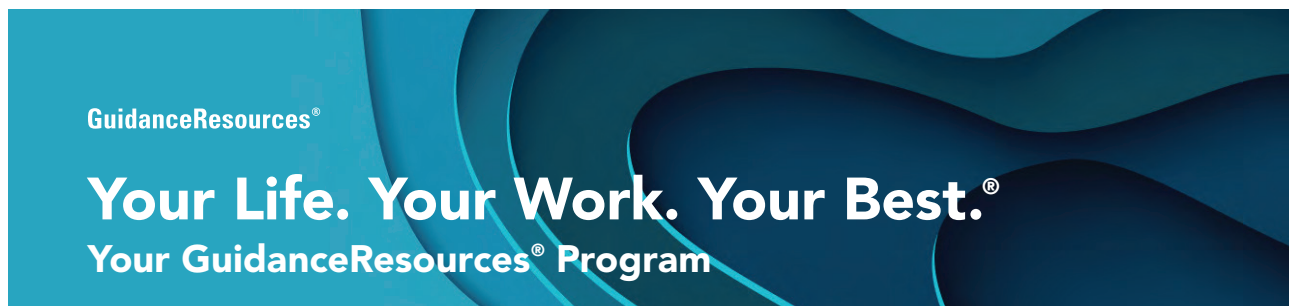
Monthly Benefit	60% of Pre-Disability Earnings
Maximum Monthly Benefit	\$4,000
Minimum Monthly Benefit	\$100
Benefit Begin	181st day after Disability
Benefit Duration	Social Security Retirement Age (if disabled prior to age 60)
Definition of Total Disability: Inability to perform each of the main duties 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.	

For employees with less than 1 year of Service (working at least 30 hours per week) have the option to purchase Long Term Disability insurance. The monthly rate per \$100 monthly covered payroll is \$0.221. To calculate cost: \$0.221 times your monthly gross earnings divided by \$100 = Monthly Voluntary Long-Term Disability Cost.



Employee Assistance Program (EAP)

Provided by Guardian



Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych® GuidanceResources® program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

Services:

Confidential Emotional Support

3 face-to-face or virtual sessions per person, per issue, per year

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support

- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Guidance

- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local representation

Financial Resources

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Digital Support

- Connect to counseling, work-life support or other services
- Tap into an array of articles, podcasts, videos, slideshows
- Improve your skills with On-Demand trainings

Online Will Preparation

- Quickly and easily complete a will on your computer with EstateGuidance®
- Specify guardians, trustees and property division
- Provide funeral and burial instructions

Wellness Support

Flexible 3-5 coaching session model

- Make positive lifestyle changes with health coaching
- Improve your nutrition, exercise habits, weight loss efforts
- Get help with smoking cessation, back care, resiliency and more

Life is challenging. We can help.
Confidential 24/7 support.

COMPSYCH®
GuidanceResources® Worldwide

Guardian®



24/7 Live Assistance:
Call: (855) 239.0743
TRS: Dial 711



Online: guidanceresources.com
App: GuidanceNowSM
Web ID: Guardian

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Voluntary Accident Insurance

Provided by Guardian

Voluntary Accident Insurance is there for you in the event of an unexpected accidental injury off-job only. Guardian can help protect your personal finances by providing individuals and families affordable insurance that helps with expenses that may not be covered by major medical insurance. Guardian pays cash benefits directly to you, unless otherwise assigned, to use for anything you need. Coverage is available for an Employee (\$20,000), Spouse (\$10,000) and Children (\$5,000). An annual Wellness (Health Screening) Benefit is also available.

Voluntary Critical Illness Insurance

Provided by Guardian

Lump Sum Critical Illness Insurance can help with the treatment costs of certain illnesses and health events allowing you to focus on recuperation instead of the distractions and stress over the costs of medical and personal bills. You will receive cash benefits directly giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses in \$10,000 increments. Coverage is available for an Employee (minimum \$5,000 up to \$30,000), Spouse (minimum \$5,000 to 100% of employee amount, up to \$30,000) and Children (50% of the employee amount). An annual Wellness (Health Screening) Benefit is also available.



**IMPORTANT: This is a fixed indemnity policy,
NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **800.318.2596** (TTY: 855.889.4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Voluntary Hospital Indemnity Insurance

Provided by Guardian

Hospital Indemnity Insurance supplements your existing health insurance coverage by helping pay expenses for hospital stays. Based on the hospital admission and confinement, hospital indemnity insurance gives you cash payments to help you pay for the added expenses that may come while you recover.



Employee Contributions

Medical, Dental and Vision 2025 Rates

Benefit Plan	Monthly Deduction
MEDICAL PLAN – UMR HIGH DEDUCTIBLE HEALTH PLAN	
Employee	1.65% of gross pay, pre-tax
Employee + Spouse	5.55% of gross pay, pre-tax
Employee + 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 + Spouse	5.55% of gross pay, pre-tax
Employee + 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 RATES – UNITEDHEALTHCARE HIGH PLAN	
Employee	\$38.41
Employee + Spouse	\$79.06
Employee + Child(ren)	\$107.22
Family	\$149.18
DENTAL RATES – UNITEDHEALTHCARE LOW PLAN	
Employee	\$14.73
Employee + Spouse	\$29.07
Employee + Child(ren)	\$45.61
Family	\$59.94
DENTAL RATES WITH MEDICAL COVERAGE – UNITEDHEALTHCARE HIGH PLAN	
Employee	\$26.89
Employee + Spouse	\$55.34
Employee + Child(ren)	\$75.05
Family	\$104.43
DENTAL RATES WITH MEDICAL COVERAGE – UNITEDHEALTHCARE LOW PLAN	
Employee	\$0.00
Employee + Spouse	\$20.35
Employee + Child(ren)	\$31.93
Family	\$41.96
VISION RATES – VISION SERVICE PLAN (VSP) CORE	
Employee	\$8.09
Employee + Spouse	\$13.62
Employee + Child(ren)	\$13.90
Family	\$22.41
VISION RATES – VISION SERVICE PLAN (VSP) BUY UP	
Employee	\$13.27
Employee + Spouse	\$22.34
Employee + Child(ren)	\$22.81
Family	\$36.77

Employee Paid Life / AD&D Insurance Rates

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 & Dismemberment

Per \$1,000 of Benefits	\$0.017
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*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

Voluntary Accident, Voluntary Critical Illness and Voluntary Hospital Indemnity 2025 Rates

Voluntary Accident Monthly Rates		
	Plan #1	Plan #2
Employee	\$8.44	\$11.10
Employee & Spouse	\$13.71	\$18.00
Employee & Child	\$14.25	\$18.24
Family	\$19.52	\$25.14

Voluntary Hospital Indemnity Monthly Rates	
Employee	\$9.97
Employee & Spouse	\$19.66
Employee & Child	\$15.80
Family	\$25.50

Voluntary Critical Illness Monthly Rates						
Benefit Amounts	<30	30-39	40-49	50-59	60-69	70+
\$10,000	\$3.10	\$5.00	\$9.10	\$16.80	\$27.50	\$45.80
\$20,000	\$6.20	\$10.00	\$18.20	\$33.60	\$55.00	\$91.60
\$30,000	\$9.30	\$15.00	\$27.30	\$50.40	\$82.50	\$137.40

Note: Child cost is included with employee election.

Glossary of Health Insurance and Medical Terms

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.)

Prior authorization. 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.



Important Disclosures

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 stages 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 physical 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. Therefore, the following deductibles and coinsurance apply:

High Deductible Plan:

\$3,500 deductible (in-network) and 100% coinsurance (in-network)
\$7,000 deductible (out-of-network) and 70% coinsurance (out-of-network)

Traditional PPO Plan:

\$1,450 deductible (in-network) and 90% coinsurance (in-network)
\$3,200 deductible (out-of-network) and 70% coinsurance (out-of-network)

If you would like more information on WHCRA benefits, please call your Plan Administrator:

Human Resources
Earlham College – Human Resource Bldg. 301
Email: HR@Earlham.edu
Ph: 765.983.1619

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid http://myalhipp.com 855.692.5447	IOWA – Medicaid and CHIP (Hawki) Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp 888.346.9562
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	KANSAS – Medicaid https://www.kancare.ks.gov/ 800.792.4884 HIPP Phone: 800.967.4660
ARKANSAS – Medicaid http://myarhipp.com 855.MyARHIPP (855.692.7447)	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://kynect.ky.gov 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
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	LOUISIANA – Medicaid www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
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.mycohibi.com/ HIBI Customer Service: 855.692.6442	MAINE – Medicaid Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 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
FLORIDA – Medicaid www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html 877.357.3268	MASSACHUSETTS – Medicaid and CHIP https://www.mass.gov/masshealth/pa 800.862.4840 TTY: 711 Email: masspreassistance@accenture.com
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	MINNESOTA – Medicaid https://mn.gov/dhs/health-care-coverage/ 800.657.3672
INDIANA – Medicaid Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ 800.457.4584	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: HSHIPPProgram@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 HIPPA program: 800.852.3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ Email: upp@utah.gov 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPPA (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, 2024, 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 1/31/2026)

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

HIPAA Notice of Privacy Practices Reminder

PROTECTING YOUR HEALTH INFORMATION PRIVACY RIGHTS

Earlham College is committed to the privacy of your health information. The administrators of the Earlham College Group Health Benefit Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources | HR@Earlham.edu | 765.983.1619.

HIPAA Special Enrollment Rights

ICIBC – EARLHAM COLLEGE GROUP HEALTH BENEFIT PLAN

NOTICE OF YOUR HIPAA SPECIAL ENROLLMENT RIGHTS

Our records show that you are eligible to participate in the ICIBC – Earlham College Group Health Benefit 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 Premium Assistance Under 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 Human Resources | HR@Earlham.edu | 765.983.1619.

General FMLA Notice

GENERAL NOTICE POSTER

Every employer covered by the FMLA must provide a general notice to employees regarding the FMLA. Satisfying this requirement is twofold. Employers must first display or post a general notice (referred to as a poster), and, second, if the employer has any FMLA eligible employees, the employer must provide a written General Notice to employees (discussed in the next section). The poster must be displayed even if no employees are currently eligible for FMLA leave. This should not be taken to mean that the posting requirement applies to all employers regardless of whether the employer is subject to the FMLA. Rather, the posting requirement applies to employers subject to the FMLA even if they do not have employees eligible for FMLA leave. The posting must satisfy the following requirements:

- » The poster must be displayed in plain view where all employees and applicants can readily see it and must have large enough text so it can be easily read.
- » The information displayed on the poster must explain the FMLA provisions and provide information on how to file a complaint with the DOL Wage and Hour Division.
- » If a significant portion of an employer's employees do not read and write English, the employer must provide the poster in a language in which they can read and write. When providing FMLA notices to sensory-impaired individuals, employers must also comply with all applicable requirements under federal and state law.

You may make the poster available electronically, create your own poster, or use another format, as long as the information provided includes, at a minimum, all the information contained in the DOL's model FMLA Poster and meets all other posting requirements. Of course, you may use the DOL's FMLA Poster, which is free and publicly available at the following link (<https://www.dol.gov/whd/regs/compliance/posters/fmla.htm>).

Spanish language FMLA posters are available online from the DOL as well: (<https://www.dol.gov/whd/regs/compliance/posters/fmlaspan.htm>).

Employers who willfully violate this posting requirement may be assessed a civil money penalty for each separate offense.

GENERAL NOTICE TO EMPLOYEES

In addition to displaying a poster, if a covered employer has any FMLA eligible employees, it must also provide each employee with a General Notice about the FMLA in the employer's employee handbook or other written materials about leave and benefits. If no handbook or written leave materials exist, you must distribute this General Notice to each new employee upon hire.

This general notice requirement can be met either by duplicating the general notice language found on the DOL's FMLA Poster or by using another format as long as the information provided includes, at a minimum, all the information contained in the DOL's FMLA Poster (please refer to the links provided in the previous section to access the model DOL FMLA Poster). The General Notice may be distributed electronically provided all the requirements of the FMLA Poster are met.

Notice of Creditable Coverage

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.

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—Office:	Human Resources – Human Resource Bldg. 301
Office Address:	801 National Rd W Richmond, IN 47374
Phone Number:	765.983.1619



YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590

Publication Date — April 2017

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

No Surprise Act Notice

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

WHAT IS “BALANCE BILLING” (SOMETIMES CALLED “SURPRISE BILLING”)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. “Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. “Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in [1] network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

<https://www.in.gov/healthcarereform/no-surprises-act/>

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

<https://www.in.gov/healthcarereform/no-surprises-act/>

When balance billing isn't allowed, you also have the following protections:

- » You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- » Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit <https://www.cms.gov/files/document/memo-no-surprises-act-phone-number-and-website-url-clean-508-mm2.pdf> for more information about your rights under federal law.

MHPAEA NOTICE: This notice to employees is only needed if the employer has established a valid cost based exemption to MHPAEA based on an actuarial certification. We do not have a model form for this notice. It would simply state that the MHPAEA standards would not apply to the plan for that particular plan year.

GINA Notice

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

COBRA General Notice

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

(FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS)

****CONTINUATION COVERAGE RIGHTS UNDER COBRA****

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- » Your hours of employment are reduced, or
- » Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- » Your spouse dies;
- » Your spouse's hours of employment are reduced;
- » Your spouse's employment ends for any reason other than his or her gross misconduct;
- » Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- » You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- » The parent-employee dies;
- » The parent-employee's hours of employment are reduced;
- » The parent-employee's employment ends for any reason other than his or her gross misconduct;
- » The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- » The parents become divorced or legally separated; or
- » The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- » The end of employment or reduction of hours of employment;
- » Death of the employee; or
- » The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this notice to:

Human Resources
Earlham College – Human Resource Bldg. 301
Email: HR@Earlham.edu
Ph: 765.983.1619

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- » The month after your employment ends; or
- » The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Human Resources
Earlham College – Human Resource Bldg. 301
Email: HR@Earlham.edu
Ph: 765.983.1619

Marketplace Notice

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

WHEN CAN I ENROLL IN HEALTH INSURANCE COVERAGE THROUGH THE MARKETPLACE?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 800.318.2596. TTY users can call 855.889.4325.

WHAT ABOUT ALTERNATIVES TO MARKETPLACE HEALTH INSURANCE COVERAGE?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency.

Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Human Resources

Earlham College – Human Resource Bldg. 301

Email: HR@Earlham.edu

Ph: 765.983.1619

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Earlham College		4. Employer Identification Number (EIN) 35-0868073	
5. Employer address 801 National Rd W		6. Employer phone number 765.983.1619	
7. City Richmond	8. State IN	9. ZIP code 47374	
10. Who can we contact about employee health coverage at this job? Human Resources			
11. Phone number (if different from above)		12. Email address HR@Earlham.edu	

Here is some basic information about health coverage offered by this employer:

» As your employer, we offer a health plan to:

- ☒ **Some employees. Eligible employees are:**
All full-time employees working 30 or more hours per week.

» With respect to dependents:

- ☒ **We do offer coverage. Eligible dependents are:**
Legal spouse, Domestic Partner and dependent children to age 26

- ☒ **If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.**

**** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.**

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

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.



Notes

Notes

Earlham

COLLEGE

This benefit guide prepared by



Gallagher

Insurance | Risk Management | Consulting