READY, SET, ENROLL

THE CLAREMONT COLLEGES

2023 BENEFITS

Pomona College · Claremont Graduate University · Scripps College · Claremont McKenna College · Harvey Mudd College · Pitzer College · KGI Keck Graduate Institute · The Claremont Colleges Services · California Botanic Garden

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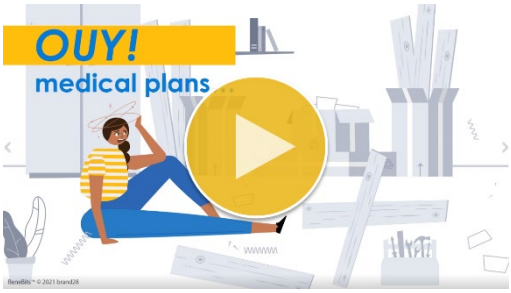
MEDICARE PART D NOTICE

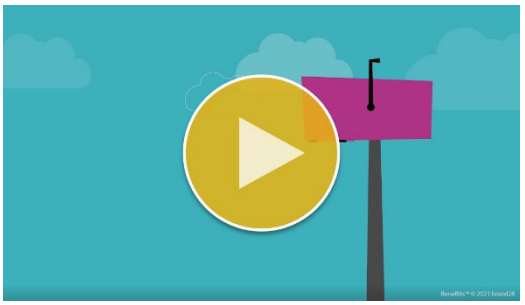
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notices section for more details.

VIDEO LIBRARY

All About Medical Plans



Balance Billing



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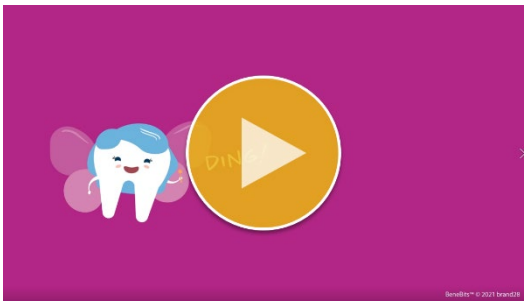

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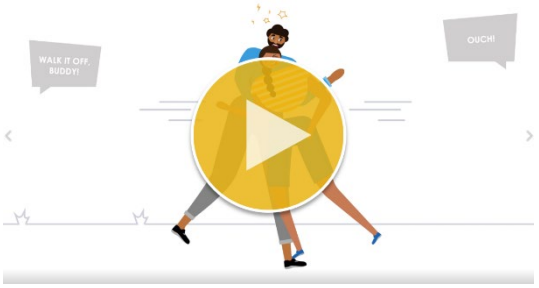

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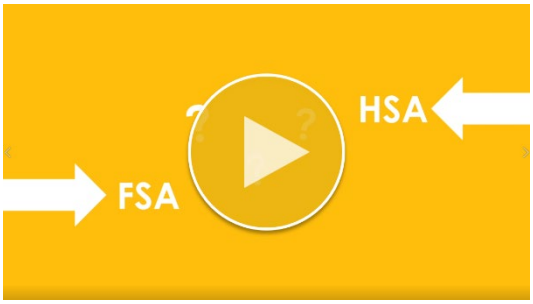

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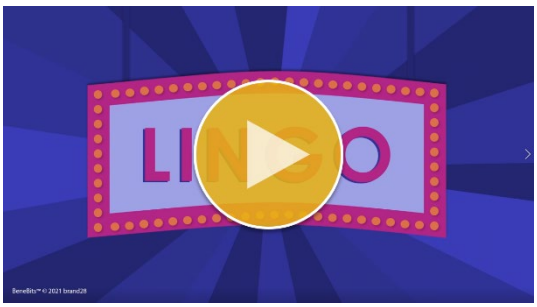

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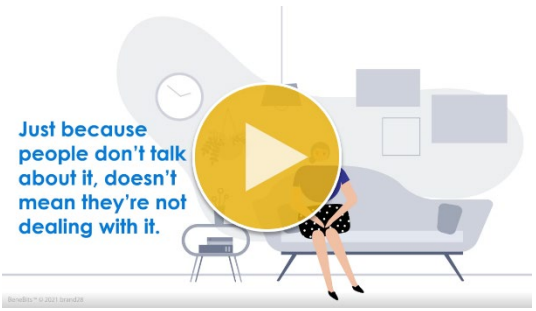

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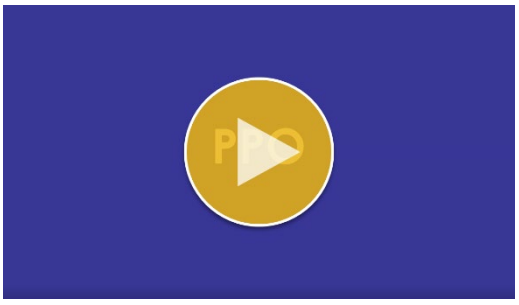

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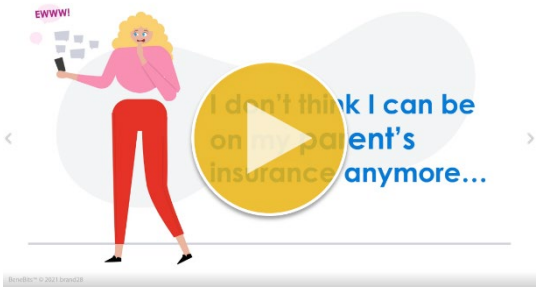


Vision

GETTING STARTED

2023 BENEFITS
January 1, 2023
through
December 31, 2023

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, The Claremont Colleges supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

WHEN YOU CAN ENROLL

You can enroll in benefits as a new hire or during the annual open enrollment period. You must enroll within 31 days following your Benefits Eligibility Date.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason). If you enroll late, premiums will be deducted back to the effective date of coverage.

Employees

You are eligible if you are a regular employee scheduled to work at least 20 hours per week, or a California Botanic Garden employee who is scheduled to work at least 30 hours per week.

Benefit-eligible employee is defined as:

- A faculty member who is scheduled to work at least half-time for at least one semester, with the exception of adjunct faculty at Claremont Graduate University (CGU), or
- A faculty member who is scheduled to teach at least three classes over the academic year, or
- A staff member in a regular position who is scheduled to work at least 20 hours per week, or
- A benefits-eligible, grant based employee at CGU, as follows:
    - An employee hired in a position that is funded by a grant specifically including employer expense for benefit coverage, AND
    - The employee meets the required number of scheduled work hours defined above, or
- California Botanic Garden staff members in a regular position who are scheduled to work 30 or more hours per week.

Eligible dependents

- Spouse
- Domestic partner
- Natural, adopted or stepchildren up to age 26 Domestic partner's child(ren) are eligible
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

Domestic Partner Coverage *– The IRS does not recognize domestic partners as legal dependents for purposes of tax reporting. For this reason, The Claremont Colleges must report the value (employer subsidy) of medical benefits. Employee contributions for domestic partner benefits are made after tax.*

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs. If you enroll late, premiums will be deducted back to the effective date of coverage
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 31 days after the event.

ENROLLING FOR BENEFITS

NEED MORE INFORMATION?

Find contacts, tips, forms and more at services.claremont.edu/benefits-administration.

Workday

Workday is an online system that enables you to make all your benefit decisions in one place.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- Log onto Workday — www.myworkday.com/theclaremontcolleges
- Select your institution from the drop-down list
- Enter your network credentials (for username and password assistance, please contact your IT department)
- Check your Workday Inbox for either:
  - Change Benefits for open enrollment task; or
  - Benefits Change task (New Hires)
- Go through the enrollment process, check “I agree” at the bottom of the page, and click “Submit”
- During open enrollment, your elections will be processed and take effect on January 1; for New Hires, your elections will be sent for approval, and you will receive an email once they have been processed.

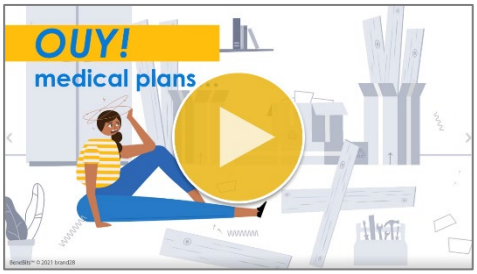
MEDICAL

OUR PLANS

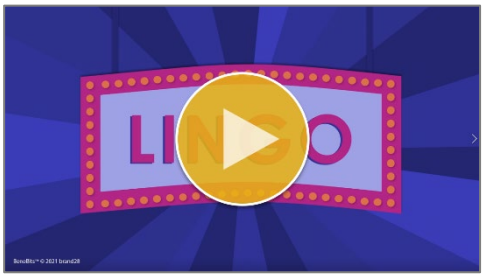
Kaiser Permanente HMO

Anthem Advantage HMO

Anthem Act Wise HDHP



All About Medical Plans



Play the Health Lingo Game!

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations. We offer 3 medical plans through Anthem Blue Cross and Kaiser Permanente.

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities (Kaiser HMO)

Consider a High Deductible Health Plan (HDHP) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings

Kaiser HMO Plan

You always pay the copayment ($) amount for selected services listed below.

	KAISER HMO PLAN
	Kaiser Permanente Network
Annual Deductible Individual Family	 N/A N/A
Annual Out-of-Pocket Maximum Individual Family	 $1,500 $3,000
Office Visit Primary Care Specialist	 $20 copay $30 copay
Preventive Services	No charge
Chiropractic	Not Covered
Lab and X-ray	No charge
Urgent Care	$20 copay
Emergency Room	$100 copay; waived if admitted
Inpatient Hospitalization	$200 copay per admission
Outpatient Surgery	$30 copay
PRESCRIPTION DRUGS	
Retail- 30 Day Supply Generic Brand Formulary	 $10 copay $25 copay
Mail Order- Up to a 100 Day Supply Generic Brand Formulary	 $20 copay $50 copay

Anthem Advantage HMO

You always pay the copayment ($) amount for selected services listed below.

	ANTHEM ADVANTAGE HMO
	Anthem Blue Cross Preferred Provider/In-Network
Annual Deductible Individual Family	 N/A N/A
Annual Out-of-Pocket Maximum Individual Family	 $1,500 $3,000 (two party) $4,500 (family)
Office Visit Preferred Provider In-Network Provider	 You pay a $15 copay (PCP) or $30 copay (specialist) You pay a $25 copay (PCP) or $40 (specialist)
Preventive Services	No charge
Chiropractic	Referral from PCP required; then Preferred Provider: $15 copay In-Network Provider: $25 copay
Lab and X-ray	No charge
Urgent Care	$15 copay Preferred / $25 copay In-Network
Emergency Room	$150 copay; waived if admitted
Inpatient Hospitalization	$300 copay per admission
Outpatient Surgery	$100 copay
PRESCRIPTION DRUGS	
Retail- 30 Day Supply Generic Brand Formulary Brand Non-Formulary	 $10 copay $30 copay $50 copay
Mail Order- 90 Day Supply Generic Brand Formulary Brand Non-Formulary	 $10 copay $60 copay $100 copay

Anthem Act Wise HDHP

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	ANTHEM ACT WISE HDHP	
	In-Network	Out-of-Network
Annual Deductible Individual Family Member Family	 $2,000 $3,000 $4,000	 $4,000 $4,000 $8,000
Annual Out-of-Pocket Maximum Individual Family Member Family	 $3,000 $3,000 $6,000	 $7,000 $7,000 $14,000
HSA Employer Contribution Individual Family	$1,000 $2,000	
Office Visit Primary Care Specialist	 20% after deductible 20% after deductible	 40% after deductible 40% after deductible
LiveHealth Online	$0 copay per visit after deductible is met	
Preventive Services	No charge	40% after deductible
Chiropractic (up to 12 visits/year)	20% after deductible	40% after deductible
Lab and X-ray	20% after deductible	40% after deductible
Urgent Care	20% after deductible	40% after deductible
Emergency Room	20% after deductible	20% after deductible
Inpatient Hospitalization	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
PRESCRIPTION DRUGS		
Deductible	Combined with medical deductible	
Out-of-Pocket Maximum	Combined with medical out-of-pocket limit	
Retail- 30 Day Supply[1,2] Tier 1a - Tier 1b Tier 2 Tier 3 Tier 4	 $5 - $15 $40 $60 30% up to $250 per Rx	 40% up to $250 after deductible 40% up to $250 after deductible 40% up to $250 after deductible 40% up to $250 after deductible
Mail Order- 90 Day Supply[1,2] Tier 1a - Tier 1b Tier 2 Tier 3 Tier 4	 $12.50 - $37.50 $75 $135 30% up to $250 per Rx	 Not Covered

[1]Preventive Rx medications are not subject to the Deductible. All other medications are subject to the deductible.
[2]Tier 1a Typically Lower Cost Generics, Tier 1b Typically Generic, Tier 2 Typically Preferred Brand, Tier 3 Typically Non-Preferred Brand, Tier 4 Typically Specialty

Compare the Medical Plans

	KAISER HMO PLAN	ANTHEM ADVANTAGE HMO	ANTHEM ACT WISE HDHP	
	Kaiser Permanente Network	Preferred Provider/In-Network	In-Network	Out-of-Network
Annual Deductible Individual Family Member Family	N/A	N/A	$2,000 $3,000 $4,000	$4,000 $4,000 $8,000
Annual Out-of-Pocket Maximum Individual Family	$1,500 $3,000	$1,500 $3,000 two party $4,500 family	$3,000 $3,000 family member $6,000 family	$7,000 $7,000 family member $14,000 family
Office Visit Primary Care	$20 copay	Preferred PCP: $15 copay In-Network PCP: $25 copay	20% after deductible	40% after deductible
Specialist	$30 copay	Preferred Specialist: $30 copay In-Network Specialist: $40 copay	20% after deductible	40% after deductible
Preventive Services	No charge	No charge	No charge	40% after deductible
Chiropractic	Not Covered	Short-term; referral from PCP required; then Preferred: $15 copay In-Network: $25 copay	20% after deductible	40% after deductible
Lab and X-ray	No charge	No charge	20% after deductible	40% after deductible
Urgent Care	$20 copay	Preferred: $15 In-Network: $25	20% after deductible	40% after deductible
Emergency Room	$100 copay; waived if admitted	$150 copay; waived if admitted	20% after deductible	20% after deductible
Inpatient Hospitalization	$200 copay/ admission	$300 copay/ admission	20% after deductible	40% after deductible
Outpatient Surgery	$30 copay	$100 copay	20% after deductible	40% after deductible
PRESCRIPTION DRUGS				
Retail- 30 Day Supply Generic Brand Formulary Brand Non-Formulary	$10 copay $25 copay N/A	$10 copay $30 copay $50 copay	Combined with medical deductible $5-$15 $40 $60	40% after deductible 40% after deductible 40% after deductible
Mail Order- Up to a 100 Day Supply Generic Brand Formulary Brand Non-Formulary	$20 copay $50 copay N/A	$10 copay $60 copay $100 copay	$12.50 - $37.50 $75 $135	Not Covered

KAISER RESOURCES

NEW KAISER FEATURE WITH CIGNA

Beginning August 2022, Kaiser HMO members have access to Cigna's national network of physicians and providers for urgent or emergency care during their travels. Call 951-268-3900 (TTY 711) for travel support anytime, anywhere (closed major holidays). To learn more about this enhancement, please visit kp.org

KAISER AWAY FROM HOME

Kaiser Members are covered for emergency and urgent care anywhere in the world. Whether you're traveling in the United States or a foreign country, Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip.

NEED MORE INFORMATION?

To access these tools and services, visit kp.org or call Member Services at 800-464-4000.

Stay engaged with your health and simplify your busy life by using the Kaiser Permanente Website.

KP Oncall

Kaiser's after hours nurse advice is available at 833-574-2273. You can speak with a licensed health care professional by phone after regular business hours on health questions, advice about seeking medical care or to let you know what to do if the medical office is closed.

myStrength

myStrength is designed to help navigate life's challenges, make positive changes, and support your overall well-being. The app can help you set goals and work towards them in the ways that work best for you. You can get myStrength at kp.org/selfcareapps and choose the mental health and wellness areas you want to focus on.

Calm

Try the Calm app for self-care and better sleep. Calm is an app that uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps .

ClassPass

Kaiser has teamed up with fitness industry leader ClassPass to make it easier for you to exercise from the comfort of your home or local gym/studio. Kaiser Permanente members can get on demand video workouts at no cost and reduced rates on livestream and in-person fitness classes. To get started, visit kp.org/exercise.

ChooseHealthy

The ChooseHealthy program provides discounts on a variety of complementary and alternative care resources. You can take advantage of reduced rates to help you stay healthy. Receive discounts on alternative care such as acupuncture or massage.

Healthy Lifestyle Programs

Kaiser offers healthy lifestyle programs for weight loss, maternity and pregnancy, smoking cessation, insomnia, diabetes, depression and stress management, and pain management

ANTHEM RESOURCES

Click to play video

LIVEHEALTH ONLINE

LiveHealth Online is your telemedicine vendor and lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. Register online and make sure to download the mobile app.

NEED MORE INFORMATION?

To access these tools and services, visit www.anthem.com/ca

Did you know that Anthem offers several programs to help you manage your healthcare? Learn more about them here.

Sydney

Meet Sydney, Anthem's mobile app. With Sydney, you can find everything you need to know about your personalized Anthem benefits all in one place. Sydney makes it easier to get things done, so you can spend more time to focus on your health.

Future Moms Program

Future Moms with Digital Maternity Support is here to give you the information, tools and resources you need for a healthy pregnancy, delivery and baby. Once you're pregnant and have seen a doctor, you should get an email, text or interactive voice response inviting you to enroll in Future Moms. Make sure you're registered at anthem.com/ca, so we know how to get in touch with you. You can also download the My Advocate Helps app or go to MyAdvocatehelps.com. It doesn't cost you anything extra to sign up and you'll have support for up to 12 weeks after birth.

24/7 Nurse Line

Health issues can arise at the most inconvenient times and places for you and your loved ones. Whether it's 3 a.m. at home or 10 a.m. while you're in the office. You have access to a nurse you can talk to any time, day or night, 365 days a year. Just call the number on the back of your ID card.

ConditionCare

The ConditionCare uses a collaborative and holistic health management approach that provides nurse advice and resources for health problems (asthma, diabetes, heart failure)

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Anthem Act Wise HDHP.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited scope health care " FSA for dental and vision expenses.

FIND OUT MORE

- Eligible Expenses
- Ineligible Expenses

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future. Enroll in the Anthem Act Wise HDHP and an interest-bearing HSA, managed by WealthCare Saver.

How the HSA Plan works

- Your HSA account is set up automatically after you enroll in the Anthem Act Wise HDHP Plan .
- You can contribute up to the 2023 annual limit set by the IRS:
  Individual: $3,850 per year
  Family: $7,750 per year
  Are you age 55 or over? You can contribute an additional $1,000 per year
- To help you get started, The Claremont Colleges makes a contribution to your HSA (this is included in the IRS maximums noted above):
  Individual: $1,000
  Family: $2,000

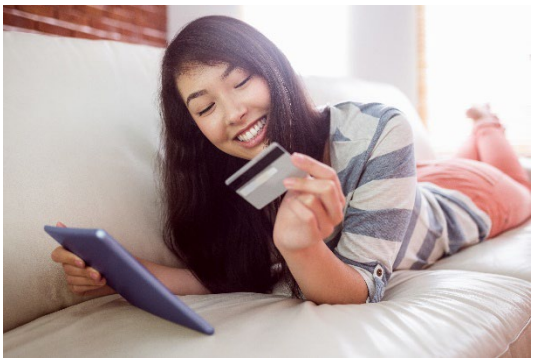
Note: you will only receive the employer contribution to your HSA if the account is with WealthCare Saver. If joining after the beginning of the year, contribution amount will be prorated. Only non-highly compensated participants (employees who had an annual compensation of less than $135,000 in 2022) are eligible for the employer contribution.

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use later.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

HEALTH SAVINGS ACCOUNT (HSA) – WEALTHCARE SAVER RESOURCES



SAVE YOUR RECEIPTS

We recommend saving itemized receipts and EOBs for tax purposes. At the end of the year, WealthCare Saver will provide you with the tax forms required to file your taxes. You are responsible for reporting your HSA contributions and distributions at tax time.

How to set up and manage your account online

WealthCare Saver makes it easy for you to manage your HSA with an online account through www.anthem.com/ca

Features of the online account:

- Set up direct deposit to ensure you receive your funds quickly
- Request reimbursements for qualified medical expenses
- Check your claims activity, including status
- Order a debit card for your dependent(s)
- Access claims, disclosures, account and IRS resources
- Access WealthCare Saver's HSA calculator to calculate your contribution amounts and your tax savings

How to set up your online account:

- Visit anthem.com/ca to register

Please note: to open an account with WealthCare Saver, you must have a physical mailing address (not a P.O. Box)

Your HSA Debit Card

You will receive a Debit Card when you enroll in the WealthCare Saver HSA; mailed directly to your home address. To activate your card, you may call the toll-free number on the activation sticker on the front of your card.

You can use the debit card to pay for eligible services and products. When you use the debit card, payments are automatically withdrawn from your HSA, resulting in fewer out-of-pocket costs for you.

You can also request a debit card for your dependents and/or spouse. A dependent must be 18 years of age or older to receive a debit card in their own name.

How to file a claim if you pay out-of-pocket

If you choose to pay for your HSA eligible expenses out-of-pocket, you can file for a reimbursement.

- Login to your online account to request a payment be sent directly to your provider or to you.
- Don't forget about direct deposit! You can set up direct deposit online and allow WealthCare Saver to deposit reimbursements in your bank account!

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our Anthem Act Wise HDHP) you can only participate in the **Limited Scope Health Care FSA** for dental and vision expenses and only available to use after you have reached your medical plan's deductible

Find out more

- www.payflex.com
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through PlayFlex.

How the 2023 PayFlex FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $2,850, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/2023 and 03/15/2024 (2 ½ month "grace period" after the end of the plan year) and claims must be submitted for reimbursement no later than 06/30/2024. If you don't spend all the money in your account, you forfeit the leftover balance.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

Limited Scope Health Care FSA

- If you/your spouse are enrolled in a high deductible health plan (like our Anthem Act Wise HDHP plan), you can only participate in the Limited Scope Health Care FSA for dental and vision expenses. Medical services are only available to use AFTER you have reached your medical plan's deductible.
- All other considerations listed above also apply to the Limited Scope Health Care FSA.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA) – PAYFLEX RESOURCES

PAYFLEX MOBILE APP

- Check your balance and view account activity
- File a claim and upload documentation in seconds
- Report a card lost or stolen
- Use the barcode scanner to verify eligible items in-store

How to set up and manage your account online

PayFlex makes it easy for you to manage your FSA with an online account through PayFlex.com, free benefits mobile app as well as text and email alerts.

Features of PayFlex:

- Set up direct deposit to ensure you receive your funds quickly
- Pay your provider directly from your account
- Request reimbursements for qualified medical expenses
- Check your claims activity, including status
- Order a debit card for your dependent(s)
- Access claims, disclosures, account and IRS resources

How to set up your online account:

- Create an account at payflex.com

Your FSA Debit Card

You will receive a Debit Card in the mail when you enroll in the FSA; mailed directly to your home address. To activate your card, you may call the toll-free number on the activation sticker on the front of your card.

You can use the debit card to pay for eligible services and products. When you use the debit card, payments are automatically withdrawn from your FSA, resulting in fewer out-of-pocket costs for you.

You can also request a debit card for your dependents and/or spouse. A dependent must be 18 years of age or older to receive a debit card in their own name.

How to file a claim if you pay out-of-pocket

Online Claim Filing:

- You can file your claim online. It's quick and easy. Login to the PayFlex member website and under Quick Links select File a Spending Account Claim. You'll just need to the follow the four steps to quickly file your claim

Paper Claim Filing:

- Click on the Resource Center and then click on Administrative Form – Reimbursement Account Forms
- Fill out and print the correct claim form and complete
- Sign and date claim form
- Include supporting documents
- Mail or fax to address or fax number on claim form

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

ESTIMATE CAREFULLY!

The Claremont Colleges allows you to make changes when costs change; no qualifying life event is necessary. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by PayFlex.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care. An eligible dependent is a person who shares the same primary place of residence with you for more than six months each year whom you can claim as a dependent on your federal income tax return.

You can set aside up to $5,000 ($2,500 if married and filing separate tax returns) per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

How to file a claim if you pay out-of-pocket

Claim Form Only:

- Complete all requested information. Pay attention to the below:
    - Date of service**
    - Caregiver information
    - Employee signature

Claim Form with itemized statement or receipt:

- Complete all requested information
- Employee signature
- Include itemized statement or receipt*, which includes:
    - Provider name
    - Qualifying person name
    - Date of service**
    - Amount charged for the care services

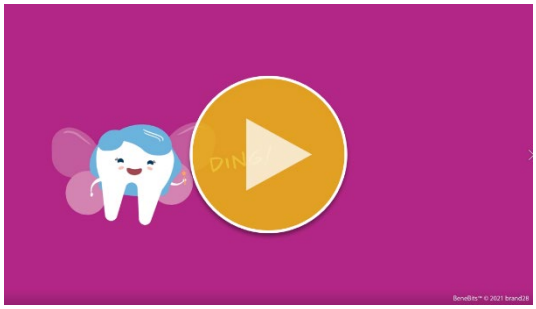
*Payflex cannot accept a canceled check or debit or credit card receipt as documentation
** We can only reimburse eligible expenses after you have received the care or service. This is when you have incurred the expense. This is true even if you have already paid, or have been billed or charged, for the service.

DENTAL

OUR PLANS

CIGNA Dental PPO
CIGNA Dental HMO

Click to play video



Cigna Dental Resources

If you have Cigna dental coverage, you also have access to Cigna Healthy Rewards, a discount plan for products and programs such as weight management, fitness, vision and hearing, alternative medicine, and healthy lifestyle. Log on to www.mycigna.com to get started.

Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

CIGNA DENTAL PLANS

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	CIGNA DENTAL HMO	CIGNA DENTAL PPO	
	In-Network	In-Network	Out-of-Network
Annual Deductible[1] Individual Family	None	$50 $150	$50 $150
Annual Plan Maximum Individual Family	Unlimited	Progressive Maximum Benefit[2]:	
		Year 1: $2,000 Year 2: $2,200 Year 3: $2,400 Year 4: $2,600	Year 1: $2,000 Year 2: $2,200 Year 3: $2,400 Year 4: $2,600
Diagnostic & Preventive[1] Routine Examination: cleaning	Up to two cleanings per year	Up to three cleanings per year	Up to three cleanings per year
Fluoride treatment (including bitewing x-rays)	No charge	No charge	No charge
Office Visits	No Charge	20% after deductible	20% of maximum allowed amount after deductible
Basic Services (Restorative) Fillings: Amalgam Composite/Resin	$0-$40 copay (depending on number of surfaces)	20% after deductible	20% of maximum allowed amount after deductible
Simple Extractions	$5 copay	20% after deductible	20% of maximum allowed amount after deductible
Major Services Caps, Crowns, Dentures, Implants	Copays as listed in the schedule of covered services and copays	50% after deductible	50% of maximum allowed amount after deductible
Orthodontia Adults	$0-$1,488 copay depending on the service performed	50% up to a $2,500 lifetime maximum benefit; deductible does not apply	
Children (up to age 19)	$0-$984 copay depending on the service performed		

What you need to know about these plans

Features:	**Cigna PPO:** You must first meet a deductible for non-preventive and non-orthodontic services. Once you do, you and the plan will share in the cost up to an annual maximum. For every consecutive year you receive preventive dental care, $200 will be added to next year's maximum annual benefit (up to an overall maximum benefit of $2,600 after four years). **Cigna HMO:** You pay a flat copay for most services.
Am I restricted to in-network providers?	**Cigna PPO**: No, but you will pay less if you use in-network dentist **Cigna HMO:** Yes
Do I have to select a primary dentist?	**Cigna PPO:** See any provider, but you'll pay more out of network **Cigna HMO:** Must select a primary care dentist (PCD) from the Cigna total network

[1] Calendar-year deductible and maximum benefit are not applicable to preventive or diagnostic services.

[2] If you receive preventive dental care during a plan year, your calendar-year maximum benefit for the next year will increase by $200, until you reach a maximum dental benefit of $2,600. If preventive care is not received, the maximum benefit for the next year will be lowered to $2,000.

VISION

OUR PLANS

Anthem Core Plan

Anthem Buy-Up Plan

Click to play video

WHERE CAN I GET MORE DETAILS?

Visit anthem.com/ca to check out extra savings and discounts.

Importance of Vision coverage

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services.

Eligible employees are automatically enrolled in the Core Vision plan through Anthem Blue View at no cost.

Anthem Vision Plans

Your vision checkup is fully covered after your Exam copay. Eligible employees are automatically enrolled in the Core Vision plan through Anthem Blue View at no cost. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	CORE PLAN	BUY-UP PLAN	
	In-Network	In-Network	Out-of-Network
Exams Benefit	$10 copay then plan pays 100% (plan reimburses up to $79 out-of-network)	$10 copay then plan pays 100%	Plan pays up to $79
Frequency	Once every 12 months	Once every 12 months	Once every 12 months
Eyeglass Lenses[1,2] Single Vision Lens Lined Bifocal Lens Lined Trifocal Lens Frequency	You pay $50 You pay $70 You pay $105 **No out-of-network coverage** Once every 12 months	$15 copay then plan pays 100% $15 copay then plan pays 100% $15 copay then plan pays 100% Once every 12 months	Plan pays up to $36 Plan pays up to $60 Plan pays up to $79 Once every 12 months
Frames Benefit	You receive a 35% discount No out-of-network coverage	Plan pays up to a $130 allowance[1]; you receive a 20% discount on amounts over allowance	Plan pays up to $100
Frequency	Once every 24 months	Once every 12 months	Once every 12 months
Contacts Lenses[1] Benefit Frequency	You receive a 15% discount **No out-of-network coverage** Once every 12 months, in lieu of glasses	Plan pays up to a $130 allowance[1]; you receive a 15% discount on doctors' professional fees. Materials are paid at usual and customary rates Once every 12 months, in lieu of glasses	Plan pays up to $115 Once every 12 months, in lieu of glasses

[1] Allowance applies to frames OR contact lenses
[2] Special materials or coatings are subject to additional copays

What you need to know about this plan

Features:

See any provider, but you'll pay more out of network.

What other services are covered?

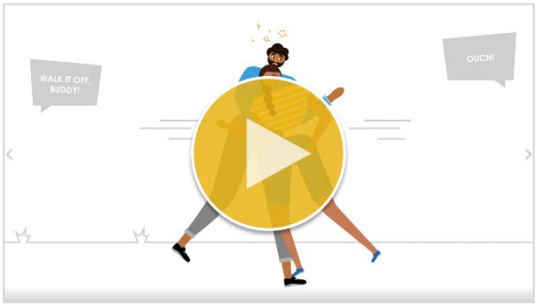
The plan can also help you save money on LASIK procedures, non-prescription sunglasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

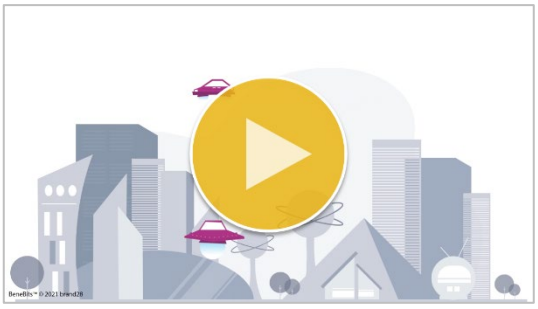
Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in an HSA or healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

ENGAGE

Click to play video



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost[1]
Nurseline 	Quick answers from a trained nurse **Anthem:** (800) 700-9184 **Kaiser:** (800)464-4000	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions **Anthem:** Virtual visits are offered through LiveHealth Online (primary care & behavioral health). See page 15 for more information **Kaiser:** virtual visits are offered by visiting kp.org	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

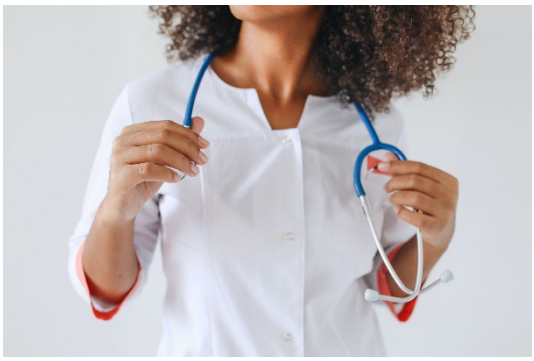
[1] Average out-of-pocket cost after deductible (if applicable). Your cost may vary depending on your plan and location.

MENTAL HEALTH RESOURCES

These are challenging times, and we understand that you or people close to you may also be faced with additional work and family stresses. Feelings of isolation, depression or despair should never be taken lightly. This is a reminder that our medical plans include coverage for mental health care. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

Mental Health Services	
Anthem Mental Health Resources	▪ Available 24/7 ▪ Face-to-face counseling sessions with licensed professional mental health providers ▪ stress management services ▪ Critical Incident Response coordination ▪ MyStrength mobile app for emotional health and well-being To access these tools and services, visit www.anthem.com/ca
Kaiser Mental Health Resources	▪ Face-to-face counseling sessions with licensed professional mental health providers ▪ Crisis intervention ▪ Chemical dependency treatment ▪ Condition-specific online classes and emotional wellness podcasts ▪ Online self-assessment tools ▪ Support groups To access these tools and services, visit www.kp.org or call Member Services at (800) 464-4000.
Optum EAP	Our EAP can assist you with parenting or relationship problems, financial advice, or legal referrals. Employees and their dependents can receive up to five counseling sessions with a licensed therapist by phone or in person per family member, per issue. Alternatively, you may choose to connect with a licensed therapist online – from anywhere, at any time. In addition, you can get support and referrals for everyday tasks, including childcare and elder care, household services, and personal services (such as shopping or dog walking). View page 43 for more information regarding your Optum EAP program.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit cdc.gov/prevention for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

FIND A PROVIDER

CIGNA DENTAL HMO

1. Go to www.Cigna.com and click on “Find a Doctor, Dentist or Facility” at the top of the screen.
2. Under “How are you covered?” click on “Employer or School.”
3. Enter the address, city, or ZIP code under “Find a Doctor, Dentist, or Facility in.”
4. Select “Doctor by Type, Doctor by Name, or Health Facilities.”
5. Select “Continue as a guest” or “Continue without a plan.”

ANTHEM VISION

Find the right Anthem eye doctor for you at www.anthem.com/ca

Kaiser Permanente

1. Go to www.kp.org/newmember
2. Click “choose a doctor”
3. Select California-Southern
4. Enter your location and other key words, such as a doctor’s name or specialty. (Or you may select your physician on the My Doctor portal.)

Anthem Advantage HMO

1. Go to www.anthem.com/ca. Click “Find Care.”
2. Click “Select a plan for basic search”.
3. Select “Medical Plan or Network” when asked what type of care are you searching for.
4. Select “California” when asked what state you want to search within. *This selection is due to TCC’s physical location.*
5. Select “Medical (Employer Sponsored)” when asked what type of plan you want to search.
6. Select “Advantage HMO” for plan/network and hit “Continue”
7. Enter your city, county or ZIP code
8. Under “Search by Care Provider” select either “Primary Care” or type of specialist or facility you need

Note: The medical groups and physicians with lower office visit copays will say Advantage HMO Copay Indicator

Anthem Act Wise HDHP

1. Go to www.anthem.com/ca. Click “Find Care.”
2. Click “Select a plan for basic search”.
3. Select “Medical Plan or Network” when asked what type of care are you searching for.
4. Select “California” when asked what state you want to search within. *This selection is due to TCC’s physical location.*
5. Select “Medical (Employer Sponsored)” when asked what type of plan you want to search.
6. Select “Blue Cross PPO (Prudent Buyer) — Large Group” for the Anthem Act Wise HDHP for plan/network and hit “Continue.”
7. Enter your city, county or ZIP code. *This location is not limited to California providers and should reflect the area you would like to receive services.*
8. Under “Search by Care Provider,” select “Primary Care.”

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses or medical bills during a pregnancy or illness-related disability leave. Also consider how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of Life Insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children.

COMPANY-PROVIDED LIFE INSURANCE

Life Insurance

Basic Life Insurance pays your beneficiary a lump sum if you die. All benefits-eligible faculty and staff receive Basic Life Insurance. Coverage is provided by Unum and premiums are paid in full by The Claremont Colleges

Basic Life insurance

1x base annual earnings up to a maximum of $50,000 and a minimum of $20,000.

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

BASIC AND VOLUNTARY LIFE INSURANCE

EVIDENCE OF INSURABILITY (EOI)

You don't need to provide EOI within 31 days of your hire date unless you purchase coverage above a certain amount:

- For you: Amounts above $355,000
- For your spouse: Amounts above $50,000

You will be required to provide EOI if you enroll in or increase your coverage at any time throughout the year or at Open Enrollment. When EOI is required, you will be notified to complete an online submission process.

Protecting those you leave behind

In addition to your employer-paid basic life insurance, Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Unum and available for your spouse and/or child(ren).

Unum Voluntary Life

Employee	Get up to $1,000,000 in $1,000 increments up to 4x your earning Guaranteed Issue: $355,000
Spouse	$10,000 increments, to a maximum of $250,000 or 100% of your Basic Life Insurance coverage Guaranteed Issue: $50,000
Child(ren)	$15,000 (benefit is limited to $1,000 for infants up to 6 months) Guaranteed Issue: up to 6 months is $1,000

Note: Coverage amounts are reduced beginning at age 65.

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury the plan pays a benefit to you. Coverage is provided by Zurich and is available for your spouse and/or child(ren).

Zurich Voluntary AD&D

Employee	$25,000 increments, up to $500,000, but not exceeding 10x your annual salary* if the selection is over $250,000
Spouse	• If only a spouse/domestic partner is covered, the spouse's coverage amount is 100% of the employee's coverage amount • If a spouse/domestic partner and child(ren) are covered, the spouse's coverage amount is 80% of the employee's coverage amount
Child(ren)	• If only children are covered, the children's coverage amount is 30% of the employee's coverage amount • If a spouse/domestic partner and child(ren) are covered, the children's coverage amount is 20% of the employee's coverage amount

*if you attempt to elect coverage that is more than 10x your annual salary, your coverage amount will be automatically be lowered to 10x your annual salary.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE (STD)

CA EMPLOYEES ONLY

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

If you live in California, you're eligible to receive disability benefits. You're eligible for STD after missing five continuous days of work due to non-work –related illness or injury, pregnancy, or childbirth.

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. You pay the cost of this coverage.

Weekly Benefit Amount	Plan pays up to 70% of weekly earnings

Submitting a Claim

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. Please contact disability@claremont.edu

LONG-TERM DISABILITY INSURANCE (LTD)

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. You are automatically enrolled in Long-Term Disability Insurance through Unum on your first day of employment if you work 30 hours or more per week.

The Claremont Colleges pays the cost of this coverage.

LTD Plan

Monthly benefit amount	66 2/3 % up to a maximum of $15,000
Benefits begin	After 180 days of disability

Note: California Botanic Garden employees may elect LTD coverage and share the cost of the premium (50%) with The Claremont Colleges.

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

- Retirement Savings Plan

Is it time for a “financial wellness” checkup?

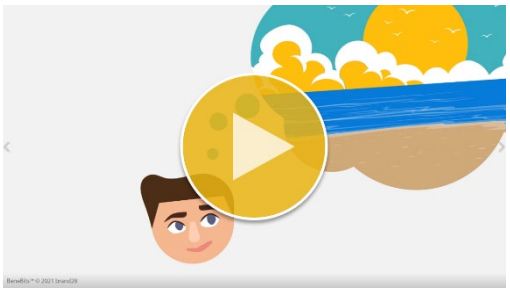
Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future.

ACADEMIC RETIREMENT PLAN

Click to play video



WHAT ARE YOUR PLANS?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our Academic Retirement Plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

Academic Retirement Plan (ARP)

Each college offers an Academic Retirement Plan (ARP) as the primary way for employees to save for retirement.

Who's Eligible	All faculty and staff are eligible to participate through elective deferral upon date of hire.
How to Enroll	Visit www.TIAA.org/theclaremontcolleges Contributions are invested into the appropriate Vanguard Target Retirement Fund for your age group by default if an enrollment is not completed.
The Claremont Colleges Contributions	Certain employees are eligible to receive The Claremont Colleges contributions — calculated on a percentage of eligible compensation — based on job classification, length of service, and attainment of age 21. Check with your HR office for details.
Vesting	Your contributions and The Claremont Colleges contributions (if eligible) are yours to keep once they are deposited into your account.
Distributions	Generally, the plan is designed for you to take distributions upon severance of employment. However, you may qualify for a loan, a hardship withdrawal, or in-service withdrawals on or after obtaining age 59½.

Note: Different retirement plan options apply for employees of California Botanic Garden.

For more information on the Academic Retirement Plan, click here.

SAVE NOW, ENJOY LATER

NEED THE SALARY DEFERRAL FORM?

Click HERE to access the form.

457(b) Plan

Who's Eligible	Eligibility is restricted to employees with a monthly base salary of $12,917 or higher.
How to Enroll	Visit www.TIAA.org/theclaremontcolleges
Your Contributions	If eligible, you can contribute on a pre-tax basis each pay period up to the IRS limit of $20,500. It is recommended that you maximize deferrals in the ARP first and use the 457(b) Plan for any additional deferral opportunity.
The Claremont Colleges Contributions	Contact Loo Hsing, Supervisor Retirement Services for details: Loo.hsing@claremont.edu or (909) 607-3780.
Vesting	Your contributions and The Claremont Colleges contributions (if applicable) are yours to keep once they are deposited into your account.
Distributions	Generally, the plan is designed for you to take distributions upon severance of employment. However, you may qualify for a distribution prior to a separation of employment. You will have sixty days from the date of your severance of employment to elect when you want funds to be paid to you. If you fail to make an election within sixty days, the entire amount of funds in your 457(b) account will be paid to you immediately in one lump sum payment, less applicable tax withholdings.

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Auto & Home Insurance

Pet Insurance

Identity Protection Insurance

Legal Assistance Insurance

Accident Insurance

Critical Illness Insurance

Hospital Indemnity Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

The Claremont Colleges offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues
- save money on protection for your pets, home and auto.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

VOLUNTARY HEALTH-RELATED PLANS

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from Voya helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose. Coverage is available for you and your eligible dependents.

Critical Illness Insurance

Critical illness insurance from Voya can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. There are two coverage options for you: $15,000 or $30,000. coverage is available for your eligible dependents.

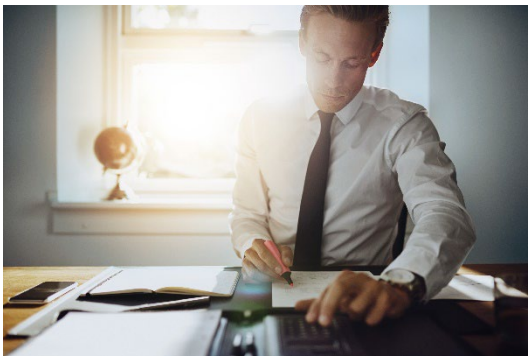
Hospital Indemnity Insurance

Hospital indemnity insurance from Voya enhances your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide. Coverage is available for you and your eligible dependents.

Need more information?

For more details on these plans, visit
https://presents.voya.com/EBRC/Claremont

PLANS TO KEEP YOU AND YOUR FAMILY SECURE



CONTACT INFORMATION

See the Plan Contacts section of this guide.

Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from Allstate helps protect your personal information through proactive monitoring, identity restoration, and resolution. Visit myaip.com for more details.

Legal Program

Do you have an attorney on retainer? Most people don't, so our legal program offers you access to legal advice and even representation for an affordable monthly premium. Whether you need assistance reviewing a rental agreement, fighting a criminal matter, immigration assistance, family issues, debt-related challenges, driving matters, wills and estate planning Legal coverage from ARAG Legal offers reputable attorney assistance for you and your family. Visit https://www.araglegal.com/authenticate (code18437ccs) for details.

Home and Auto Insurance

Your home, its contents, and your car would be expensive, perhaps even unaffordable, to replace. The Claremont Colleges has partnered with Farmers Insurance to provide you with access to special group rates on auto, home or condo, mobile home, renters, recreational vehicle, boat and personal excess liability insurance. Visit the Farmer's Insurance website HERE for details (use employer name, The Claremont Colleges).

Pet Insurance

Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. Nationwide provides coverage for this program. Premiums vary by coverage; premiums are paid directly to Nationwide

WELLBEING & BALANCE

" THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT. "

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

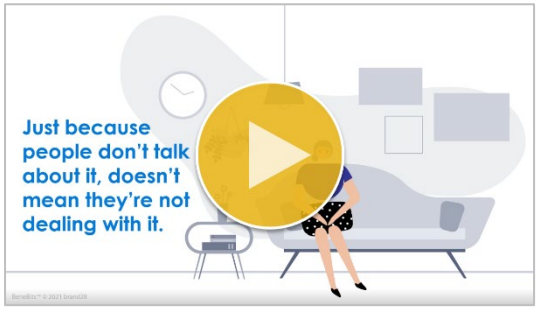
We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Click to play video



CONTACT THE EAP

Phone: **800-234-5465**

Website:
www.liveandworkwell.com
(use access code: claremontcolleges)

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Optum, Inc. can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 per incident
- Unlimited web access to helpful articles, resources, and self-assessment tools.

COUNSELING BENEFITS

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for 2023
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

YOUR 2023 PLAN RATES

Medical Plans*	Kaiser Permanente HMO			Anthem Advantage HMO**			Anthem Act Wise HDHP		
	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly
Employee Only	$63.98	$29.53	$31.99	$64.59	$29.81	$32.30	$86.86	$40.09	$43.43
Two Party	$268.70	$124.02	$134.35	$271.26	$125.20	$135.63	$342.36	$158.01	$171.18
Family	$575.78	$265.74	$287.89	$580.72	$268.02	$290.36	$719.25	$331.96	$359.63

For Faculty and Staff of Pitzer College						
Medical Plans	Kaiser Permanente HMO		Anthem Advantage HMO		Anthem Act Wise HDHP	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Under $52,000						
Employee Only	$51.18	$23.62	$51.67	$23.85	$86.86	$40.09
Two Party	$214.96	$99.21	$217.00	$100.15	$342.36	$158.01
Family	$460.63	$212.60	$464.58	$214.42	$719.25	$331.96
Over $52,000						
Employee Only	$63.98	$29.53	$64.59	$29.81	$86.86	$40.09
Two Party	$268.70	$124.02	$271.26	$125.20	$342.36	$158.01
Family	$575.78	$265.74	$580.72	$268.02	$719.25	$331.96

For Faculty and Staff of Pomona College						
Medical Plans	Kaiser Permanente HMO		Anthem Advantage HMO		Anthem Act Wise HDHP	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Under $52,000						
Employee Only	$63.98	$31.99	$64.59	$32.30	$86.86	$43.43
Two Party	$134.35	$67.18	$135.63	$67.82	$342.36	$171.18
Family	$191.93	$95.97	$193.57	$96.79	$719.25	$359.63
Over $52,000						
Employee Only	$63.98	$31.99	$64.59	$32.30	$86.86	$43.43
Two Party	$268.70	$134.35	$271.26	$135.63	$342.36	$171.18
Family	$575.78	$287.89	$580.72	$290.36	$719.25	$359.63

Note: Imputed income taxation applies when enrolling a domestic partner; please see your benefits representative for additional information. Hourly employees of Pomona College and The Claremont Colleges Services will pay semi-monthly rates.

**See separate sheet for rates for RSABG employees.*

In January 2022, Anthem provided The Claremont Colleges with a premium credit. This premium credit was applied as a subsidy to the Anthem medical premiums to reduce the amount employees enrolled in an Anthem Plan paid each pay period throughout the year. The subsidy will end on December 31, 2022. To help offset the impact of removing the subsidy along with the overall Anthem renewal increase for the 2023 year, The Claremont Colleges has made the decision to apply a* ***premium holiday *to all employees who are enrolled in the Anthem Advantage HMO or Anthem HDHP plan for 2023. You will be receiving more details about how this impacts you via email, company mail and/or your mailing address.*

Dental Plans	Cigna Dental DHMO			Cigna Dental DPPO		
	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly
Employee Only	$5.61	$2.59	$2.81	$40.31	$18.60	$20.16
Two Party	$15.35	$7.08	$7.68	$79.20	$36.55	$39.60
Family	$31.38	$14.48	$15.69	$156.32	$72.15	$78.16

**RSABG employees pay 100% of Dental.*

Vision Plans	Vision Core			Vision Buy-Up		
	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly
Employee Only	$0.00	$0.00	$0.00	$7.19	$3.32	$3.60
Two Party	$1.53	$0.71	$0.77	$12.14	$5.60	$6.07
Family	$3.41	$1.57	$1.71	$20.10	$9.28	$10.05

ACCIDENT INSURANCE

	Low	High
EMPLOYEE	$7.97	$11.52
EMPLOYEE + SPOUSE	$13.28	$19.20
EMPLOYEE + CHILD	$15.72	$22.73
FAMILY	$21.03	$30.41

HOSPITAL INDEMNITY INSURANCE

	Low	High
EMPLOYEE	$18.91	$37.82
EMPLOYEE + SPOUSE	$39.62	$79.24
EMPLOYEE + CHILD	$28.56	$57.13
FAMILY	$49.27	$98.55

MONTHLY VOLUNTARY PET INSURANCE RATES

Rates
Varies based on pet's species and age, and the state in which you live. For a quote, visit www.petinsurance.com/claremont or call 877-738-7874.

MONTHLY VOLUNTARY LEGAL ASSISTANCE INSURANCE

Rates
$18.25 (employee only and family)

MONTHLY VOLUNTARY IDENTITY PROTECTION INSURANCE

Rates	
$7.95 (employee only)	$13.95 (family)

CRITICAL ILLNESS COVERAGE OPTIONS

	EMPLOYEE AMOUNT: $15,000 SPOUSE AMOUNT: $7,500 CHILD AMOUNT: $5,000				EMPLOYEE AMOUNT: $30,000 SPOUSE AMOUNT: $15,000 CHILD AMOUNT: $10,000			
Age	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD	EMPLOYEE + FAMILY	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD	EMPLOYEE + FAMILY
< 29	$6.10	$10.25	$8.05	$12.20	$10.90	$17.90	$14.80	$21.80
30-39	$7.15	$11.90	$9.10	$13.85	$13.00	$21.20	$16.90	$25.10
40-49	$14.20	$22.78	$16.15	$24.73	$27.10	$42.95	$31.00	$46.85
50-59	$28.75	$46.25	$30.70	$48.20	$56.20	$89.90	$60.10	$93.80
60-64	$43.00	$68.23	$44.95	$70.18	$84.70	$133.85	$88.60	$137.75
65-69	$52.90	$85.10	$54.85	$87.05	$104.50	$167.60	$108.40	$171.50
70+	$78.25	$119.45	$80.20	$121.40	$155.20	$236.30	$159.10	$240.20

VOLUNTARY INSURANCE COSTS

If you elect Voluntary Life and/or AD&D coverage, your monthly premium rate is calculated based on your age and/or the amount of coverage. Use the table below to estimate the premium amount that will be deducted from your paycheck.

VOLUNTARY LIFE INSURANCE

Rates for employees & spouse/domestic partner are based on the employee's age as of January 1, 2023.

Monthly Rate Per $1,000 of Coverage

Age	Employee & Spouse Monthly Rates
< 29	$0.023
30 - 34	$0.028
35 - 39	$0.041
40 - 44	$0.069
45 - 49	$0.103
50 - 54	$0.158
55 - 59	$0.282
60 - 64	$0.434
65 - 69	$0.874
70 +	$1.418
Dependent Child(ren) Life Insurance:	$1.05 for $15,000 of coverage per child

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Coverage amounts may not exceed ten times your annual base salary. AD&D benefit amount cannot be increased after age 70. Coverage for children is 30% of the AD&D benefit amount up to a maximum of $50,000.

Monthly Rate Per $1,000 of Coverage

AD&D Benefit Amount	Employee Only	Family
$25,000	$0.48	$0.93
$50,000	$0.95	$1.85
$75,000	$1.43	$2.78
$100,000	$1.90	$3.70
$125,000	$2.38	$4.63
$150,000	$2.85	$5.55
$175,000	$3.33	$6.48
$200,000	$3.80	$7.40
$225,000	$4.28	$8.33
$250,000	$4.75	$9.25
$275,000	$5.23	$10.18
$300,000	$5.70	$11.10
$325,000	$6.18	$12.03
$350,000	$6.65	$12.95
$375,000	$7.13	$13.88
$400,000	$7.60	$14.80
$425,000	$8.08	$15.73
$450,000	$8.55	$16.65
$475,000	$9.03	$17.58
$500,000	$9.50	$18.50

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy No.
Anthem Advantage HMO	Anthem Blue Cross	800-888-8288	www.anthem.com/ca	C23782
Anthem Act Wise HDHP	Anthem Blue Cross	844-860-3535	www.anthem.com/ca	C23782
Kaiser HMO Plan	Kaiser Permanente	800-464-4000	www.kp.org	101582
Cigna Dental HMO & PPO	Cigna	800-244-6224	www.cigna.com	3340182
Anthem Vision	Anthem Blue View	866-723-0515	www.anthem.com/ca	C23782
FSA	PayFlex	800-284-4885	www.payflex.com	N/A
Employee Assistance Program	Optum	800-234-5465	www.liveandworkwell.com	claremontcolleges
Life Insurance	Unum	866-679-3054	www.unum.com	442162
Voluntary AD&D	Zurich	866-841-4771	www.zurichna.com	GTU -5091313
Supplemental Medical	Voya	877-236-7564	https://presents.voya.com/EBRC/Claremont	Claremont
Retirement	TIAA	800-842-2776	www.tiaa-cref.org	Select the institution of your employment
Identity Theft Protection	Allstate	800-789-2720	www.myaip.com	The Claremont Colleges
Legal	ARAG	800-247-4184	www.ARAGLegalCenter.com	18437CC3
Auto & Home	Farmers GroupSelect	844-296-9641	www.myautohome.farmers.com	The Claremont Colleges
Pet Insurance	Nationwide	855-874-4944	petinsurance.com/Claremont	Claremont
Travel Assistance	Zurich	800-555-0870	www.zurichna.com	GTU-5091313
Medicare	Medicare	1-800-MEDICARE (1-800-633-4227)	www.medicare.gov	N/A
Health Rights	Centers for Health Rights	213-383-4519	chcsbc.org	N/A

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Note: Beginning January 1, 2023 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age
13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP)
A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non- preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located in this guide.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

PLAN DOCUMENTS

Important documents for our health plan and retirement plan are available in this guide Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format.

- The Claremont Colleges Group Health Plan

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the Claremont Colleges Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

AFFORDABLE CARE ACT REQUIREMENTS

The information below explains how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Under the ACA, employers are required to report specific benefits information to IRS on “full-time” employees as defined by the ACA. A “full-time” employee is generally an employee whose works on average 130 hours per month. ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. Claremont Colleges uses the look-back measurement method to determine group health plan eligibility.

NEW EMPLOYEES HIRED TO WORK FULL-TIME: If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for group health plan coverage as of First of Month Following Date of Hire.

NEW EMPLOYEES HIRED TO WORK A PART-TIME, VARIABLE HOUR OR SEASONAL SCHEDULE: If you are hired into a part-time position, a position where your hours vary and Claremont Colleges is unable to determine — as of your date of hire — whether you will be a full-time employee, or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of . Your IMP will begin on . If, during your IMP, you average 130 or more hours a month, you will become full-time and, if otherwise eligible for benefits, you will be offered coverage . Your full-time status will remain in effect during an associated stability period that will last . If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES: An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the period during which Claremont Colleges counts employee hours to determine which employees work full-time. Those employees who average 130 or more hours a month over the standard measurement period will be deemed full time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect during an associated stability period for . If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

Claremont Colleges uses the standard measurement period and associated stability period annual cycle set forth below:

MEASUREMENT PERIOD: STARTS: November 1st. DURATION: 12 months. Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility.

STABILITY PERIOD: STARTS: January 1st. DURATION: 12 months. Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

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 meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.61% for 2023 of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your plan administrator at 909-621-8151.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit 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: The Claremont Colleges		4. Employer Identification Number (EIN): 95-4786748
5. Employer address: 101 South Mills Avenue		6. Employer phone number: 909-621-8151
7. City Claremont	8. State: CA	9. Zip code: 91711
10. Who can we contact about employee health coverage at this job? Dennis Miller		
11. Phone number (if different from above)		12. Email address: benreps@claremont.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: Regularly scheduled to work at least 20 hours per week shall become eligible to participate in the plan on the first of the month following date of hire.

With respect to dependents:

We do offer coverage. Eligible dependents are: Spouse or Domestic Partner or Dependent child of an Employee who are Natural children, Stepchildren, Legally adopted (or placed for adoption), disabled children and children for who the employee is legal guardian.

** 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.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Notice of Certain Deadline Extensions and Summary of Material Modifications

Prepared for The Claremont Colleges Participants
Effective 1/1/2023

This document provides notice of the potential expiration of the deadline relief that began on March 1, 2020 and an explanation of how that expiration will affect certain deadlines tolled under prior guidance applicable to ERISA plans. Specifically deadlines cannot be tolled for longer than one-year, **so depending on the date an individual action would have been required, some deadline extensions will be expiring on February 28, 2021. Whether deadlines are tolled or resume will depend on the specific date you were required to take action or provide notice to the plan.** This is a Summary of Material Modifications ("Summary") to the extent those extensions applied to ERISA benefits under the health and welfare benefit plans. You should take the time to read this Summary carefully and keep it with the Summary Plan Description ("SPD") document that was previously provided to you. If you need another copy of the SPD or if you have any questions regarding these changes to the Plan, please contact your plan administrator during normal business hours at 101 S. Mills Avenue Claremont, CA 91711 or call 909-621-8151.

End of Relief Period Extending Certain Deadlines in Response to the COVID-19 Crisis will Depend on the Date an Individual Action Would Have been Required with some Deadlines resuming Feb. 28, 2021

On April 28, 2020 Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period beginning **March 1, 2020**. Those deadlines included and were limited to the following:

- The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
    - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
    - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
    - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs;
- The 60-day election period for COBRA continuation coverage;
- The deadline for making COBRA premium payments;
- The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;
- The deadline for individuals to file an ERISA benefit claim under the plan's claims procedure (including a H-FSA run out period deadline that ends during the outbreak period); or
- The deadline for claimants to file an appeal of an adverse benefit determination, a request for an external review, and to file information related to a request for external review for an ERISA plan.

Medicare Part D Notice

Important Notice from The Claremont Colleges 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 The Claremont Colleges 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. The Claremont Colleges has determined that the prescription drug coverage offered by Kaiser Permanente, Anthem Blue Cross and Anthem ActWise 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 the Claremont Colleges coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the Kaiser Permanente, Anthem Blue Cross and Anthem ActWise plan is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop The Claremont Colleges prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 The Claremont Colleges 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. 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 The Claremont Colleges 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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).

Date:	01/01/2023
Name of Entity/Sender:	The Claremont Colleges
Contact-Position/Office:	TCCS Benefits Administration
Address:	101 S. Mills Avenue Claremont, CA 91711
Phone Number:	909-621-8151

Women's Health and 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 this plan. Therefore, the following deductibles and coinsurance apply: Kaiser HMO and Anthem Advantage HMO: none; Anthem ActWise HDHP: $1,500/$3,000, 80% coinsurance. If you would like more information on WHCRA benefits, call your plan administrator at 909-621-8151.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 909-621-8151.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for The Claremont Colleges describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in The Claremont Colleges' health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in some coverages under this plan(s) without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in The Claremont Colleges' health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Notice of Choice of Providers

The Kaiser Permanente and Anthem Blue Cross HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Kaiser or Anthem will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser (www.kp.org) or Anthem (www.anthem.com/ca)

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser or Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser (www.kp.org) or Anthem (www.anthem.com/ca).

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 1-877-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 1-866-444-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 January 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid | Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP | Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm | Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Websi Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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.

OMB Control Number 1210-0137 (expires 1/31/2023)

THE
CLAREMONT
COLLEGES