Ready, Set, Enroll

The Claremont Colleges

2023 Benefits

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.

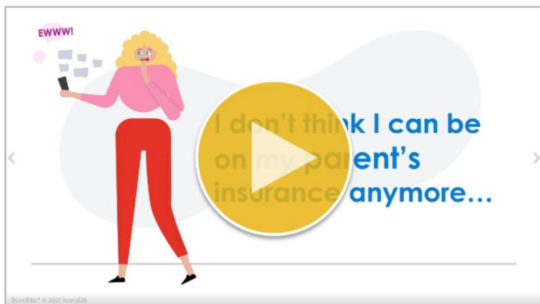
Eligible dependents

- 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.

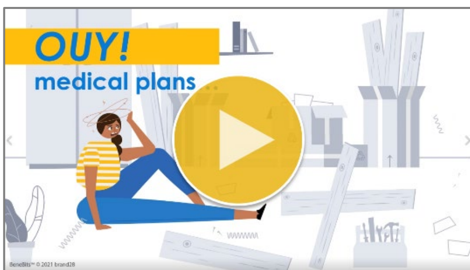
MEDICAL

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

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			Combined with medical deductible	
Generic Brand Formulary Brand Non-Formulary	$10 copay $25 copay N/A	$10 copay $30 copay $50 copay	$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

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.

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

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.

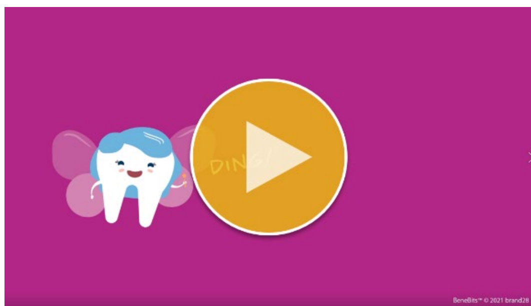
DENTAL

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	You pay $50 You pay $70 You pay $105 **No out-of-network coverage**	$15 copay then plan pays 100% $15 copay then plan pays 100% $15 copay then plan pays 100%	Plan pays up to $36 Plan pays up to $60 Plan pays up to $79
Frequency	Once every 12 months	Once every 12 months	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	You receive a 15% discount **No out-of-network coverage**	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	Plan pays up to $115
Frequency	Once every 12 months, in lieu of glasses	Once every 12 months, in lieu of glasses	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.

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.”

BASIC AND VOLUNTARY LIFE INSURANCE

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.

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.

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

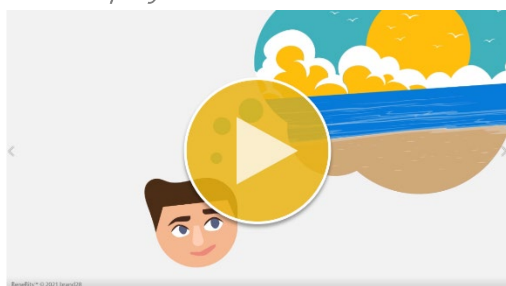
*if you attempt to elect coverage that is more than 10x your annual salary, your coverage amount will be automatically be lowered to 10x your annual salary.

ACADEMIC RETIREMENT PLAN

Academic Retirement Plan (ARP)

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

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.

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.

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

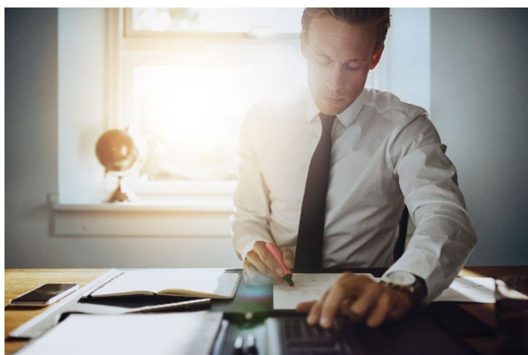
PLANS TO KEEP YOU AND YOUR FAMILY SECURE

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

CONTACT INFORMATION

See the Plan Contacts section of this guide.

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

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.

- The Claremont Colleges Group Health Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

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.

<table>
<tr><td colspan="2">3. Employer Name:
The Claremont Colleges</td><td>4. Employer Identification Number (EIN):
95-4786748</td></tr>
<tr><td colspan="2">5. Employer address:
101 South Mills Avenue</td><td>6. Employer phone number:
909-621-8151</td></tr>
<tr><td>7. City
Claremont</td><td>8. State:
CA</td><td>9. Zip code:
91711</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
Dennis Miller</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)</td><td>12. Email address:
benreps@claremont.edu</td></tr>
</table>

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.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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.

The Claremont Colleges