



HAVERFORD COLLEGE

BENEFITS GUIDE 2024

HAVERFORD
COLLEGE

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A group of young people are dancing in a studio. They are wearing colorful bucket hats and casual clothing. The background is a plain wall with a wooden floor. The lighting is warm and focused on the dancers.

WELCOME, FRIEND.

We look forward to working with you in the vibrant community of students, faculty, and staff that is Haverford College. At Haverford, you'll find a professional environment informed by the same core values—trust, concern, and respect—that have driven the College's educational mission since 1833.

We support and value our faculty and staff as highly regarded professionals who dedicate their work to the mission and students of Haverford College. In keeping with this standard, the Office of Human Resources is pleased to offer a generous and comprehensive benefits program to all benefits-eligible employees. In the pages of this Guide, you'll find information about the College's health and welfare, retirement, tuition, and ancillary benefits for your consideration. Plan summaries are available in the Office of Human Resources and online at hav.to/hr. If, after reviewing this Guide, you have any questions regarding your benefits or the enrollment process, please call the office at (610) 795-6124 or email hc-hr@haverford.edu.



BENEFITS PROGRAM OVERVIEW

Haverford College provides a comprehensive benefits package. The plan year is based on a calendar year and runs from January 1 through December 31. As a new employee of the College, the benefit elections you make now will remain in effect for the rest of the calendar year, except in the case of a mid-year qualifying life event (see Key Terms below) that may allow you to change certain benefit elections. This Guide provides information about the following benefits:

- Medical Plan Choices for 2024
- Health Savings Account (HSA)
- Medical Insurance Opt-Out
- Vision Insurance
- Clinical Dental Panel
- Flexible Spending Accounts (Health Care, Dependent Care, Limited Purpose)
- Life Insurance
- Long-Term Disability Insurance (LTD)
- Additional Resources (Carebridge Employee Assistance Program, Health Advocate, and RideEco Transportation Benefit)
- Tuition Grant Program
- Retirement Plans

COVERAGE CHANGES

For all Haverford employees, the annual Open Enrollment period takes place every fall and has a January 1 effective date. **The annual Open Enrollment period is the only time you can make changes to your plans, including adding or removing coverage for dependents, without having to demonstrate a qualifying life event as defined below. Coverage changes based on qualifying life events must be entered in Workday within 31 days of the event.**

KEY TERMS

QUALIFYING LIFE EVENT

A qualifying life event is a significant occurrence in your life that permits you to make changes to your coverage during the current plan year. Qualifying events include the birth or adoption of a child; marriage, domestic partnership, or divorce; death; judgment, decree, or court order; Medicare eligibility; and a change in your employment status or that of your spouse or partner. The IRS requires that the benefits you elect remain in effect for the entire plan year unless you experience a qualifying life event.

ELIGIBILITY

A **benefit-eligible** employee is a full-time employee who works at least 35 or more hours per week in a position lasting at least 9 months; or a part-time employee who works at least 20 or more hours per week in a position lasting 12 months (at least 1,000 hours per year). Additional eligibility rules are found under each benefit section.

DEPENDENTS

Generally, “dependents” are (1) the legal spouse of an employee; (2) a domestic partner in a long-term, committed, and financially interdependent relationship with the employee, as certified by the employee on the College’s Domestic Partnership Affidavit; (3) a child of an employee who on January 1 of any year is under 26 years of age; and (4) a child of an employee, of any age, who is physically or mentally incapable of earning a living. The term “child” will include (a) a child born of the employee, (b) a child legally adopted by the employee, and (c) a step-child of the employee living in a normal parent-child relationship with, and dependent on, the employee. Contact the Office of Human Resources for further details.

DEPENDENT STATUS

When a covered dependent gains / loses dependent status, you must add / remove that dependent from coverage through Workday—Life Event Change. If a covered dependent is removed from medical, dental, or vision coverage, that person may be eligible for coverage continuation under COBRA.

DOMESTIC PARTNERSHIP

Haverford College provides certain benefits to your domestic partner and their eligible children under the Haverford College Health & Welfare Benefits Plan, provided you and your domestic partner complete and sign the “Affidavit of Domestic Partnership”. You must sign this Affidavit in the presence of a Notary Public, and return it along with supporting documentation to the Office of Human Resources. Once your Affidavit and documentation have been reviewed, you and your domestic partner will be informed as to whether any further information or action is required. *(Note: If a domestic partner is covered by a medical plan, the amount of the “College contribution” attributable to their portion of the overall cost of the coverage, is taxable to the employee as regular income.)*

MEDICAL PLAN CHOICES FOR 2024

The College offers three medical plan options through Independence Blue Cross (IBC) for 2024, consisting of:

- Keystone HMO Plan
- Personal Choice PPO Plan
- High Deductible Health Plan (HDHP) with HSA

MEDICAL INSURANCE OVERVIEW

Eligibility: The College offers medical insurance coverage to full-time and part-time benefit-eligible employees in accordance with the federal Affordable Care Act. Employees working 30 hours per week over 39 weeks, are eligible for medical coverage at the “full-time premium rate.” Part-time employees working at least 1,000 hours per year, are eligible for medical coverage at the “part-time premium rate.” (Please refer to the respective premium rate tables on page 11.)

It’s good to have choices. When it comes to health insurance, you have your choice of several plan types. **Two plan types which are offered at Haverford College are HMO and PPO plans.** Differences between HMO (Health Maintenance Organization) and PPO (Preferred Provider Organization) plans include network size, referrals to see specialists, costs, and out-of-network coverage. Compared to PPOs, HMOs cost less in premiums. However, PPOs generally offer greater flexibility in seeing specialists without a referral, have larger networks than HMOs, and offer some out-of-network coverage.

An HMO gives you access to certain doctors and hospitals within its network. A network is made up of providers that have agreed to negotiated rates for plan members and also meet quality standards. But unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO’s network. In addition, referrals are needed from a primary care physician in order to see specialists.

PPO plans provide more flexibility when selecting a doctor or hospital. In most cases referrals from a primary care physician are not required in order to see specialists. They also feature a network of providers, but there are fewer restrictions on seeing non-network providers. In addition, your PPO insurance plan will cover some of your cost if you see a non-network provider, although it may be at a lower reimbursement rate and with out-of-pocket cost.

A third type of plan offered by the College is a high deductible health plan (HDHP). An HDHP is PPO-based and requires greater member out-of-pocket expense in exchange for lower monthly premiums. This plan also combines with a Health Savings Account (HSA).

KEYSTONE HMO PLAN

With the Keystone HMO (Health Maintenance Organization):

- **A Primary Care Physician (PCP) is required.** You must select a PCP when enrolling, and treat with that physician before treating with a participating specialist.
- **Referrals are required.** Specific documentation is required from your PCP, authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification is required.** Approval from Independence Blue Cross (IBC) is required for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. Your participating provider will contact Independence Blue Cross for authorization.

For more details regarding the HMO plan, please refer to the HMO Plan Summary and the HMO Rx Benefits Summary, available at haverford.edu/human-resources/benefits, or call (800) ASK-BLUE/(800) 275-2583.



Please see the charts on pages 10–11 for a high-level comparison of medical plans and coverage, as well as monthly premiums.



PERSONAL CHOICE PPO PLAN

With the Personal Choice PPO (Preferred Provider Organization):

- You do not need to specify a Primary Care Physician (PCP).
- Typically you do not need a referral to see a specialist; you can go directly for care.

The Personal Choice PPO Plan provides you greater freedom of choice by allowing you to select from an expansive network of doctors and hospitals. You can maximize your coverage by accessing care through Personal Choice's network (in-network) of hospitals, doctors and specialists, or by accessing care through preferred providers that participate in the BlueCard® PPO program across the country. With Personal Choice, you also have the freedom to select providers who do not participate in the Personal Choice network or BlueCard® PPO program (out-of-network). However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit paid claims for reimbursement.

For more details regarding the PPO plan, please refer to the PPO Plan Summary and the PPO Rx Benefits Summary, available at haverford.edu/human-resources/benefits, or call (800) ASK-BLUE/(800) 275-2583.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) WITH HSA

With the PPO-based High Deductible Health Plan (HDHP):

- You are responsible for higher initial out-of-pocket expenses, because of the higher deductible.
- You do not need to specify a Primary Care Physician (PCP).
- Typically you do not need a referral to see a specialist; you can go directly for care.
- You will have access to a Health Savings Account (HSA). See details in the following section.

The HDHP provides you greater freedom of choice by allowing you to select from an expansive network of doctors and hospitals. You can maximize your coverage by accessing in-network care through the Personal Choice PPO network of hospitals, doctors and specialists, or by accessing care through preferred providers that participate in the BlueCard® PPO program across the country. With the HDHP, you also have the freedom to select out-of-network providers who do not participate in the Personal Choice PPO network or BlueCard® PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit paid claims for reimbursement.

For more details regarding the HDHP plan, please refer to the HDHP Plan Summary and the HDHP Rx Benefits Summary, available at haverford.edu/human-resources/benefits, or call (800) ASK-BLUE/(800) 275-2583.

HEALTH SAVINGS ACCOUNT (HSA)

Employees participating in the HDHP will have access to a Health Savings Account (HSA). This is an interest bearing "pretax" savings vehicle, which can be funded with either College or employee pre-tax contributions. It can be used to pay for qualified health care expenses on a tax-free basis. If elected, the employee's contribution is deposited into this account during the year. (Changes to the contribution amount can be made during the year, subject to maximum IRS contribution limits.)

An HSA works very much like a flexible spending account (FSA) with some advantages. In addition to higher annual contribution limits versus an FSA, the money in the HSA account is fully owned by the employee, and the balance can be carried forward into future years without fear of forfeiture. *Note: IRS guidelines prohibit an employee from participating in a Health Care FSA account if they are enrolled in the HDHP/HSA account option.*

Bank of America is the HSA plan administrator for 2024. Employees initially enrolling in the HSA account for 2024 will receive an HSA debit card from Bank of America.

IMPORTANT: HSA ACCOUNTS AND MEDICARE

If you are enrolled in a Medicare Plan for 2024, or plan to enroll in 2024, you may not be permitted to make contributions (including both College and Employee contributions) to an HSA account for all, or part, of the 2024 calendar year. Please consult with your tax advisor for further guidance.

HSA contribution limits for 2024 are as follows:

- Individual: \$4,150
- Family: \$8,300
- Age 55 catch-up: \$1,000 (additional)

The College only makes an annual contribution (seed) to an HSA account if the employee elects the HDHP during the annual Open Enrollment.

MEDICAL INSURANCE OPT-OUT

Benefit-eligible employees who have adequate coverage through an external qualifying health plan and provide proof of this insurance to the Office of Human Resources (via Workday), will receive a monetary taxable addition with their regular pay. (See amounts on page 11.)

VISION INSURANCE

Eligibility: Full-time and part-time benefit-eligible employees are eligible to participate in voluntary vision insurance coverage.

The College offers IBC Vision for vision care insurance for 2024. This coverage uses the Davis Vision Network and offers members comprehensive routine eye care coverage, including discounted exams and corrective eyewear (frames/lenses and contact lenses). Benefits are maximized when using a participating Davis Vision Provider.

For more details regarding the Davis Vision plan, please refer to the Vision Plan Summary and Highlights available at haverford.edu/human-resources/benefits, or call (800) ASK-BLUE / (800) 275-2583.

CLINICAL DENTAL PANEL

Eligibility: Full-time and part-time benefit-eligible employees are eligible to elect participation in the Clinical Dental Panel.

Employees and their eligible dependents have access to five local participating Dental Panel providers who provide an extensive list of covered dental services.

For more information, please refer to the Dental Panel summary of covered services, available at haverford.edu/human-resources/benefits.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Eligibility: Full-time and part-time benefit-eligible employees are eligible to elect participation in Flexible Spending Accounts.

PayFlex is the administrator for the Flexible Spending Accounts program. This program allows employees to save money on a pre-tax basis to pay for unreimbursed (out-of-pocket) qualified health/medical care expenses, and certain dependent care expenses. In these accounts, you save a portion of your pay with pre-tax dollars (through payroll deduction), thereby reducing your federal income tax burden. Specifically, the plan allows you to contribute your own money, before federal income tax, Social Security tax, and state tax (exceptions apply) to accounts, which will then be used to reimburse you for qualified out-of-pocket health care or dependent care costs. Reimbursements are, in essence, the employee's own money paid back tax-free. A Grace Period (for Health and Limited Purpose FSAs only) exists to allow participants to incur claims through March 15, 2025, and submit them by March 31, 2025, against the 2024 plan year account balance. Visit payflex.com.





Important: The IRS applies a “forfeiture rule” to FSA accounts: If the amount in the FSA account is not used by the end of the calendar year (for Dependent Care), or by the end of the Grace Period (for Health and Limited Purpose)—that remaining balance is forfeited and returned to the College. Remember that you should only fund the flex accounts for eligible expenses that you can reasonably expect to incur in 2024.

HEALTH CARE FSA

You may have money deducted from your pay on a pre-tax basis to cover qualified medical expenses that are not covered by your medical, prescription drug, dental, or vision insurance. The annual Health Care FSA contribution maximum for 2024 is \$3,200.

Reminder: Because of the healthcare reform legislation, you may utilize funds in your Health Care FSA to pay for qualified medical expenses for dependents to age 26. Flexible spending accounts operate on a calendar year basis. If you wish to participate for 2024, you must enroll via Workday. An FSA debit card will be issued to all new members who are enrolling in the Health Care FSA for 2024.

Note: IRS guidelines prohibit an employee from participating in a Health Care FSA account if they are enrolling in the HDHP/HSA option.

DEPENDENT CARE FSA

You may have money deducted from your pay on a pre-tax basis (federal tax) to cover the costs for qualified dependent care expenses. This account would include expenses related to child care for children up to age 13, and for expenses incurred for the care of other qualified dependents. The maximum annual contribution amount for the 2024 plan year is \$5,000 per family. You save money by paying for these expenses with pre-tax dollars.

LIMITED PURPOSE FSA

You may have money deducted from your pay on a pre-tax basis to cover qualified dental or vision care expenses. You must be enrolled in a HDHP and enrolled in an HSA in order to elect this type of FSA arrangement. The maximum annual contribution amount for a Limited Purpose FSA for 2024 is \$3,200.

For more details regarding the PayFlex FSA plans, please refer to the Flexible Spending Account information at haverford.edu/human-resources/benefits, or visit PayFlex at payflex.com.

LIFE INSURANCE

Eligibility: Full-time employees (employees who work 35 or more hours per week over nine or more months) are eligible for all life insurance coverage options.

BASIC LIFE/ACCIDENTAL DEATH (AD&D) INSURANCE

Eligible employees under age 65 receive Basic Group Term Life and AD&D Insurance coverage through Unum Insurance in the amount of \$50,000 at no cost to the employee. Coverage is effective on the first of the month following, or concurrent with, the first day of employment. Beginning at age 65, employees receive Basic Group Term Life Insurance coverage with age-based reductions in coverage amounts.

EMPLOYEE VOLUNTARY LIFE /ACCIDENTAL DEATH (AD&D) INSURANCE

Over and above the Basic Life Insurance (described above) provided by the College, employees may elect additional Voluntary Life Insurance, offered by Haverford through Unum Insurance. Premiums, which are determined by the amount of coverage elected and the age of the employee (based on age-banded rates), are fully paid by the employee through payroll deduction.

At the time of hire, new employees may purchase Voluntary Life and AD&D Insurance for themselves in increments of \$10,000, up to five times their annual salary (not to exceed \$500,000). (*Evidence of Insurability may be required.*)

- For elected coverage amounts up to \$150,000 (not to exceed five times annual salary), evidence of insurability is not required. (*Guarantee issue*)
- For elected coverage amounts greater than \$150,000, evidence of insurability is required. (*See sidebar, Providing Evidence of Insurability.*)

After the time of hire, employees may purchase or adjust levels of Voluntary Life Insurance and AD&D only after a qualifying life event (see Key Terms, page 2) or during the annual Open Enrollment period, held each fall for benefits coverage during the following calendar year. After a qualifying life event or during Open Enrollment:

- An employee who currently holds Voluntary Life Insurance coverage in an amount less than \$150,000 may elect \$10,000 of additional coverage without providing evidence of insurability.
- An employee electing Voluntary Life coverage for the first time; electing more than \$10,000 of additional coverage; or increasing coverage above current coverage of \$150,000 must provide evidence of insurability. (*See sidebar, Providing Evidence of Insurability.*)

DEPENDENT LIFE/ACCIDENTAL DEATH (AD&D) INSURANCE

Qualified, benefit-eligible employees may purchase Dependent Life Insurance for their spouse/partner and/or dependent children (to age 26), and Accidental Death Insurance (AD&D) for themselves and for their spouse/partner and/or dependent children (to age 26). Please note these important conditions for enrollment:

- Employees must hold Voluntary Life and AD&D coverage for themselves before electing Dependent Life and AD&D for dependents.
- Voluntary/Dependent Life must be elected for all covered persons before electing AD&D coverage for those same people.
- Employees cannot elect more Dependent Life or AD&D coverage for their spouse/partner or dependents than they hold for themselves.

Dependent Life and AD&D coverage is also available during Open Enrollment or after an IRS qualifying life event. Coverage amounts are listed below.

Dependent Life coverage amounts:

Spouse/Partner: Up to 100% of employee's Voluntary Life coverage amount, in increments of \$5,000, not to exceed \$500,000. (Note: Any request for new coverage, an increase to existing coverage greater than \$5,000, or coverage greater than \$25,000, requires Evidence of Insurability. (*See sidebar, Providing Evidence of Insurability.*))

Each Child: Up to 100% of employee's Voluntary Life coverage, in increments of \$2,000, not to exceed \$10,000. (*Evidence of Insurability is not required.*)

AD&D coverage amounts:

Employee: Up to 100% of Voluntary Life coverage amount, in increments of \$10,000, not to exceed \$500,000.

Spouse/Partner: Up to 100% of employee's Voluntary Life coverage amount, in increments of \$5,000, not to exceed \$500,000. (*Must elect Dependent Life first.*)

Each Child: Up to 100% of employee's Voluntary Life coverage amount, in increments of \$2,000, not to exceed \$10,000. (*Must elect Dependent Life first.*)



PROVIDING EVIDENCE OF INSURABILITY

When evidence of insurability is required, the employee **MUST** complete and submit the Evidence of Insurability form, a health questionnaire provided by Unum and available via Workday. Unum will review the form and make a determination. Elected coverage amounts will not take effect until approved by Unum.

Please note these important deadlines:

- For coverage elected at the time of hire, the Evidence of Insurability form **MUST** be completed by the employee and submitted to Unum within 31 days of the employee's date of hire.
- For coverage elected during Open Enrollment, the Evidence of Insurability form **MUST** be completed by the employee and submitted to Unum within 31 days of the effective date of coverage.

If the form is not received by Unum by the deadline, the requested additional coverage will not be in place.



LONG-TERM DISABILITY INSURANCE (LTD)

Eligibility: Full-time employees (employees who work 35 or more hours per week over nine or more months) are eligible for LTD.

Eligible employees receive College-paid Long-term Disability Insurance (LTD) through Unum. This insurance provides income replacement benefits of up to 60% of base monthly earnings (maximum monthly benefit of \$15,000). LTD insurance payments begin after a 180-day elimination period (considered Short-Term Disability) for a qualified medical condition which causes the employee an inability to perform the essential functions of their job, resulting in a loss in earnings. LTD payments provide an income-replacement component and a retirement plan contribution component. The duration of benefit payments depends on the age at which disability begins and may continue until Social Security Normal Retirement Age.

ADDITIONAL RESOURCES

CAREBRIDGE EMPLOYEE ASSISTANCE PROGRAM

Eligibility: Full-time and part-time benefit-eligible employees are eligible for Carebridge services.

Carebridge is a free, confidential resource that provides counseling, information, and referral services to help address personal, family, and work-related concerns, and provides support for you in completing daily life responsibilities. Counselors have advanced degrees and are credentialed and experienced in helping you or your eligible dependents. **You can contact Carebridge at (800) 437-0911 or log on to myliferesource.com with Haverford's code TTY4N. (Please see page 19.)**

HEALTH ADVOCATE

Eligibility: Full-time and part-time benefit-eligible employees are eligible for Health Advocate services.

Health Advocate, Inc. is a U.S. national health advocacy, patient advocacy, and assistance company, offering a spectrum of services to help employees navigate the healthcare system and to facilitate interactions with insurers and providers. Health Advocate uses registered nurses, medical directors, and benefits specialists to assist employees in addressing a range of health care and health insurance issues. Personal Health Advocates can help members locate providers, address errors on medical bills, answer questions about coverage denials, and assist with insurance appeals. There is no cost to the employee for this program. **Visit healthadvocate.com/members or call (866) 695-8622. (Please see pages 20–21.)**

RIDEECO TRANSPORTATION BENEFIT

Eligibility: Full-time and part-time benefit-eligible employees are eligible to participate in the RideEco program.

RideEco is a College-offered benefit that helps commuters pay for the cost of getting to work on public transportation. RideEco allows commuters to use pre-tax dollars to pay for transportation from their residence to the College. Transportation benefits are exempt from federal income tax withholding, Social Security and Medicare (FICA) taxes. View the RideEco instructions and then enroll at rideecoselect.com. (The employer ID is 1072.)

TUITION GRANT PROGRAM

Eligibility: Employees who have held a benefit-eligible position for seven consecutive years preceding the utilization of the Tuition Grant benefit may request this benefit for tax-qualified dependent children of the employee.

Once eligible, employees can receive a 50% tuition grant benefit (50% of the tuition of the school being attended, not to exceed 50% of Haverford's tuition for that academic

year). The maximum tuition grant benefit payable “per child” is 8 academic semesters; the maximum grant benefit payable for “all children” is 16 academic semesters.

For further details, please contact the Office of Human Resources.

RETIREMENT PLANS

HAVERFORD COLLEGE RETIREMENT PLAN

Eligibility: Benefit-eligible exempt, non-fixed term, faculty and staff scheduled to work 1000 hours per year are immediately eligible for the College contribution. After a one-year waiting period, benefit-eligible non-exempt and fixed term faculty and staff scheduled to work 1000 hours per year, are eligible for the College contribution. All employees of Haverford College are eligible to participate in the Haverford College Retirement Plan at any time, through the employee’s own voluntary pre-tax contributions (elective deferrals) to the Plan.

Upon meeting eligibility requirements, the College contributes an amount equal to 10% of base salary each pay period to a 403(b) defined contribution retirement plan. No contribution by the employee is required to receive this 10% College contribution. Additional voluntary contributions can be made to the plan at any time of the year.

The Haverford College Retirement Plan is a “defined contribution” plan covered under Section 403(b) of the Internal Revenue Codes. All contributions to the plan, both Employer and Employee (voluntary) are 100% and immediately vested. (Employee has full and immediate ownership of these contributions.)

Although a target-date investment fund is the default fund when a new employee is hired, employees can select from a diverse investment fund lineup that collectively covers all major asset classes. Employees can choose investment funds on the Fidelity Investments fund platform. Fund allocations and contribution amounts can be changed at any time of the year within the employee’s portfolio via the Fidelity NetBenefits website, netbenefits.com.

In-service distributions are permitted from the plan (all sources) upon attaining age 59 ½. Loans and hardship withdrawals are also permitted from the plan subject to certain restrictions and limitations.

Please refer to the Haverford College Retirement Plan Summary Plan Description (SPD) for further details about the plan, available on the HR website and at netbenefits.com.

EMERITI RETIREMENT HEALTH PLAN

The Emeriti Retirement Health Plan is a way to help you prepare and pay for your qualified medical expenses in retirement. As you get older, healthcare costs are likely to take up a larger portion of your budget, and Medicare may not be enough. The Emeriti plan complements your retirement plan, and it offers a number of tax advantages, both while you are accumulating savings and later when you are retired, including:

- Tax-free employer contributions
- Tax-free investment earnings
- Tax-free reimbursement for qualified medical expenses during retirement.

The College makes contributions to an Emeriti account (pro-rated per pay), for each benefit-eligible employee age 40 and above. Employees may make after-tax voluntary contributions at any time of the year.* There is a seven-year vesting requirement for employer contributions, before the employee owns the account balance. (Employee after-tax voluntary contributions are immediately vested.) Funds can be used only after termination of employment with Haverford College, or after retirement, to pay for qualified medical expenses through a reimbursement process. In addition, qualified retired employees may be eligible to enroll in post-65 medical and/or prescription drug plans, and a dental plan offered through Aetna.

**Employer contributions and voluntary after-tax contributions are subject to forfeiture. Assets remaining in your account at time of death, if there are no surviving eligible dependents (spouse, domestic partner, IRS dependent children or relatives), forfeit back to Haverford College.*



BRIEF COMPARISON OF MEDICAL PLANS & COVERAGE

For January 1, 2024, through December 31, 2024

BENEFITS	KHMO	PC PPO		HDHP/HSA	
	Referred Care	In Network	Out of Network	In Network	Out of Network
DEDUCTIBLE					
Individual	\$0	\$300	\$1,500	\$1,600	\$5,000
Family	\$0	\$900	\$4,500	\$3,200	\$10,000
OUT OF POCKET MAXIMUM (INCLUDES DEDUCTIBLE, COPAYMENTS AND COINSURANCE)					
Individual	\$6,350	\$3,000	\$6,000	\$6,350	\$10,000
Family	\$12,700	\$9,000	\$18,000	\$12,700	\$20,000
PHYSICIAN SERVICES					
Primary Care	\$15 Copay	\$20 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
Specialists	\$25 Copay	\$40 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
Retail Health Clinic	\$15 Copay	\$20 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
Telemedicine (Teladoc)	\$15 Copay	\$20 Copay, No Deductible	Not Covered	100% After Deductible	Not Covered
Urgent Care	\$105 Copay	\$105 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
RADIOLOGY AND LAB WORK					
Xrays/ Radiology	100%	\$40 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
Lab Work/ Pathology	100%	100% After Deductible	70% After Deductible	100% After Deductible	50% After Deductible
WELL CHILD CARE					
Office Visits	100%	100%, No Deductible	70%, No Deductible	100%, No Deductible	50% No Deductible
Immunizations	100%	100%, No Deductible	70%, No Deductible	100%, No Deductible	50% No Deductible
ADULT PREVENTATIVE CARE					
Routine Physicals	100%	100%, No Deductible	70%, No Deductible	100%, No Deductible	50% No Deductible
Gyn Exam	100%	100%, No Deductible	70%, No Deductible	100%, No Deductible	50% No Deductible
Prostate Exams	100%	100%, No Deductible	70%, No Deductible	100%, No Deductible	50% No Deductible
Mammograms	100%	100%, No Deductible	70%, No Deductible	100%, No Deductible	50% No Deductible
HOSPITAL CARE					
Inpatient Treatment	\$500 Copay Per Admission	\$150/day Copay, Max 5 Days; No Deductible (After 5 Days Full Coverage, No Copay)	70% After Deductible	100% After Deductible	50% After Deductible
OUTPATIENT FACILITY AND PHYSICIAN SERVICES					
Facility	\$250 Copay	\$150 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
Physician	100%	100% After Deductible	70% After Deductible	100% After Deductible	50% After Deductible
BEHAVIORAL HEALTH					
Inpatient	\$500 Copay Per Admission	\$150/day Copay, Max 5 Days; No Deductible, Same As Above	70% After Deductible	100% After Deductible	50% After Deductible
Outpatient	\$25 Copay	\$40 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPIES					
Office Visits	100%	\$40 Copay, No Deductible	70% After Deductible	100% After Deductible	50% After Deductible
RETAIL DRUGS (30 DAY SUPPLY)					
Generic	\$20 Copay	\$20 Copay	30% Reimbursement	\$5 Copay, After Deductible	50% After Deductible
Preferred Brand	\$40 Copay	\$40 Copay	30% Reimbursement	\$20 Copay, After Deductible	50% After Deductible
Non-Preferred Brand	\$80 Copay	\$80 Copay	30% Reimbursement	\$45 Copay, After Deductible	50% After Deductible
MAIL ORDER DRUGS					
Generic	\$40 Copay	\$40 Copay	Not Covered	\$10 Copay, After Deductible	Not Covered
Preferred Brand	\$80 Copay	\$80 Copay	Not Covered	\$40 Copay, After Deductible	Not Covered
Non-Preferred Brand	\$160 Copay	\$160 Copay	Not Covered	\$90 Copay, After Deductible	Not Covered

MEDICAL COVERAGE MONTHLY PREMIUM RATES For January 1, 2024, through December 31, 2024

TIER 1 SALARY UP TO \$50,999						
TIER 1	KHMO		PC PPO		HDHP/HSA	
	YOU PAY	HC PAYS	YOU PAY	HC PAYS	YOU PAY	HC PAYS
■ INDIVIDUAL	\$26	\$767	\$66	\$731	\$12	\$704
■ EMPLOYEE & CHILDREN	\$113	\$1,473	\$209	\$1,384	\$18	\$1,415
■ COUPLE	\$136	\$1,648	\$245	\$1,548	\$29	\$1,583
■ FAMILY	\$191	\$2,386	\$348	\$2,241	\$35	\$2,294

Opt-out waiver amount is \$159.20 per month (paid to you as taxable income).

TIER 2 SALARY \$51,000 TO \$102,000						
TIER 2	KHMO		PC PPO		HDHP/HSA	
	YOU PAY	HC PAYS	YOU PAY	HC PAYS	YOU PAY	HC PAYS
■ INDIVIDUAL	\$58	\$735	\$113	\$684	\$23	\$693
■ EMPLOYEE & CHILDREN	\$191	\$1,395	\$288	\$1,305	\$74	\$1,359
■ COUPLE	\$225	\$1,559	\$337	\$1,456	\$95	\$1,517
■ FAMILY	\$321	\$2,256	\$479	\$2,110	\$131	\$2,198

Opt-out waiver amount is \$142.10 per month (paid to you as taxable income).

TIER 3 SALARY ABOVE \$102,000						
TIER 3	KHMO		PC PPO		HDHP/HSA	
	YOU PAY	HC PAYS	YOU PAY	HC PAYS	YOU PAY	HC PAYS
■ INDIVIDUAL	\$113	\$680	\$177	\$620	\$36	\$680
■ EMPLOYEE & CHILDREN	\$334	\$1,252	\$479	\$1,114	\$205	\$1,228
■ COUPLE	\$387	\$1,397	\$551	\$1,242	\$241	\$1,371
■ FAMILY	\$553	\$2,024	\$791	\$1,798	\$343	\$1,986

Opt-out waiver amount is \$125.00 per month (paid to you as taxable income).

PART-TIME EMPLOYEES <small>Opt-out waiver amount is \$79.60 per month (paid to you as taxable income).</small>						
	KHMO		PC PPO		HDHP/HSA	
	YOU PAY	HC PAYS	YOU PAY	HC PAYS	YOU PAY	HC PAYS
■ INDIVIDUAL	\$373	\$420	\$374	\$423	\$337	\$379
■ EMPLOYEE & CHILDREN	\$745	\$841	\$749	\$844	\$673	\$760
■ COUPLE	\$838	\$946	\$842	\$951	\$758	\$854
■ FAMILY	\$1,211	\$1,366	\$1,217	\$1,372	\$815	\$1,514

DENTAL PANEL RATES			
	SALARY TIER		
	1	2	3
■ INDIVIDUAL	\$4.12	\$9.54	\$17.01
■ EMPLOYEE + 1 DEPENDENT	\$7.47	\$13.92	\$21.39
■ EMPLOYEE + 2 OR MORE DEPENDENTS	\$8.76	\$15.21	\$22.68

VISION COVERAGE PREMIUM RATES	
■ INDIVIDUAL	\$7.53
■ EMPLOYEE & CHILDREN	\$15.06
■ COUPLE	\$15.06
■ FAMILY	\$15.06

For a complete list of covered services, please refer to the Summary of Benefits and Coverage.

NOTICES

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

- One year from the start of the medically necessary leave of absence; or
- The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

- 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.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter. Additional consumer information on WHCRA is available in the publication *Your Rights After A Mastectomy*.

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 healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, 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-KIDSNOW or 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 askebsa.dol.gov or call 1-866-444-EBSA (3272).

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the

information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited circumstances.

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

MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

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

What is the health insurance Marketplace?

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

Can I save money on my health insurance premiums in the Marketplace?

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

Does employer health coverage affect eligibility for premium savings through the Marketplace?

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the

1 Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2024.

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

NOTICES, cont.

health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

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

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

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

Marketplace-eligible individuals who live in states served by HealthCare.gov and either submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

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

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How can I get more information?

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: Haverford College	4. Employer Identification Number (EIN): 23-6002304	
5. Employer address: 370 Lancaster Avenue	6. Employer phone number: 610-896-1219	
7. City: Haverford	8. State: PA	9. Zip code: 19041
10. Who can we contact about employee health coverage at this job? Charles Crawford – Director, Benefits Administration		
11. Phone number (if different from above)	12. Email address: ccrawford1@haverford.edu	

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

As you know, if you have declined enrollment in Haverford College’s health plan for you or your dependents (including your spouse/partner) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

- Haverford College will also allow a special enrollment opportunity if you or your eligible dependents either:
- Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible; or
- Become eligible for a state’s premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have *60 days*—instead of 31—from the date of the Medicaid/CHIP eligibility change to request enrollment in the Haverford College group health plan. Note that this new 60-day extension doesn’t apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

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

NOTICE OF CREDITABLE COVERAGE

IMPORTANT NOTICE FROM HAVERFORD COLLEGE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

- 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.
- Haverford College has determined that the prescription drug coverage offered by the Independence Blue Cross (IBC) PPO, IBC High Deductible Health Plan (HDHP), and Keystone HMO plans are, on average for all plan participants, expected to pay out as much as

NOTICES, cont.

standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Haverford College coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For More Information About Medicare Prescription Drug Coverage

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: October 13, 2023

Name of Entity/Sender: Charles F. Crawford

Position/Office: Haverford College – Office of Human Resources

Address: 370 Lancaster Ave., Haverford, PA 19041

Phone Number: (610) 896-1219

CMS Form 10182-CC Updated April 1, 2011

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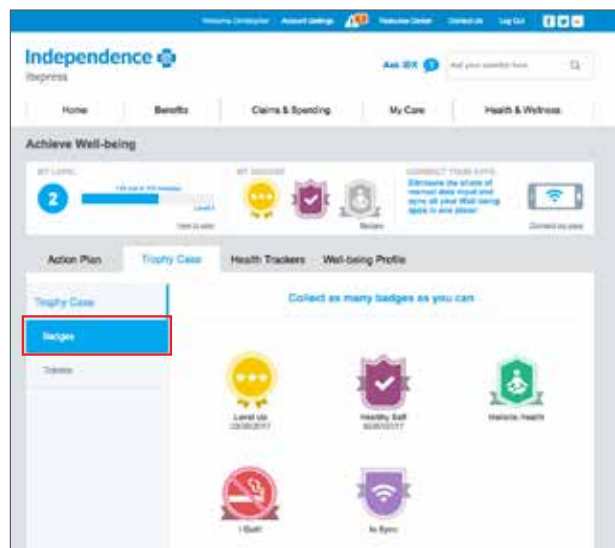
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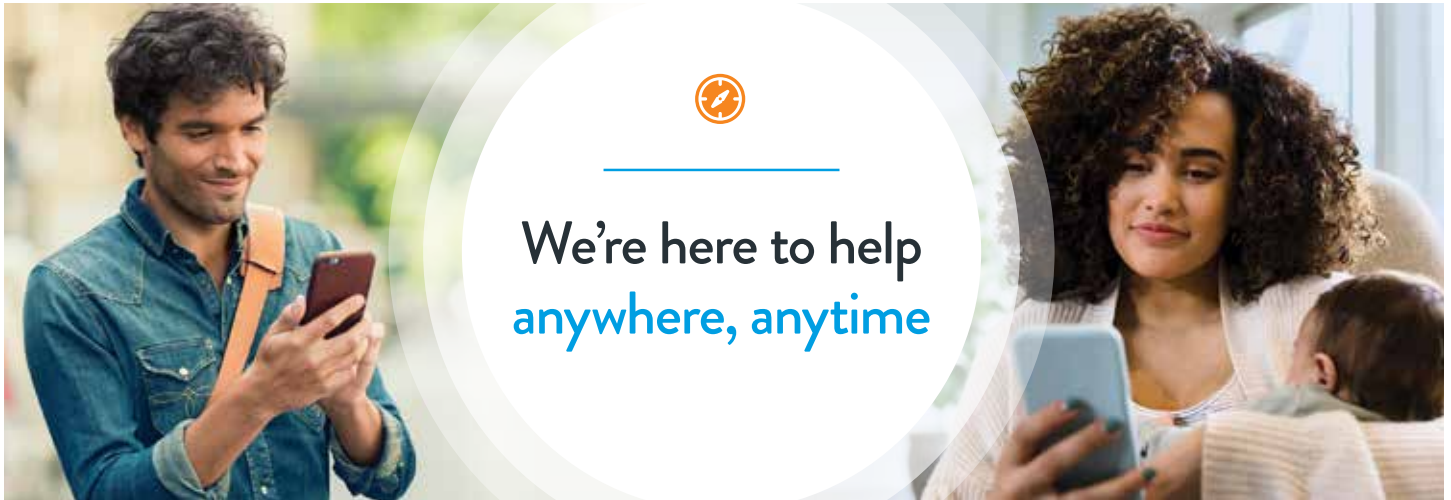
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Web: HealthAdvocate.com/members

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Call TruHearing today

Your dedicated Hearing Consultant can answer your questions, explain your coverage, and schedule an appointment with a TruHearing provider near you.

Call **1-888-933-7861 (TTY: 711)**,
Monday – Friday, 8 a.m. – 8 p.m.

Get complete hearing care

- Access to a large provider network
- Risk-free 60-day trial period
- One year of follow-up visits
- 80 free batteries per non-rechargeable hearing aid
- Full three-year manufacturer warranty

Treating hearing loss can help improve your balance,⁴ mental health, and quality of life.

Hearing coverage with TruHearing

The TruHearing program includes coverage for a hearing exam and discounts on a range of hearing aids. No matter your lifestyle, budget, or level of hearing loss, you have a variety of options.

Service	Your cost	Average retail cost	How often?
Hearing exam	\$0	\$59–\$95	1 exam, per year
Hearing aid – Basic ³	\$295	\$1,850	1 aid per ear, every 3 years
Hearing aid – Standard ³	\$695	\$2,000	
Hearing aid – Advanced ³	\$1,095	\$2,450	
Hearing aid – Premium ³	\$1,495	\$3,100	



Would you like to take a quick hearing test?

Grab your headphones, find a quiet spot, and click the button below to get started.

Take the test

Visit TruHearing.com/IndependenceCommercial-HS

1 Smartphone-compatible hearing aids connect directly to iPhone®, iPad®, and iPod® Touch devices. Some TruHearing models connect to Android® phones directly. Connectivity also available to many Android phones with use of an accessory. TV streaming available through most TVs with use of an accessory. In-app interfacing requires provider activation.

2 Features may vary by model. Activation required.

3 Price based per hearing aid.

4 Attitudes and Actions Towards Hearing Health Summary Report of U.S. Adults Ages 18+, ASHA, 2021.

This is a value-added program and not a benefit under an Independence health plan and is, therefore, subject to change without notice. The TruHearing program is provided by TruHearing, Inc., an independent company. TruHearing, Inc. does not provide Blue Cross products or services.

TruHearing® is a registered trademark of TruHearing, Inc. All other trademarks, product names, and company names are the property of their respective owners. Retail pricing based on prices for comparable aids. Follow-up provider visits included for one year following hearing aid purchase. Free battery offer is not applicable to the purchase of rechargeable hearing aid models. Three-year warranty includes repairs and one-time loss and damage replacement. Hearing aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant.

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.





OFFICE OF HUMAN RESOURCES

If you have any questions or concerns about Open Enrollment or your benefits, please contact our office at **(610) 795-6124** or email hc-hr@haverford.edu; or reach out directly to individual staff.

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The information in this guide is only a summary of plan benefits and Haverford College's policies and is not intended to be a complete description. If there are differences between this guide and any plan documents or contracts, the plan documents or contracts will prevail. This guide is not intended to constitute a contract of employment, a promise of employment for any length of time, or a guarantee of the benefits or policies stated in it. Provisions described herein are subject to change with or without notice to the employees.



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