WELCOME!

Each year, we strive to offer comprehensive and competitive benefit plans to our employees. In the following pages, you will find a summary of our Flexible Benefit Plan for 2022-2023. Please read this guidebook carefully as you prepare to make your elections for the upcoming Plan Year.

About this Benefits Guidebook

This Benefits Guidebook describes the highlights of Bryn Mawr College’s Flexible Benefit Plan in non-technical language. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official plan documents, and not the information in this guidebook. If there is any discrepancy between the description of the plan elements as contained in this benefits guidebook and the official plan documents, the language in the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. You should be aware that any and all elements of Bryn Mawr College’s benefits program may be modified in the future, at any time, to meet Internal Revenue Service rules, or otherwise as decided by Bryn Mawr College.
Plan Rules, Dates, and Eligibility

PLA N YEAR

ELIGIBILITY

DEPENDENT COVERAGE

The Plan Year for Bryn Mawr College's Flexible Benefit Plan begins on November 1, 2022 and ends on October 31, 2023.

ELIGIBILITY

All active employees working 26 or more hours per week are eligible for company-sponsored benefit plans on the first day of the month on or following the date of hire.

DEPENDENT COVERAGE

Employees who are eligible to participate in Bryn Mawr College's Flexible Benefit Plan may also enroll their dependents. For the purposes of our Flexible Benefit Plan, your dependents are defined as follows:

- Your spouse:
  - legal wife/husband
- For medical, dental and vision:
  - your dependent children to age 26 (your dependent children are eligible for medical coverage until the end of the month in which they turn 26, regardless of student status, marital status, residency or financial dependency);
- For additional life insurance:
  - your unmarried children 14 days of age but less than 26 years old;
- Your children age 26 and over who are mentally or physically disabled and dependent upon you for support (proof of condition and dependence must be submitted)
MEDICAL PLAN OPTIONS

Bryn Mawr College offers a choice of four medical plans through Independence Blue Cross. If you elect medical insurance, you must choose one of these plans or you may choose to waive benefits if you have coverage elsewhere.

The Keystone HMO and POS Plans: are both considered Health Maintenance Organization plans. These plans require you to select a primary care physician (PCP) who coordinates your care and authorizes visits to specialists or other providers for in-network services. Generally, you are charged a copayment when you visit your PCP, a specialist or receive a service from an in-network provider. For certain services, x-ray, lab, podiatry and physical/occupational therapy, your PCP is contractually required to refer you to a designated network location. Please Note: referrals can be sent electronically and can be written for up to 90 days. You may change your PCP at any time.

The Keystone POS plan allows you the additional feature of visiting doctors and providers outside the network without referral (self-referral). However, there is a deductible and coinsurance, and balance billing will apply. Out-of-Network expenses are paid at the stated percentage of the lesser of the provider’s charges or Medicare’s allowable amount.

The Personal Choice PPO Plan: allows you and your dependents to visit the physician or specialist of your choosing without selecting a Primary Care Physician (PCP) or obtaining referrals. This option has no deductible, but a higher employee contribution. If you use an out-of-network provider, you may pay more for services.

The Personal Choice High Deductible Health Plan (HDHP): features a higher annual deductible that applies to all services (except preventive services) and must be met before the plan will pay benefits. The High Deductible Health Plan may be paired with a Health Savings Account (HSA), which allows you to set aside funds on a pre-tax basis to pay for qualified medical care (including deductibles and coinsurance).

HEALTH SAVINGS ACCOUNTS (HSA)

If you enroll in the HDHP, you will be eligible to open a HSA. An HSA allows you to save pre-tax money through payroll deductions and to use those funds to pay for qualified medical expenses for you and your family.

» An HSA is a bank account that is controlled by you.
» You will never forfeit money you have deposited (unused funds roll over year after year).
» You may keep your account if you ever leave Bryn Mawr College.
» The balance of your account is available for health care purchases now, or at any time in the future, even if you no longer participate in a qualified HDHP plan (though you may only contribute to an HSA while you are enrolled in a HDHP).
» The maximum amount that can be contributed to your HSA in 2022 is $3,650 for employee only coverage and $7,300 for all other coverage tiers.
» If you are age 55 or over, you can make a $1,000 annual “Catch-up” contribution.
» Contributions to an HSA are tax-free (federal tax and FICA).
» Interest earnings are tax-free as well.

Mid-Year Enrollment

If you enroll in the HDHP mid-year due to being newly eligible or experiencing a qualifying life event and limit your HSA contributions to a prorated amount of 1/12 of the annual maximum per each month you are in the HDHP, then you have no restrictions. You may change plans at the next Open Enrollment if desired.

However, if you place more than the prorated annual amount into the HSA (IRS allows you to contribute the maximum regardless of effective date) then you must remain in the HDHP for a minimum of 12 months following the end of the current plan year (so you cannot change plans for two Open Enrollments) or you will pay taxes and a 10% penalty.

For example, if you enroll February 1st, you can only contribute and receive up to 9/12 of the annual maximum, otherwise you are subject to IRS enrollment rules or taxes and penalties.
## HMO & POS Plans

<table>
<thead>
<tr>
<th>Benefit</th>
<th><strong>Keystone HMO</strong></th>
<th><strong>Keystone POS Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Out-Of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,350</td>
<td>$6,350</td>
</tr>
<tr>
<td>Family</td>
<td>$12,700</td>
<td>$12,700</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>Office Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$150 copay (waived if admitted)</td>
<td>$150 copay (waived if admitted)</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>Diagnostic X-Ray and Laboratory</strong></td>
<td>X-ray = $50</td>
<td>X-ray = $50</td>
</tr>
<tr>
<td></td>
<td>Lab = 100% covered</td>
<td>Lab = 100% covered</td>
</tr>
<tr>
<td><strong>Inpatient Hospitalization</strong></td>
<td>$150 copay/day</td>
<td>$150 copay/day</td>
</tr>
<tr>
<td></td>
<td>$750 maximum/admission</td>
<td>$750 maximum/admission</td>
</tr>
<tr>
<td><strong>Outpatient Surgical Facility Charges</strong></td>
<td>$250 copay</td>
<td>$250 copay</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>100% covered</td>
<td>100% covered</td>
</tr>
<tr>
<td><strong>Inpatient Mental Health Care or Substance Abuse Treatment</strong></td>
<td>$150 copay/day</td>
<td>$150 copay/day</td>
</tr>
<tr>
<td></td>
<td>$750 maximum/admission</td>
<td>$750 maximum/admission</td>
</tr>
<tr>
<td><strong>Outpatient Mental Health Care or Substance Abuse Treatment (Facility and Clinic)</strong></td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td><strong>Prescription Retail (30 Day)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$20 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Brand</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Nonformulary</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td><strong>Prescription Mail Order (90 Day)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$40 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Brand</td>
<td>$100 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Nonformulary</td>
<td>$200 copay</td>
<td>$200 copay</td>
</tr>
</tbody>
</table>

*If you use out-of-network benefits, Independence will pay based on the Medicare allowance for services rendered. The provider has the right to balance bill you the difference. *Specialty Prescriptions* - if you are filling a specialty drug on the HMO or POS plan that has a manufacturer copay card, you may be contacted to enroll in the copay program which will save you and the plan money.

Note: This chart is a summary of options offered under the plan. For more information, please refer to the plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.
# PPO & HDHP Plans

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>Personal Choice PPO Plan</th>
<th>Personal Choice HDHP Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK*</td>
</tr>
<tr>
<td></td>
<td>IN-NETWORK</td>
<td>OUT-OF-NETWORK*</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$0 Individual</td>
<td>$500 Individual</td>
</tr>
<tr>
<td></td>
<td>$0 Family</td>
<td>$1,000 Family</td>
</tr>
<tr>
<td>Family</td>
<td>$1,500 (Employee Only Coverage)</td>
<td>$5,000 (Employee Only Coverage)</td>
</tr>
<tr>
<td>Out-Of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$6,350 Individual</td>
<td>$3,000 Individual</td>
</tr>
<tr>
<td></td>
<td>$12,700 Family</td>
<td>$6,000 Family</td>
</tr>
<tr>
<td>Family</td>
<td>$10,000 (Employee Only Coverage)</td>
<td>$20,000 (Employee + Dependent Coverage)**</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$15 copay</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Primary Care Specialist</td>
<td>$25 copay</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>100% covered</td>
<td>70% no deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$150 copay (waived if admitted)</td>
<td>$150 copay no deductible (waived if admitted)</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>90% after in-network deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50 copay</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Diagnostic X-Ray and Laboratory</td>
<td>X-ray = $20 Lab = 100% covered</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Inpatient Hospitalization</td>
<td>$250 copay /admission</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgical Facility Charges</td>
<td>$100 copay</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$25 copay</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Inpatient Mental Health Care or Substance Abuse Treatment</td>
<td>$250 copay /admission</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Outpatient Mental Health Care or Substance Abuse Treatment (Facility &amp; Clinic)</td>
<td>$25 copay</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Prescription Retail (30 Day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$20 copay</td>
<td>Covered 30% at a non-participating pharmacy</td>
</tr>
<tr>
<td>Brand</td>
<td>$50 copay</td>
<td></td>
</tr>
<tr>
<td>Nonformulary</td>
<td>$100 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(after ded. unless on the preventive list)</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Prescription Mail Order (90 Day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$40 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Brand</td>
<td>$100 copay</td>
<td></td>
</tr>
<tr>
<td>Nonformulary</td>
<td>$200 copay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(after ded. unless on the preventive list)</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

*If you use out-of-network benefits, Independence will pay based on the Medicare allowance for services rendered. The provider has the right to balance bill you the difference.**

**Specialty Prescriptions** if you are filling a specialty drug on the PPO plan that has a manufacturer copay card, you may be contacted to enroll in the copay program which will save you and the plan money. The copay program does not apply to the HDHP.

Note: This chart is a summary of options offered under the plan. For more information, please refer to the plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

*If you use out-of-network benefits, Independence will pay based on the Reasonable and Customary charges for services rendered. The provider has the right to balance bill you the difference.

**The Personal Choice HDHP’s Out-Of-Pocket Maximum is embedded. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Payment Limit amount.**
CATAPULT

Catapult Health offers you and your family a comprehensive health evaluation through a VirtualCheckup home kit. The VirtualCheckup from Catapult Health is an easy way to schedule your annual checkups virtually with a board-certified nurse practitioner. Once you complete and send your home kit via two-day mail, a Catapult Health Nurse Practitioner will meet with you privately via video chat to deliver a personal action plan based on your results. During your review with the nurse practitioner, you will also be screened for COVID-19 and depression. This is covered 100% as a preventive screening with no cost to you.

MDLIVE

For quick, convenient access to a provider while you are at the office or on the go, you can use Telehealth, a telemedicine service. Board certified doctors and pediatricians are available by secure video, phone, or mobile app — anytime, anywhere — and can treat non-emergency medical conditions such as:

» Colds and flu
» Allergies
» Asthma
» Pink eye
» Ear infections
» Sinus problems
» Respiratory infections
» Joint aches and pains
» Vomiting and nausea
» And more

Telehealth visit charges are based on the PCP copay for the applicable plan. For the HDHP, you are responsible for the full charge until you have met your deductible. For calendar year 2022, the full visit charge is $56.

OVA

Ovia is a maternity and family benefit designed to assist you through the parenthood journey. With Ovia Health, you will have access to enhanced, personalized health and wellness features to help you navigate infertility, sexual health, birth planning, preterm delivery, mental health, breastfeeding and more. To learn more, download the Ovia app that is right for you - Ovia Fertility, Ovia Pregnancy or Ovia Parenting. When signing up with your email choose, “I have Ovia Health as a benefit” before clicking “Sign-up.”

PROPELLER

Propeller aids employees in effectively treating chronic respiratory disease. By simply attaching the Propeller sensor to your inhaler, you can gain a better understanding of your triggers and what may be causing your symptoms. Propeller works alongside your current treatment plan and helps reduce the hassle of managing asthma and COPD. To register visit ibx.propellerhealth.com or call 877-251-5451.

LIVONGO “NEW IN 2023”

Livongo Diabetes Management program helps members understand their blood sugar, develop healthy lifestyle habits, and improve glycemic control. The program provides you with an advanced cellular-connected glucose monitor, unlimited strips and lancets, personalized insights, one-on-one coaching to better manage your health. All at no cost to you! Call IBC Member Services to see if you qualify for the Livongo Diabetes Management Program.

WONDR HEALTH “NEW IN 2023”

Wondr Health is a digital behavioral counseling program for weight management, diabetes prevention and metabolic syndrome reversal. The program teaches members a healthy balance, so they understand how to eat their favorite foods, but still lose weight and improve their physical and mental health. The year-long program is broken up into three phases: WondrSkills (foundations), WondrUp (reinforcement), and WondrLast (maintenance). Register by visiting wondrhealth.com.
DENTAL PLAN

Good dental health is important to your overall well-being. That is why Bryn Mawr College is pleased to offer employees a comprehensive dental plan through Delta Dental.

You may obtain services from a Delta Dental participating PPO provider or an out-of-network provider. The level of benefits is the same for in- and out-of-network services. However, utilizing a Delta Dental participating (in-network) dentist may result in savings for you because participating dentists have agreed to accept the insurance carrier’s fees as full payment for covered services. There is no balance billing for covered services when they are provided by a participating dentist. Out-of-network (non-participating) dentists are not obligated to accept the insurance carrier’s approved costs. If you choose a non-participating dentist, you may be responsible for paying the balance of that dentist’s fees that are above the insurance carrier’s approved amount.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>Delta Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>$1,750 per person each calendar year</td>
</tr>
<tr>
<td>Diagnostic &amp; Preventive: exams, cleaning, x-rays, sealants</td>
<td>100%</td>
</tr>
<tr>
<td>Basic Services: fillings, denture repair, stainless steel crowns, posterior composites</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontic (root canal)</td>
<td>80%</td>
</tr>
<tr>
<td>Periodontics (gum treatments)</td>
<td>50%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80%</td>
</tr>
<tr>
<td>Major Services: crowns, inlays, onlays, cast restoration</td>
<td>50%</td>
</tr>
<tr>
<td>Prosthodontics: Bridges and dentures, implants</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontics Benefits: Dependent children to the end of the calendar year that dependent turns 19</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontics Maximum</td>
<td>$1,500 Lifetime</td>
</tr>
</tbody>
</table>

*Delta Dental Premier® dentists are considered out-of-network dentists.
*Reimbursement is based on PPO contracted fees for PPO dentists; Premier contracted fees for Premier dentists; and Premier contracted fees for non-Delta Dental dentists.

Looking for a DENTIST?

Visit: www.deltadentalins.com

On the homepage, complete the information under “Find a Dentist.” Select the Delta Dental PPO Network. Delta Dental PPO dentists provide you with the greatest discounts.
VISION PLAN RIDERS

Bryn Mawr College offers two vision plans through Davis Vision. One version is a rider to the Personal Choice PPO and HDHP plans and the other is a rider to the Keystone HMO and POS plans. The HDHP vision rider is not subject to the HDHP deductible. The plans allow you to receive an eye exam once every two calendar years, and provides substantial savings on your eye-care purchases. The plans are available through thousands of provider locations participating in the Davis Vision network. Go to [www.davisvision.com](http://www.davisvision.com) or call 1-888-393-2583 to find a nearby provider.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>PPO/HDHP $75 Benefit</th>
<th>HMO/POS $100 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>100% Covered</td>
<td>$50 Copay</td>
</tr>
<tr>
<td>Frames</td>
<td>Up to $75</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Davis Collection of Frames; 100% for Fashion &amp; Designer, $20 for Premier Selection, $60 credit for other frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglass lenses: Standard Lenses, single vision, bifocal, trifocal, lenticular</td>
<td>100% covered</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Eyeglass lenses: glass grey #3 prescription, tinting</td>
<td>100% covered</td>
<td>Up to $100</td>
</tr>
<tr>
<td>Contacts</td>
<td>$75 allowance</td>
<td>$100 allowance</td>
</tr>
<tr>
<td>Contact lens evaluation and fitting</td>
<td>Included in $75</td>
<td>Included in $100</td>
</tr>
<tr>
<td>Exam Frequency</td>
<td>Once every two calendar years</td>
<td>Once every two calendar years</td>
</tr>
<tr>
<td>Hardware Frequency</td>
<td>Once every two calendar years</td>
<td>Once every two calendar years</td>
</tr>
</tbody>
</table>

*Note: This chart is a summary of benefit options offered under the plan. For more information, please refer to the plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.*
BASIC LIFE INSURANCE

Bryn Mawr College provides full-time benefit eligible employees working 26 hours or more with Basic Life Insurance of $50,000. This coverage is insured by Lincoln Financial and is 100% paid for by the College.

VOLUNTARY LIFE INSURANCE

Employees may elect to purchase supplemental life insurance. Coverage is available in $10,000 increments up to $300,000. Lincoln Financial's Evidence of Insurability (EOI) Health Questionnaire must be completed by new hires that elect supplemental life insurance in excess of $50,000. All existing employees are generally subject to EOI on all elections unless otherwise instructed. The combined maximum benefit for basic and supplemental life is $350,000.

Spouse Life Insurance Coverage
Employees are also given the option to purchase life insurance for their spouse in $10,000 increments up to $300,000. Spouse supplemental life insurance coverage in excess of $50,000 will require a completed Lincoln Financial's EOI Health Questionnaire. All existing spouses are generally subject to EOI on all elections unless otherwise instructed.

Dependent Child(ren) Life Insurance Coverage
Insurance for dependent children may be purchased in increments of $5,000 to a maximum of $10,000.
## Employee Payroll Contributions

### Full-Time Medical (Monthly)

<table>
<thead>
<tr>
<th>Plan Coverage</th>
<th>Keystone HMO Plan</th>
<th>Keystone POS Plan</th>
<th>Personal Choice Plan</th>
<th>High Deductible* Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$14.00</td>
<td>$44.87</td>
<td>$130.45</td>
<td>- $126.61</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$36.65</td>
<td>$91.77</td>
<td>$248.37</td>
<td>- $209.17</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$249.40</td>
<td>$320.55</td>
<td>$520.36</td>
<td>- $69.83</td>
</tr>
<tr>
<td>Family</td>
<td>$626.73</td>
<td>$717.47</td>
<td>$969.76</td>
<td>$217.41</td>
</tr>
</tbody>
</table>

*The college provides $130 per month to employees who waive medical coverage. In order to waive medical coverage, the employee has to document that she or he has comprehensive medical coverage from a group medical plan that is not affiliated with the College.

### Dental (Monthly)

<table>
<thead>
<tr>
<th>Plan Coverage</th>
<th>Delta Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$0</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$32.15</td>
</tr>
<tr>
<td>Family*</td>
<td>$66.22</td>
</tr>
</tbody>
</table>

*Married employees who are insuring two or more dependent children should be enrolled as family coverage. The employee who is electing family coverage will receive a dental subsidy equivalent to two times the cost of single dental coverage.
## Employee Payroll Contributions

### Life Insurance (Monthly)

#### Life Coverage for You

<table>
<thead>
<tr>
<th>Benefit Tier</th>
<th>Rates per $1,000 of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the age of 30</td>
<td>$0.072</td>
</tr>
<tr>
<td>Age 30 to 34</td>
<td>$0.083</td>
</tr>
<tr>
<td>Age 35 to 39</td>
<td>$0.112</td>
</tr>
<tr>
<td>Age 40 to 44</td>
<td>$0.178</td>
</tr>
<tr>
<td>Age 45 to 49</td>
<td>$0.299</td>
</tr>
<tr>
<td>Age 50 to 54</td>
<td>$0.477</td>
</tr>
<tr>
<td>Age 55 to 59</td>
<td>$0.757</td>
</tr>
<tr>
<td>Age 60 to 64</td>
<td>$0.954</td>
</tr>
<tr>
<td>Age 65 to 69</td>
<td>$1.524</td>
</tr>
<tr>
<td>Age 70 to 74</td>
<td>$2.693</td>
</tr>
<tr>
<td>Age 75 and Over</td>
<td>$4.563</td>
</tr>
</tbody>
</table>

#### Life Coverage for your Spouse

<table>
<thead>
<tr>
<th>Benefit Tier</th>
<th>Rates per $1,000 of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the age of 25</td>
<td>$0.072</td>
</tr>
<tr>
<td>Age 25 to 29</td>
<td>$0.072</td>
</tr>
<tr>
<td>Age 30 to 34</td>
<td>$0.083</td>
</tr>
<tr>
<td>Age 35 to 39</td>
<td>$0.112</td>
</tr>
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</tr>
<tr>
<td>Age 75 and Over</td>
<td>$4.563</td>
</tr>
</tbody>
</table>

#### Life Coverage for your Dependent Children

<table>
<thead>
<tr>
<th>Benefit Tier</th>
<th>Rates per $10,000 of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A child 14 days of age but less than 26 years old</td>
<td>$1.20</td>
</tr>
</tbody>
</table>

*Life insurance purchased for dependents is on an after-tax basis. The first $50,000 in employee life insurance is on a pre-tax basis, which for employees under the age of 70 applies to the basic life insurance of $50,000. Employee life insurance in excess of $50,000 is treated as imputed income under the terms of Internal Revenue Code 79, which for employees under the age of 70 is the entire supplemental life insurance election.

** The Life Insurance benefit will reduce by 50% at the plan anniversary on or following the insured’s 70th birthday.
MEDICAL CARE FSA

A Medical Care Flexible Spending Account (FSA), administered by PayFlex, provides you with the ability to save money on a pre-tax basis to pay for any IRS-allowed medical, Rx, dental or vision expense that is not covered by your health care plan. Examples of these types of expenses include:

» Deductibles and copayments,
» Expenses for medical services or supplies not covered by your plan,
» Dental, vision, and hearing care expenses,
» Transportation expenses related to medical care,
» Nursing care.

Your annual contribution is divided by your number of pay periods and that amount will be deducted pre-tax each pay period. The amount you elect may not be changed or revoked during the plan year unless you experience a qualifying life event. Also, you may not transfer funds between a Medical Care FSA and a Dependent Care FSA.

For the 2022 Plan Year, the maximum amount that you may contribute to a Medical Care FSA is $2,850.

DEPENDENT CARE FSA

A Dependent Care Flexible Spending Account (FSA), administered by PayFlex, provides you with the ability to set aside money on a pre-tax basis for day care expenses for your child, disabled parent, or spouse. Generally, expenses will qualify for reimbursement if they are the result of care for:

» Your children, under the age of 13, for whom you are entitled to a personal exemption on your federal income tax return.
» Your spouse or other dependent, including parents, who are physically or mentally incapable of self-care.

For 2022, the IRS has set the maximum allowable contribution per calendar year for a Dependent Care Flexible Spending Account as follows:

» $5,000 for a married couple filing jointly
» $5,000 for a single parent
» $2,500 for a married person filing separately

Use It or Lose It

Both the Medical Care FSA and the Dependent Care FSA have a “use it or lose it” feature; however, the grace period allows you to incur claims until March 15th of the following year.
EMPLOYEE ASSISTANCE PLAN (EAP)

Just when you think you have life figured out, along comes a challenge. Whether those challenges are big or small, Aetna’s Assistance Program is available to help you and your family find a solution and restore your peace of mind. Take advantage of Aetna’s Resources For Living EAP service to help you with emotional, relationship, health and workplace issues. The following services are available to you and your family:

» Telephonic and Online Worklife Resources
» Up to six free face-to-face sessions per employee and household member per year
» Services are confidential and available 24/7 at no charge
» Monthly webinars on various topics
» Unlimited access to online research and other key resources
» Life events research and qualified referrals (i.e., child care providers)

LONG TERM DISABILITY

Long Term Disability (LTD) insurance is available to benefit eligible employees at no cost to you. Coverage protects your income in the event of a non-work related injury or illness. LTD premiums are based upon your salary and your maximum long term disability benefit is available. The plan pays 60% of your base earnings after a 180-day elimination period. The maximum monthly benefit is $14,000.

24/7 Assistance

You can take advantage of these services by calling toll-free any time, any day.

For Personal Assistance:
Call Aetna at 1.800.865.3200
Changing Your Benefits

31-DAY Window

Qualifying Life Events allow you to make plan changes at any time during the year in which they occur. For any allowable changes, you must inform Human Resources within 31 calendar days of the event.

Benefit changes that are requested due to a ‘change of mind’ cannot be allowed until the next Annual Enrollment Period.

The Internal Revenue Service (IRS) rules require that employees enrolled in pre-tax benefit plans may only make elections or changes to their plans once per year. Because of these rules, your benefit elections (with the exception of optional life insurance) will be binding through October 31, 2023; however, you may make changes to your election if you experience one or more of the following special circumstances, which are known as Qualifying Life Events:

» Marriage, divorce or legal separation
» Birth, adoption or placement for adoption of an eligible child
» Loss of spouse's job or change in work status (when coverage is maintained through spouse's plan)
» A significant change in you or your spouse's health coverage that is attributable to your spouse's employment
» Death of spouse or dependent
» Loss of dependent status
» Becoming eligible for Medicare or Medicaid during the year
» Receiving a Qualified Medical Child Support Order (QMCSO)
HIPAA INFORMATION NOTICE OF PRIVACY PRACTICES

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer recognizes your right to privacy in matters related to the disclosure of health-related information. The Notice of Privacy Practices (provided to you upon your enrollment in the health plan) details the steps your employer has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge, by request through your Human Resources Department.

SPECIAL ENROLLMENT RIGHTS

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, 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 of adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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.

NEWBORNS’ 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.

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.
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 July 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: https://health.alaska.gov/dpa/Pages/default.aspx

**ARKANSAS – Medicaid**
Website: http://myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

**CALIFORNIA – Medicaid**
Health Insurance Premium Payment (HIPP) Program Website: 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 (CHIP)**
Health First Colorado Website: https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHIP: https://www.colorado.gov/pacific/hcpf/chip-health-plan-plus
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/hipp/index.html
Phone: 1-877-357-3268

**GEORGIA – Medicaid**
GA HIP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
Phone: 678-564-1162, Press 2

**INDIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip
Healthy Indiana Plan for low-income adults 19-64 Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid
All other Medicaid Phone 1-800-457-4584

**IOWA – Medicaid**
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
KI-HIPP Phone: 1-855-459-6328
KI-HIPP Email: KIHIPP@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
KCHIP Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

**LOUISIANA – Medicaid**
Website: https://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
Enrollment Phone: 1-800-442-6003 / TTY: Maine relay 711
Private Health Insurance Premium Phone: 1-800-977-6740 / TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**
Website: https://www.mass.gov/masshealth/ma
Phone: 1-800-862-4840 / TTY: 617-886-8102
To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration
[www.dol.gov/agencies/ebsa](http://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](http://www.cms.hhs.gov)
1-877-267-2323, Menu Option 4, Ext. 61565
NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE FOR EMPLOYEES WHO ARE ELIGIBLE FOR MEDICAL COVERAGE

Part A: General Information

When key parts of the health care law took effect in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. 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. Open enrollment for health insurance coverage through the Marketplace begins in November 2022 for coverage starting January 1, 2023.

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 9.83% 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.*

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 Human Resources.

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

*An employer-sponsored 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.
Part B: Information About Health Coverage Offered by Your Employer

Information About Health Coverage Offered by Bryn Mawr College

If you decide to complete an application for coverage in the Marketplace, you will be asked to provide the following information. This information is numbered to correspond with the Marketplace application.

3. EMPLOYER NAME: ...................................................................................................................................................................Bryn Mawr College
4. EMPLOYER IDENTIFICATION NUMBER (EIN): ..........................................................................................................................23-1352621
5. EMPLOYER ADDRESS: ..............................................................................................................................................................101 N Merion Avenue
6. PHONE NUMBER: ...........................................................................................................................................................................610-526-5261
7. CITY: ..............................................................................................................................................................................................................Bryn Mawr
8. STATE: ........................................................................................................................................................................................................................PA
9. ZIP CODE: ...............................................................................................................................................................................................................19010
10. WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE? ...........................................................................Mary Eldon or Marty Mastascusa
12. E-MAIL ADDRESS: ........................................................................................................................................................................meldon@brynmawr.edu or mmastasc@brynmawr.edu

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

You are considered benefits eligible if you work 26 hours per week or more.

With respect to dependents:

We do offer coverage. Eligible dependents are: 1. Spouse who is legally married to you and is treated as a spouse under the Internal Revenue Code of 1986; 2. Your son, daughter, stepchild, legally adopted child or eligible foster child who has not attained age 26. Dependent child coverage will end at the end of the month the child turns 26.

This coverage meets the minimum value standard, and the cost of this coverage is intended to be affordable** to most of our employees based on employee wages.

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

Please note that if you decide to shop for coverage in the Marketplace, [www.healthcare.gov](http://www.healthcare.gov) will guide you through the process.
MEDICARE PART D – CREDITABLE COVERAGE

Important Notice from Bryn Mawr 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 Bryn Mawr 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 of ering 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. Bryn Mawr has determined that the prescription drug coverage offered by the College’s Independence plans 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 15 through December 7; 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.

MEDICARE PART D – CREDITABLE COVERAGE (CONTINUED)

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 Bryn Mawr coverage will be affected. If you do decide to join a Medicare drug plan and drop your current Bryn Mawr College coverage, be aware that you and your dependents will 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 Bryn Mawr 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. Starting on the last day of the month in which you were initially eligible to join a Medicare drug plan, 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 Human Resources Office (whose information is provided below) for further information. NOTE: You'll receive 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 Bryn Mawr College changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:
» Visit www.medicare.gov
» Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
» Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date: September 2022  
Name of Entity/Sender: Bryn Mawr College  
Contact: Position/Office: Human Resources  
Address: 101 N. Merion Ave, Bryn Mawr PA 19010  
Phone Number: 610-526-5261

WOMEN’S HEALTH AND CANCER RIGHTS ACT (JANET’S LAW)

The Women’s Health and Cancer Rights Act requires that all medical plans cover breast reconstruction following a mastectomy. Under this law, if an individual who has had a mastectomy elects to have breast reconstruction, the medical plan must provide the following coverage as determined in consultation with the attending physician and the patient:
» Reconstruction of the breast on which the mastectomy has been performed;
» Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
» Prostheses and physical complications at all stages of the mastectomy, including lymphedemas

Benefits received for the above coverage will be subject to any deductibles and coinsurance amounts required under the medical plan for similar services. The Act prohibits any group health plan from:
» Denying a participant or a eligible beneficiary to enroll or renew coverage under the plan in order to avoid the requirements of the Act;
» Penalizing, reducing, or limiting reimbursement to the attending provider (e.g. physician, clinic or hospital) to induce the provider to provide care inconsistent with the Act; and providing monetary or other incentives to an attending provider to induce the provider to provide care inconsistent with the Act.
Contact Information

Medical Benefits
Independence Personal Choice and Keystone Health Plan East
www.ibx.com
Personal Choice: 215.557.7577 (Philadelphia Area) or 1.800.626.8144
Keystone: 215.241.2273 (Philadelphia Area) or 1.800.227.3114

Health Savings Account (HSA)
HealthEquity
www.healthequity.com 1.877.694.3942

Dental Benefits
Delta Dental
www.deltadentalins.com 1.800.932.0783

Vision Benefits
Davis Vision
www.davisvision.com 1.888.393.2583

Life Insurance / Long Term Disability
Lincoln Financial
www.lfg.com
General questions: 1.800.948.9214
Report a claim: 1.800.713.7384
Claim Status: 1.800.440.6118

Flexible Spending Accounts
PayFlex
www.payflex.com 1.800.284.4885

Employee Assistance Program
Aetna
www.MyLifeValues.com 1.800.865.3200

Long Term Care Insurance
Genworth
www.genworth.com/groupltc 1.800.416.3624

Human Resource Benefit Issues
Mary Eldon or Marty Mastascusa
meldon@brynmawr.edu or mmastasc@brynmawr.edu 610.526.5261

Liberty Mutual Auto and Home Insurance
David Heitz
www.libertymutual.com/DavidHewitt
David.Hewitt@LibertyMutual.com 215.345.4422 Ext. 53223

Federal Credit Union
TruMark Financial Credit Union
www.trumarkonline.org 1.877.TRUMARK

Child and Adult Care
Care.com
www.care.com 1.855.781.1303

Retirement Plan
Transamerica
brynmawr.trsretire.com 1.800.755.5801

Retirement Plan
TIAA
www.tiaa.org/brynmawr 1.800.842.2252