Bard College

2019

Benefit Enrollment Guide

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Marshall & Sterling GROUP BENEFITS

Please Note: This enrollment guide is a summary of the benefits provided to benefit eligible employees. Bard College reserves the right to modify, amend, suspend or terminate any plan at any time for any reason without prior notification. The plans described in this guide are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make explanations of the plans in this guide as accurate as possible. However, should there be any discrepancy between this guide and the provisions of the insurance contract or plan documents, the provisions of the insurance contract or plan documents will govern. In addition, you should not rely on any descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

This is the only written summary of benefits. Please consult the Plan Document for more detailed information.

Bard College

P.O. Box 5000
30 Campus Road
Annandale-on-Hudson, NY - 12504
Phone Number: (845)758-7372
Fax: (845) 758-7826

Dear Employee:

Welcome to Bard College's 2019 Benefits Open Enrollment. Our goal is to provide you and your family with cost-efficient and comprehensive benefits. These programs are reviewed annually to ensure they are in line with the current trends and remain in compliance with government regulations such as the Health Care Reform legislation. Please read this Benefits Guide to gather important details about your benefits, and learn about your contributions as an aid to making your final decisions.

The definition of "full-time" for healthcare benefit eligibility purposes is working on average 30 or more hours per week. Bard College will track your hours and notify you if you are eligible for benefits. More information on eligibility to participate in our healthcare plan can be found in the Summary Plan Description, which can be obtained by contacting our Human Resources department.

Open Enrollment

Open Enrollment is the window of opportunity to make changes to your benefit elections, or enroll if you previously waived coverage. It is the time of year to make sure that you have enrolled in the health benefits that meet your healthcare needs and fit into your overall financial plan. Ask yourself:

- Does your current coverage meet your family's needs?
- Did you get married, divorced, have a child or another qualifying status change since you last looked at your benefits?
- Were you covered under a spouse and now would like to be covered primarily by your employer?
- Verify that your enrolled dependents meet the definition of an eligible dependent. Medical coverage is provided for dependent children up to their 26th birthday under Health Care Reform. Other benefit plans are subject to plan age limits.

The Summary of Benefits and Coverage (SBC) for our medical plans, along with the Glossary of Health Coverage and Medical Terms, are also available on iNavigator. Upon request a paper copy will be provided at no charge.

Under the Affordable Care Act you are required to maintain healthcare coverage for yourself and your dependent children.

Changing Your Benefits After Open Enrollment

After open enrollment you may change your benefits only if you have met a qualified status change, such as loss of other medical coverage, the birth of a child, divorce or a child reaching the coverage maximum age limit.

Please do not hesitate to contact Human Resources with any questions or concerns regarding your benefits.

Sincerely,

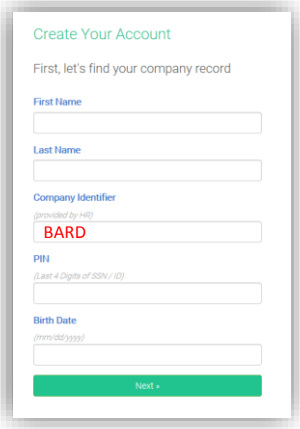
James Brudvig

Vice President for Finance & Administration, CFO

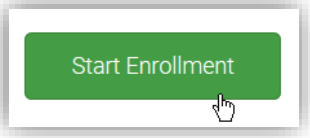
iNavigator

With iNavigator, employees enjoy convenient online access to benefits coverage, 24 hours a day, seven days a week. You can update your personal profile, report life events, make eligible benefits elections and qualifying enrollment changes, and also have access to a complete document library.

- **BEGIN** using iNavigator by going to https://www.marshallsterling.com/group-benefits/inavigator-login
- **FIRST TIME** users will select "Register as a new user" to create a User Name and Password. We highly recommend using a work email for your username, if possible, to help make it easier to remember. You will need your Company Identifier, which is: **BARD**
- **EXISTING** users will proceed by logging in with their username and password. See below if you have forgotten your username or password.



To Enroll in Benefits



1. If you are a first time user, after you have completed any onboarding tasks, you will be led to begin your enrollments. If you skip them during registration, or if you are a returning user, click Start Enrollments from your home screen.
2. Complete your personal information – please note all fields will be required. Click "Save and Continue".
3. Complete dependent information. You can "add dependents" and fill out the needed information. When all dependents have been added, click "Save and Continue"
4. From here you will be taken one by one through each benefit your company offers. If a certain benefit allows dependents to be enrolled, you will see a section at the top "Who am I enrolling?", where you can click off each dependent that you want to enroll on that individual plan.
5. You can select "Compare" to compare plans if more than one is offered, or click "Details" for information on an individual plan. There will be a column on the right for helpful resources, which will contain benefit summaries or any other needed information. As you make each selection, click "Save and Continue"
6. If any of your selections require forms to be filled out (i.e. a beneficiary form for a life insurance plan), these forms will immediately pop-up after that benefit has been elected and must be filled out.
7. Lastly, upon completion of enrollment, you will be prompted to sign your benefits, and then may print a copy of your enrollment summary. **Enrollment is not complete until you "Click to Sign" on your enrollment summary and see the checkmark that says "acknowledged and Submitted".**

Forgot Your Username and/or Password?

1. Click on "Reset Password"
2. Under "Employees", select "Click Here"
3. Enter your username and select "Next"
   - If you have forgotten your username, click "Don't know your username?" Otherwise, skip to step #4. You will be asked for your company identifier (see above), first and last name, and your PIN, which is the last four digits of your SSN. Fill in these fields and select "Request a Reset". You will see "Password Reset Has Started" and you will be prompted to check your email for instructions. Proceed with step #5.
4. Enter your birth year for verification. You will see "Password Reset Has Started" and you will be prompted to check your email for instructions.
5. Go to your email and click on "Password Reset" and enter new password. Select "Change Password" after entering. Don't forget – passwords must be between 6 and 20 characters and include both a number and a symbol.
6. You should now be logged in and you will receive an email that your password has been reset.

Bard College

Medical

You can select one of the following Empire Medical Plan options.

- **The Empire PPO medical plans contain in-network and out-of-network benefits. Benefits are determined at the point the member decides to use either in-network or out-of-network providers, giving the members greater freedom of choice. Members choosing out-of-network benefits will have reduced benefits, higher out of pocket costs and can be balance billed without limit.**
- **The Empire EPO HSA medical plan delivers in-network-only benefits. Members must seek care from participating providers, except in the case of a life-or limb-threatening emergency. If care is received from a non-participating provider, the claim will not be paid. It is the member's responsibility to confirm that the providers and specialists they are seeing participate in the network at the time of service.**

Plan Features	HIGH PPO			LOW PPO			EPO HSA
	In-Network		Out-of-Network	In-Network		Out-of-Network	In-Network
Deductible/Maximum Period	Plan Year (7/1-6/30)			Plan Year (7/1-6/30)			Plan Year (7/1-6/30)
Medicare Part D Coverage	Creditable			Creditable			Creditable
Network	Blue Card PPO		N/A	Blue Card PPO		N/A	Blue Card PPO
Deductibles (Indiv / Family)	$0 / $0		$500 / $1,250	$0 / $0		$10,000 / $20,000	$1,500 / $3,000
Deductible Type	N/A		Embedded	N/A		Embedded	Aggregate
Out-of-Pocket Max	Medical	Rx	Medical Only	Medical	Rx	Medical Only	Medical & Rx
Individual	$3,200	$1,880	$3,500	$3,200	$1,880	$20,000	$3,425
Family	$7,900	$4,800	$8,750	$7,900	$4,800	$50,000	$6,850
Out-of-Pocket Maximum Type	Embedded		Embedded	Embedded		Embedded	Embedded
Preventive Care	Covered in Full		30% after Deductible	Covered in Full		50% after Deductible	Covered in Full
Primary Care Visit	$30 Copay		30% after Deductible	$30 Copay		50% after Deductible	In Full after Deductible
Specialist Visit	$55 Copay		30% after Deductible	$55 Copay		50% after Deductible	In Full after Deductible
Acupuncture	$30 Copay		30% after Deductible	$30 Copay		50% after Deductible	In Full after Deductible
LiveHealth Online Telemedicine **Medical Only**	$5 Copay		N/A	$5 Copay		N/A	$49 Copay and Covered in Full after Deductible
Diagnostic Lab	$30 Copay		30% after Deductible	$30 Copay		50% after Deductible	In Full after Deductible
Prenatal & Postnatal Office Visit	$30 Copay		30% after Deductible	$30 Copay		50% after Deductible	In Full after Deductible
Delivery (Maternity) Inpatient Services (Maternity)	$250 Copay		30% after Deductible	$250 Copay		50% after Deductible	In Full after Deductible
X-Rays	$30 Copay		30% after Deductible	$30 Copay		50% after Deductible	In Full after Deductible
Advanced Imaging	$55 Copay		30% after Deductible	$55 Copay		50% after Deductible	In Full after Deductible
Outpatient Hospital Services	$100 Copay		30% after Deductible	$100 Copay		50% after Deductible	In Full after Deductible
Inpatient Hospital Services	$250 copay		30% after Deductible	$250 copay		50% after Deductible	In Full after Deductible
Emergency Room	$200 Copay		Paid as In-Network	$200 Copay		Paid as In-Network	In Full after Deductible
Land/Air Ambulance	No Charge		30% after Deductible	No Charge		50% after Deductible	In Full after Deductible
Urgent Care	$55 Copay		Paid as In-Network care	$55 Copay		Paid as In-Network care	In Full after Deductible
Plan Year Deductible Per Person	**$100 – Retail Only**		**Not Covered**	**$100 – Retail Only**		**Not Covered**	**Integrated w/Medical**
Retail (30-day supply)	$10/$35/$70		Not Covered	$10/$35/$70		Not Covered	$10/$35/$70
Mail Order (90-day supply)	$20/$70/$140		Not Covered	$20/$70/$140		Not Covered	$20/$70/$140
Retail Specialty (30-day supply)	$200/30%/30%		Not Covered	$200/30%/30%		Not Covered	$200/30%/30%
Mail Order Specialty (90-day supply)	$400/30%/30%		Not Covered	$400/30%/30%		Not Covered	$400/30%/30%
CanaRx – Mail Order Only **$50 Gift Card**	$0 Copay		Not Covered	$0 Copay		Not Covered	$0 Copay

Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member. Aggregate Out-of-Pocket Maximum: The entire family out-of-pocket maximum must be met, at which time medical services would be covered 100%.
Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits. Embedded Out-of-Pocket Maximum: Once the member reaches the individual out-of-pocket max, services would be covered 100% of that individual.

If you are enrolled in the PPO plans and visit an out-of-network provider, you are responsible for the deductible, coinsurance and the difference between what the provider charges and the Plan pays. Inpatient admissions, outpatient surgery, x-rays, high level imaging, mental health and substance abuse require preauthorization. Please refer to your Certificate of Coverage for detailed information.

This benefit summary provides selected highlights of the employee benefits program at Bard College. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment. All benefits plans are governed by master policies, contract and plan documents. Any discrepancies between any information through this summary and the actual items of such policies, contracts and plan documents shall be governed by master policies, contracts and plan documents. Bard College reserves the right to amend, suspend or terminate any benefit plan, all or in part, at any time. The authority to make such changes rests with the Plan Administrator.

MEMBER *Guide*

YOUR PHARMACY BENEFITS MADE EASY

Helping you get and remain healthy.

We're here to ensure that your pharmacy benefits are accessible, with ease, if and when you need them most.

PROACT PHARMACY BENEFIT MANAGEMENT

Customer Service

The ProAct Help Desk is available to serve you 24 hours a day, 7 days a week. Our knowledgeable customer service representatives can assist you with; Benefit Overview, Eligibility, Prior Authorization, and *much more*.

Tel: 877-635-9545
Fax: 315-287-7864
Web: www.ProActRx.com

Email: Support@ProActRx.com
Mail: 1230 US Highway 11
Gouverneur, New York 13642

PROACT PHARMACY SERVICES

Mail Order Pharmacy

ProAct Pharmacy Services will deliver maintenance prescriptions, up to a 90 day supply, directly to your door for the cost of your mail order pharmacy copay. You will need a new prescription from your doctor to begin using the mail service. Your doctor can e-scribe, call in, or fax your prescription to "ProAct Pharmacy Services" (NCPDP #3335468). You may also mail a prescription along with a completed profile form. To get started, call a Help Desk representative to set up your home delivery profile and method of payment.

Tel: 877-635-9545
Fax: 315-287-3330
Web: www.ProActPharmacyServices.com

Email: Support@ProActRx.com
Mail: 1226 US Highway 11
Gouverneur, New York 13642

NOBLE HEALTH SERVICES

Specialty Pharmacy

Noble Health Services is ProAct's specialty pharmacy and is available to dispense medications used to treat complex and chronic conditions. Our experts at Noble strive to support patients in all aspects of therapy and always provide the utmost care, from prescription needs and medication therapy management to financial guidance. Emergency on-call support is available at all times via our toll-free number. Your doctor may mail, fax, call, or e-scribe to "Noble Health Services" (NCPDP #5806457). Packages will ship next day delivery to your home, physician's office, or place of business. Same day delivery is available in some areas of Upstate New York. Local members may pick up specialty medications at our facility in Syracuse, New York.

Tel 888-843-2040
Fax: 888-842-3977
Web: www.NobleHealthServices.com

Email: ContactUs@NobleHealthServices.com
Mail: 6040 Tarbell Road
Syracuse, New York 13206

Mail Order Prescriptions

CanaRx is a voluntary mail order prescription drug program that is available to eligible employees and their dependents enrolled in one of Bard College's medical plans. All member copayments have been **waived** for this program **only**.

A listing of eligible medications is available on the CanaRx website at **www.BardCanaRx.com**.

Tier	CanaRx Cost	Vs.	Current Retail Copay	x	Refills	=	Annual Savings
Tier 2	$0	Vs.	$35	x	12	=	$420
Tier 3		Vs.	$70	x	12	=	$840

Employees enrolled in the EPO HSA medical plan must first meet their deductible before they can participate in the program. Once the deductible has been met, employees need to submit their EOB to CanaRx showing the deductible has been met.

Generic Medications

Generic medications provide the greatest savings to your health care plan. Therefore if you are currently taking a generic medication, you are not eligible to order the brand name medication through this program.

Ordering Instructions

To place your first order simply complete the enrollment form and include a new prescription for each medication. Please allow 4 weeks for delivery.

Ask your doctor for a prescription for a **3 month supply** with **3 refills**. Refills are not automatic, but they're easy – CanaRx will call you! As an added safety measure before processing a refill, CanaRx will need to confirm how much medication you have on hand and whether you have had any health or medication changes. You will be contacted **one month prior** to ensure you always have a sufficient supply of medication on hand.

Medications must be tried for 30 days before ordering through CanaRx. Return your completed and signed enrollment form and original prescriptions:

BY FAXING TO: 1-866-715-6337

*Faxed prescriptions are **ONLY** accepted if sent directly from the physician's office.*

OR

BY MAILING TO: BardCanaRx
P.O. Box 44650
Detroit, MI 48244

More forms are available

Additional forms may be obtained from the Human Resources Department, by visiting www.BardCanaRx.com or by contacting CanaRx customer service toll free at 866-893-6337.

Vision

Employees enrolled in one of Bard College's Empire medical plans will automatically be enrolled in the Empire vision plan at no extra cost. Blue View Vision offers you one of the largest vision care networks. Blue View Vision's network also includes convenient retail locations including LensCrafters®, TargetOptical®, JCPenney® Optical, Sears Optical, Pearle Vision®, and New York based Empire Vision and Davis Vision Centers. You will also have the ability to visit non-network providers and receive a reimbursement towards expenses.

BENEFIT	IN-NETWORK	NON-NETWORK REIMBURSEMENT
Dependent Age Limit	To Age 26	
Vision Exam		
Comprehensive Vision Exam	$20 Copay	Up to $40
Lenses		
Single	$20 Copay	Up to $25
Bifocal		Up to $40
Trifocal		Up to $55
Progressive	$65 Copay	Not Covered
Frames		
	$130 allowance then 20% off balance	Up to $45
Contact Lenses (in lieu of eyeglasses)		
Elective Contact Lenses	$130 allowance then 15% off balance	Up to $105
Elective Disposable	$130 allowance (no additional discount)	Up to $105
Non-Elective Contact Lenses	Covered in Full	Up to $210
Standard Contact Lens Fitting & Follow-Up	Up to $55 Copay	Not Covered
Premium Contact Lens Fitting & Follow-Up	10% off Retail Price	
Lens Options		
UV Coating	$15 Copay	Not Covered
Tint – Solid or Gradient		
Standard Scratch-Resistance		
Standard Polycarbonate for Adults	$40 Copay	
Anti-Reflective Coating	$45 Copay	
Frequency (Months)		
Exam	Every 24 Months	
Lenses		
Frames		
Contacts		
Discount		
LASIK Vision Correction Surgery	Discount per Eye	
1-800Contacts	Save $20 on orders of $100 or more	

- **Frequency based on last date of service.**
- **The "frame allowance" or discounts associated with this vision plan may not apply to some frames where the manufacturer has imposed a no discount policy on sales at retail or independent provider locations. Members may submit an out-of-network claim for reimbursement on such frames up to the schedule amount indicated in the member's benefit summary/certificate of coverage.**

Dental

The MetLife PPO Dental Plan allows you the freedom to see the dentist of your choice. You can utilize a large network of participating dentists who accept MetLife Maximum Allowable Charge (MAC) as payment in full after deductible and coinsurance. Dentists who participate in the MetLife network accept the MetLife as payment in full after deductible and coinsurance. Non-MetLife dentists may not accept either MAC as payment in full and may balance bill without limit.

Your Social Security Number is your ID number but it will not appear on the ID card. Metlife uses the employee's SSN for all dependents on the plan.

*** ID CARDS WILL ONLY BE SENT FOR NEW ENROLLMENTS – NEW ID CARDS WILL NOT BE SENT OUT TO CURRENT MEMBERS ***

Plan Features	Non-Union	
	In Network	Out of Network
Deductible Accumulation/ Benefit Period	Plan Year (July 1 - June 30)	
Dependent Age Limit	To Age 26	
Network	PDP	N/A
Reimbursement Level	MetLife PPO MAC	80th Percentile UCR
Annual Deductible (Individual / Family)	$0 / $0	$50 / $150
Deductible Waived For	N/A	Preventive/Orthodontic
Preventive Care	Covered 100%	Covered 100%
Basic Procedures (Extractions, fillings, etc.)	20% Co-insurance	20% Co-insurance after Deductible
Major Procedures (Crowns, dentures, etc.)	50% Co-insurance	50% Co-insurance after Deductible
Child Orthodontia under age 19	50% Co-insurance	50% Co-insurance after Deductible
Orthodontia Lifetime Max	$1,500	
Plan Year Maximum Benefit	$1,500 per person	

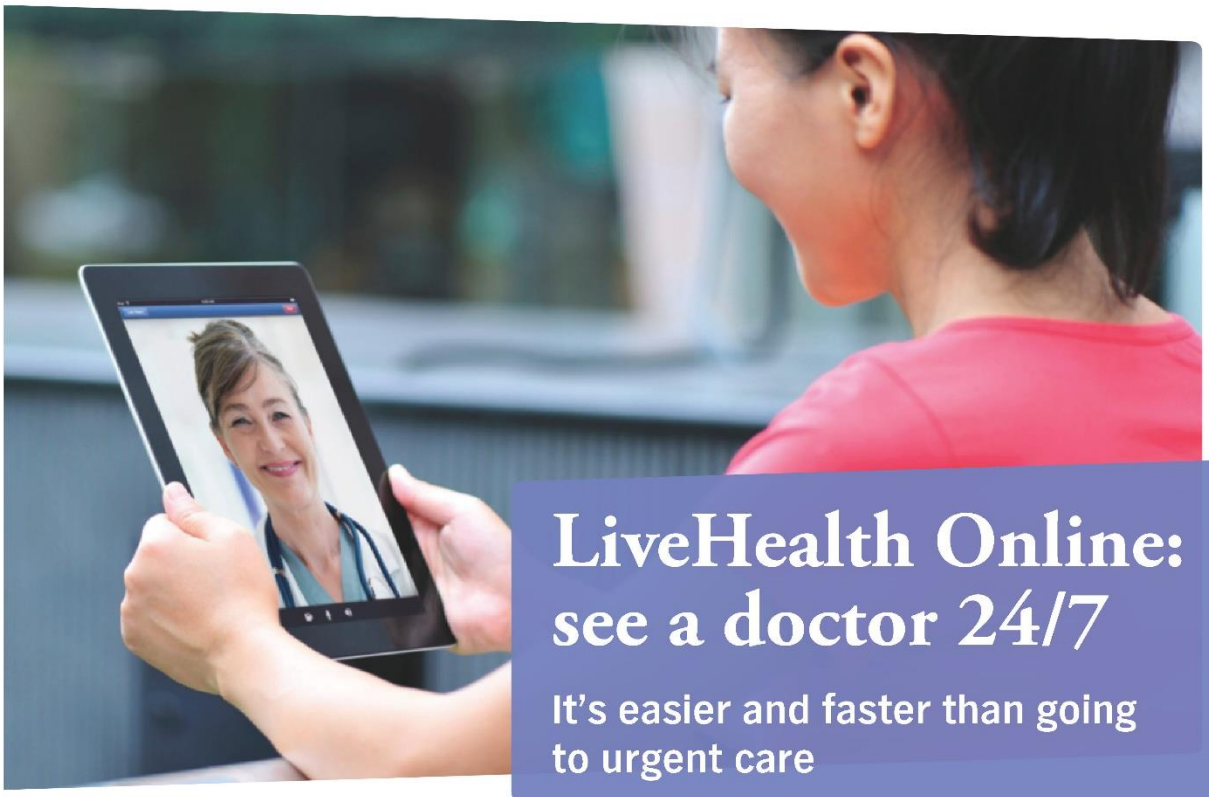
- If you visit an out-of-network provider, you are responsible for paying the deductible, coinsurance and the difference between what the provider charges and the Plan pays.
- Certain procedures may require a pre-treatment review.
- Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan.

Employee Contributions

Your employee contribution depends on the type coverage selected and the number of dependents you insure. Please note that all employees enrolled in the High Deductible EPO plan are eligible for a Health Savings Account (HSA). Your money in the HSA rolls over every year and goes with you wherever you go. There is no monthly maintenance fee for the HSA account for active employees. Employees must open their account prior to incurring any medical, dental or vision claims that the HSA will be used for and are encouraged to open their account prior to July 1, 2019. Please see table below for your **semi-monthly** contribution rates effective **July 1, 2019**.

Medical	$50,000 and Under		$50,001 to $80,000		$80,001 to $110,000		$110,001 to $140,000		$140,001 and Above	
	Single	Family	Single	Family	Single	Family	Single	Family	Single	Family
Administration & Faculty										
High PPO	$72.66	$188.92	$103.25	$268.46	$130.02	$338.07	$152.97	$397.72	$175.92	$457.38
Low PPO	$47.83	$124.35	$77.26	$200.87	$103.01	$267.83	$125.08	$325.22	$147.16	$382.61
EPO HSA	$15.59	$40.55	$46.78	$121.64	$68.62	$178.40	$87.33	$227.05	$106.04	$275.71

Dental	Single	Employee +1	Family
Administration and Faculty	$22.39	$52.15	$72.08



LiveHealth Online: see a doctor 24/7

It's easier and faster than going to urgent care

The next time you or someone in your family needs to see a doctor, use LiveHealth Online. See a doctor with a smartphone or tablet using our free app, or a computer with a webcam.[1]

With LiveHealth Online, you get:

- Immediate, 24/7 access to board-certified doctors.
- Secure and private video chats.
- Prescriptions that can be sent to your pharmacy, if needed.[2]

LiveHealth Online is part of your health plan benefits and the cost of a LiveHealth Online visit is the same or less than a primary care office visit.

Sign up today so you're just a few clicks away from seeing a doctor.

Download the free app now!

apple.com

play.google.com/store

Sign up at livehealthonline.com.

1 LiveHealth Online is offered in most states. See list regarding participation in the state of Texas. Visit the home page at livehealthonline.com to see the latest map showing where service is available.
2 As legally permitted in certain states.

High PPO: $5 Copay
Low PPO: $5 Copay
EPO HSA Plan: $49 Copay until deductible is met, then covered in full

Empire BlueCross

LiveHealth ONLINE

LiveHealth Online is a trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Empire BlueCross.
Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of Independent Blue Cross and Blue Shield plans.

Health Savings Account

Available with EPO HSA Plan Only
Plan Year: July 1, 2019 - June 30, 2020

Health Savings Accounts (HSA) are tax-exempt accounts where funds grow to pay for IRS eligible medical expenses. Bard College is offering an HSA account with First American Bank to those enrolled in the Empire HDEPO HSA plan

An HSA is your account. If you switch jobs, the HSA goes with you. **Your money rolls over every year.** There is no "use it or lose it" requirement. In order to open an HSA, you must have a qualified High Deductible Health Plan. Employees can contribute their own funds up to the annual IRS limit. The IRS determines the guidelines for qualified HSAs, which are:

2019 IRS HSA Guidelines	Single Plan	Family Plan
HDHP Minimum Deductible	$1,350	$2,700
Maximum HSA contribution	$3,500	$7,000
Catch-up contribution if you are 55 or older	$1,000	

HSA Eligible Guidelines

- You are enrolled in a qualified High Deductible Health Plan (Empire EPO HSA.)
- You cannot be claimed as a tax dependent.
- You are not enrolled in Medicare or covered under any other type of insurance plan. This includes plans that your spouse may be enrolled in, such as other group health plans, Flexible Spending Accounts (FSAs) or Health Reimbursement Arrangements (HRAs).
- Ineligible withdrawals are subject to income tax plus an additional 20% tax unless you are 65 or older, disabled or deceased.
- All participants are responsible for retaining the proper documentation to verify the eligibility of a distribution.
- Contributions can be made up to the day Federal taxes are due for the previous plan year.
- Contribution limits assume the employee is “eligible” for the entire tax year. If the employee is not eligible for the entire tax year, they can still contribute the maximum as long as they remain eligible for the entire following tax year (through December 31), otherwise they will be taxed plus a 10% penalty on a prorated amount of the contribution.

Medical Expenses

1. Present your Empire ID card to your provider. The provider bills the carrier.
2. Empire processes the claim and applies the contracted, discounted rate to your deductible and sends out an Explanation of Benefits (EOB).
3. Once you receive your EOB from Empire and the bill from your provider, verify that the amount being charged by your provider is the same as the EOB member responsibility.
    a) Remember, an EOB is a summary of the claim payment from your health insurance plan.
    b) The EOB should detail the discount and the amount of the claim applied to your deductible and your member responsibility.
    c) Pay only the amount classified as your responsibility by your health plan and eligible under your HSA.
4. You can use your HSA card to pay the amount owed when billed by the provider.

RX Expenses

1. Present your Empire ID card to the pharmacist.
2. After your pharmacist processes the claim through Empire, the pharmacist will ask you for payment at the time of service.
3. You can pay with your HSA card and the amount will be processed and applied toward your deductible.

Flexible Spending Accounts

Plan Year: July 1, 2019 - June 30, 2020

FSA funds are used to pay for medical, dental, vision and dependent care expenses for you and your dependents, regardless of whether you are covered by your employer's medical plan

Healthcare Flexible Spending Account (FSA)

Participants may elect to contribute up to $2,700 on a pre-tax basis via payroll deductions throughout the plan year into a Healthcare FSA.

The full amount you select will be available to you immediately to use towards unreimbursed medical expenses regardless of whether you are covered by one of Bard College's medical plans. You can be reimbursed for qualified medical care expenses such as copays and deductibles for medical, prescription drug, dental, prescription eye glasses, etc.

Employees enrolled in the EPO HSA medical plan may only participate in a Limited Healthcare FSA which can be used towards unreimbursed dental and vision expenses.

Participants are allowed to carry over up to $500 of unused funds remaining at the end of the Plan Year. You should plan carefully, as any unused funds in excess of the carry over amount are forfeited per IRS "Use It or Lose It" guidelines.

Dependent Care Reimbursement Account (DCA)

Participants may elect to contribute up to $5,000 on a pre-tax basis via payroll deductions throughout the plan year into a DCA.

DCA funds can be used on any child under the age of 13 or any dependent who is physically or mentally unable to care for themselves:

- **The care of the dependent must enable you and your spouse to be employed:**
- **The amount to be reimbursed must not be greater than your or your spouse's income, whichever is less;**
- **The services may be provided in your home or another location, but not by someone who is your minor child or dependent for income tax purposes (for example, an older child);**
- **If the services are provided by a daycare facility that cares for 2 or more children simultaneously, the facility must comply with state and local daycare regulations; and**
- **Services must be for the physical care of the child, not for education, meals, etc. Expenses for overnight camps and kindergarten are not eligible for reimbursement.**

Commuter Transit / Parking Account

Participants may elect to contribute on a pre-tax basis via payroll deductions into a Transit and/or Parking Account to pay for eligible mass transit, parking and van-pooling expenses. Post-tax contributions are unlimited per plan year. *All transit changes must be made by the 10th of the month prior to the change.*

<u>Transit Benefit - $265 maximum monthly pre-tax contribution</u>

- **Mass Transit Costs – The price of tickets, vouchers and passes to ride a subway, train or city bus.**
- **Vanpool Costs – The cost of riding a commuter vehicle that seats at least six adults (not including the driver) and at least:**
- **80 percent of the van's mileage is used to take employees to and from work, and**
- **At least half of the van's seating is taken by employees**

<u>Parking Benefit - $265 maximum monthly pre-tax contribution</u>

- **Parking costs at or near your primary work site.**
- **Parking costs at the place where you get transportation to work – a train station, vanpool stop, etc.**

Claims Run-Out Period

Participants will have 90 days (July 1, 2019 to September 28, 2019) to submit for reimbursement claims that have been incurred during the previous FSA plan year (July 1, 2018 to June 30, 2019). All run-out claims must be submitted manually with the claim form found on iNavigator to BRi for reimbursement. If you have $500 or less remaining in your 2018/2019 Healthcare FSA account, you will be able to roll over that amount into the FSA for the 2019/2020 plan year. **The rolled over funds will be available to you after December 1, 2019**.

FSA/HSA Eligible Health Care Expenses

Marshall & Sterling GROUP BENEFITS

Please note that Marshall & Sterling does not intend this list to be comprehensive tax advice. For more detailed information, please consult IRS Publication 502 or see your tax advisor.

FSA/HSA Eligible Health Care Expenses

- Acupuncture
- Alcoholism treatment
- Allergy shots and testing
- Ambulance (ground or air)
- Artificial limbs
- Blind services and equipment
- Car controls for handicapped*
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Crutches, wheelchairs, walkers
- Deaf services -- hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental treatment
- Dentures
- Diagnostic tests
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription Eye examinations and eyeglasses
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription Eye examinations and eyeglasses
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Oxygen/oxygen equipment
- Physical exams (except for employment-related physicals)
- Physical therapy
- Psychiatric care, psychologists, psychotherapists
- Radial keratotomy
- Schools (special, relief, or handicapped)
- Sexual dysfunction treatment
- Smoking cessation
- Surgical fees
- Television or telephone for the hearing impaired
- Therapy treatments
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Vitamins (prescription only)
- Weight loss programs
- X-rays

Copy of prescription as well as detailed receipt required for reimbursement:

- Acne medications and treatments
- Allergy and sinus, cold, flu and cough remedies (antihistimines, decongestants, cough syrups, cough drops, nasal sprays, medicated rubs, etc.)
- Antacids and acid controllers (tablets, liquids, capsules)
- Antibiotic and antiseptic sprays, creams and ointments
- Anti-diarrheals
- Anti-fungals
- Anti-gas and stomach remedies
- Anti-itch and insect bite remedies
- Anti-parasitics
- Digestive aids
- Baby care (diaper rash ointments, teething gel, rehydration fluids, etc.)
- Contraceptives (condoms, gels, foams, suppositories, etc.)
- Eczema and psoriasis remedies
- Eye drops, ear drops, nasal sprays
- First aid kits
- Hemorrhoidal preparations
- Hydrogen peroxide, rubbing alcohol
- Laxatives
- Medicated bandaids and dressings
- Hydrogen peroxide, rubbing alcohol
- Laxatives
- Medicated bandaids and dressings
- Motion sickness remedies
- Nicotine medications (smoking cessation aids)
- Pain relievers (aspirin, ibuprofen,
- acetaminophen, naproxen, etc.)
- Sleep aids and sedatives
- Wart removal remedies, corn patches

Eligible for reimbursement with detailed receipt only (no prescription required):

- Breast pumps for nursing mothers
- Braces and supports
- Contact lens solution
- Diabetic testing supplies/equipment
- Durable medical equipment (power chairs, walkers, wheelchairs, CPAP equipment and supplies, etc.)
- Home diagnostic (pregnancy tests, ovulation kits, thermometers, blood pressure monitors, etc.)
- Non-medicated bandaids, rolled bandages and dressings
- Reading glasses

Basic Life / AD&D

Plan Features	
Eligibility	All active full time employees working 30 or more hours per week excluding visiting faculty
Employee Contribution	None – 100% Employer Paid
Group Life	
Basic Benefit	$12,000
Guaranteed Issue Amount	$12,000
Accelerated Death Benefit	50%
Waiver of Premium	If employee is disabled before age 60, coverage will continue to age SSNRA after 6 month elimination period
Conversion	Included
Resource Advisor	Included
Travel Assistance	Included
Group AD&D	
Basic Benefit	Up to 100% of Life Benefit if you suffer loss in covered accident, based on schedule
Maximum Benefit	$12,000
AD&D Table of Losses	Standard table included
Airbag	10% of AD&D benefit
Seatbelt	10% of AD&D benefit
Repatriation	Up to $5,000 for transportation and related preparation expenses
Child Education	5% of AD&D benefit per year for each child's post-secondary education; annual maximum of $5,000 or actual expense. $40,000 combined maximum
Coma Benefit	1% of AD&D benefit for each full month in a coma, up to 8 years
Common Carrier	25% of AD&D benefit
Age Reduction Schedule	
At Age 65	35% Reduction
At Age 70	50% Reduction
At Retirement	Coverage Terminates

Supplemental Life/AD&D

Anthem Life

Plan Features	Employee	Spouse	Child(ren)
Eligibility	Active full-time employees working 30+ hours per week	Employee enrolled in Supplemental Life	Employee enrolled in Supplemental Life
Employee Contribution	100% Employee Paid	100% Employee Paid	100% Employee Paid
Supplemental Life			
Increment	$10,000	$5,000	N/A
Minimum Amount	$10,000	$5,000	
Maximum Amount	5 times annual salary up to $500,000	$250,000 - not to exceed 50% of employee benefit	$4,000
Guaranteed Issue	$200,000	$50,000	
Accelerated Death Benefit	50% to max of $250,000		
Waiver of Premium	If employee is disabled before age 60, coverage will continue to age SSNRA after 6 month elimination period		
Conversion/Portability	Included		
Supplemental AD&D – Employee ONLY			
Benefit	Up to 100% of Life Benefit if you suffer loss in covered accident, based on schedule	Not Covered	Not Covered
AD&D Table of Losses	Standard Table Included		
Seatbelt Benefit	10% of AD&D Benefit to max of $15,000		
Airbag Benefit	10% of AD&D Benefit to max $10,000		
Coma	1% of AD&D Benefit, payable up to 8 years		
Common Carrier	25% of AD&D Benefit		
Repatriation	Up to $5,000		
Child Education	5% of AD&D benefit per year per child; annual max of $5,000 with $40,000 combined max		
Benefit Age Reduction – Based on Employee Age			
At Age 26	N/A	N/A	Coverage Terminates
At Age 70	50% Reduction	50% Reduction	N/A
At Retirement	Coverage Terminates	Coverage Terminates	

- Guarantee Issue on voluntary life and voluntary long term life amounts only apply if you elect coverage within 30 days of your initial eligibility date. After 30 days of initial eligibility you must provide Evidence of Insurability. Evidence of Insurability will be required for any future benefit increases.
- Spouse rates based on employee age
- Unmarried dependent children are covered from 15 days to age 26.

Short-Term Disability

Plan Features	
Eligibility	All employees Eligible
Employee Contribution	None – 100% Employer Paid
Benefit	
Benefit	50% of earnings to maximum $170 per week
Benefit Qualifications	
Elimination Period	7 Days
Duration of Benefit	26 Weeks

Long-Term Disability

Plan Features	
Eligibility	All active full time employees working 30 or more hours per week who have completed 1 year of service
Employee Contribution	None – 100% Employer Paid
Benefit	
Benefit	60% of earnings to maximum $10,000 per month
Minimum Benefit	Greater of 10% or $100
Benefit Qualifications	
Elimination Period	180 Days
Duration of Benefit	Social Security Normal Retirement Age
Definition of Disability – Administrators & Faculty	Social Security Normal Retirement Age
Definition of Disability – Union	24 Months Own Occupation
Partial Disability Residual	Included
Pre-Existing Condition Limitation	3/12
Mental Illness / Substance Abuse Limitation	24 Months
Accumulation of Elimination Period	15 days if elimination period is 90 days or less 30 days for an elimination period for greater than 90 days
Additional Features	
Work Incentive Benefit	100% for 12 months
Rehabilitation Incentive	Additional 5% for 12 months
Work Retention Assistance	Included
Survivor Benefit	3 Months Net Benefit
Workplace Modification Benefit	Up to $10,000
Continuity of Coverage	Included
W-2 Preparation Service	
Resource Advisor	

* Employees have the option of having taxes deducted from their payroll upfront in order to receive tax free benefit.*

Voluntary Benefits

In case of an accident or illness, Aflac Insurance policies pay cash benefits directly to you, unless assigned, regardless of any other insurance you may have. Use the cash benefits for such expenses as:

- Deductibles, co-payments, out-of-network charges and any other expenses not picked up by your major medical coverage.
- Travel related expenses for treatment in distant medical centers, including airfare, hotels and meals.
- Everyday living expenses like house (or rent) payments, groceries and utility bills.
- Lost income, results in a "double whammy" if the healthy spouse has to leave work to care for the recuperating one.

Current Policy Holders Please Note: Aflac upgrades its policies from time-to-time and employees are not automatically enrolled in the new plan. Short Term Disability monthly benefits does not automatically increase with a salary increase. An application is required for any coverage change and may require a change in premium. You are strongly encouraged to speak with the Aflac Rep to review your personal plans each year.

Accident Advantage

Provides cash benefits in the event of an accident. Helps with expenses associated with unexpected injuries and throughout recovery.

- Specific Sum Injury Benefits
- Home Modification Benefits
- Emergency Treatment Benefit
- Hospital Confinement Benefits
- Rehabilitation Unit Benefits
- Follow-Up Treatment Benefits
- Physical Therapy Benefits
- X-Ray / Diagnostic Imaging Benefits
- Transportation, Lodging and Ambulance
- Optional Accidental Death & Dismemberment

Cancer Care with Optional Heart Attack and Stroke Rider

Helps protect your income and savings by providing critical cash benefits to care for yourself or a loved one throughout all phases of cancer diagnosis and treatment.

- Initial Diagnosis Benefit
- Chemotherapy and Radiation Benefits
- Hospital Confinement / Surgical Benefits
- Experimental Treatment Benefits
- Transportation, Lodging and Ambulance
- Wellness Benefit Paid Yearly
- Optional coverage for heart attack, stroke, end-stage renal failure and cardiac arrest

Hospital Choice

Protects against significant financial loss by providing cash benefits when you incur hospital services for sickness, accident or pregnancy.

- Inpatient Hospital Benefit
- Outpatient Surgery and Procedure Benefits
- Diagnostic Exam Benefits
- Rehabilitation Unit Benefits
- Emergency Room Benefit
- Physician Visits
- Laboratory Tests/ X-ray benefits

Short-Term Disability Income

Provides a source of income during your time of disability, which helps you focus on recovering and getting back to work, rather than worrying about how the bills get paid. The plan is customizable to meet your needs (subject to income requirements).

- Guaranteed Issue – no medical questions
- Covers sickness, accident or pregnancy
- Monthly Benefit amount of between $400 and $6,000
- Optional "On-the-Job" coverage available
- 3 to 24-month benefit periods available
- Covers total or partial disability
- 12-month pre-existing condition exclusion

To Cancel Existing Coverage an Aflac Cancellation Form must be signed prior to the annual renewal date. If there is no contact with the Rep, coverage will automatically roll over with no benefit or premium change. **Pre Tax Deductions** can only be changed at open enrollment unless the change is made within 30 days after a qualifying event.

Call ComPsych® GuidanceResources® anytime for confidential assistance.

Call: **800.272.7255**
Go online: **guidanceresources.com**
TDD: **800.697.0353**
Your company Web ID: **COM589**

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Someone to talk to.

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

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Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you... relationships, work, school, children, wellness, legal, financial, free time and more.

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  Employees save money by seeing their personalized out-of-pocket for a drug being prescribed, right at the point of care.
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  Increase adherence by knowing if step therapy or prior authorization is required before you try to fill the script.
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DoctorSolve is a trusted, established online pharmacy intermediary with more than 200,000 customers. Every member of their trained and professional staff is committed to ensuring that your health is protected, and you have a trusted source for pure and safe Canadian prescription drugs.

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  All prescriptions are filled by a professionally registered pharmacist.
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  DoctorSolve understands that patients not only require information, but reassurance and support. Their customer service relies on providing unassuming, compassionate advice.
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  Every member of our trained and professional staff is committed to ensuring that your health is protected , and you have a trusted source for pure and safe medication.

Resources

Before Enrolling, be sure to:

- **Consider your options.** Make sure you get the coverage that best suits your needs. Discuss with your spouse, partner or other family members to consider all sources of benefits coverage.
- Our insurance carriers offer a number of tools and resources available through their web sites that can help support your decision making process. You can reach the carriers at:

Empire BlueCross BlueShield	www.empireblue.com	(866) 723-0515
ProAct	www.proactrx.com	(866) 287-9885
CanaRx	www.BardcanaRX.com	(866) 893-6337
MetLife	www.metlife.com	(800) 942-0854
Anthem Life	www.anthem.com	(800) 552-2137
AFLAC	www.aflac.com	(800) 992-3522
Benefit Resource, Inc.	www.benefitresource.com	(800) 473-9595
ComPsych	www.guidanceresources.com	(800) 272-7255

Keep this guide handy - refer to the information in this guide to help you make wise benefit choices.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health 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 October 2019 for coverage starting as early as January 1, 2020.

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 9.5% 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.
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% of such costs.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

hr@bard.edu
Bard College
P.O. Box 5000
Annandale-on-Hudson, NY 12504

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.

[1] 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% of such costs.

General Group Health Plan Notices

Patient Protection Disclosure Notice

If your health plan generally allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your health insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

The Women's Health and Cancer Rights Act of 1998

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis and complications resulting from a mastectomy, including lymph edema? Contact your employer for more information.

The Women's Health and Cancer Rights Act (WHCRA), signed into law on October 21, 1998, contains protections for patients who select breast reconstruction in connection with a mastectomy. Plans offering coverage for a mastectomy must also cover reconstructive surgery and other benefits related to a mastectomy.

Women's Health and Cancer Rights Act (WHCRA):

- Applies to group health plans for plan years starting on or after October 21, 1998.
- Applies to group health plans, health insurance companies or HMOs, if the plan or coverage provides medical and surgical benefits with respect to mastectomy.
- Requires coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient.

Under WHCRA, mastectomy benefits must include coverage for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis and treatment of physical complications of the mastectomy, including lymph edema;

Under WHCRA mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage. Therefore, the following **in-network** copays, deductibles and coinsurance apply:

Benefit	HIGH PPO	LOW PPO	EPO HSA
Deductible	$0	$0	$1,500 / $3,000
PCP Office Visit	$30 Copay	$30 Copay	Covered in Full after Deductible
Specialist Office Visit	$55 Copay	$55 Copay	Covered in Full after Deductible
Inpatient Hospital Admission	$250 Copay	$250 Copay	Covered in Full after Deductible
Emergency Room	$200 Copay	$200 Copay	Covered in Full after Deductible

The law also contains prohibitions against:

- Plans and issuers denying patients eligibility or continued eligibility to enroll or renew coverage under the plans to avoid the requirements of WHCRA.
- Plans and issuers providing incentives to, or penalizing, physicians to induce them to provide care in a manner inconsistent with the WHCRA.

If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

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

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependent(s), including your spouse, because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within "30 days" after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, this special enrollment opportunity will not be available when other coverage ends unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph below, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

If you have a new dependent as result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within "30 days" after the marriage, birth, adoption, or placement for adoption.

A special enrollment opportunity may be available in the future if you or your dependent(s) lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependent(s) experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependent(s) become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependent(s) will have sixty (60) days to request special enrollment in the group health plan coverage. An individual must request this special enrollment within sixty (60) days of the loss of coverage described at bullet one, and within sixty (60) days of when eligibility is determined as described at bullet two. To request special enrollment or obtain more information, contact your HR representative.

hr@bard.edu
Bard College
P.O. Box 5000
Annandale-on-Hudson, NY 12504

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 includes states that currently offer a premium assistance program in the Tri-State region only. Contact your State for more information on eligibility.

NEW JERSEY – Medicaid and CHIP	NEW YORK - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

To see if any other states offer a premium assistance program, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-44-EBSA (3272)

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

Important Notice 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 your employer 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.

A plan's prescription drug coverage is considered creditable coverage if the amount the plan expects to pay on average for prescription drugs for individuals covered by the plan is the same or more than what standard Medicare prescription drug coverage would be expected to pay on average.

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. Your Employer has determined that the prescription drug coverage they offer 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 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 your employer 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 Marshall & Sterling at (866) 573-4768.

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