

Welcome to The Claremont Colleges Benefits for 2018!



As a valued employee of The Claremont Colleges, we're pleased to offer you a comprehensive array of benefits that help protect your health, your family, and your way of life, including:

- **Health care** coverage, including medical, dental, and vision benefits
- **Work-life resources** through the Employee Assistance Program
- **Financial protection** for you and your family, including disability and life insurance coverage
- **Retirement** savings opportunities through a 403(b) plan
- **Other voluntary** benefits like Flexible Spending Accounts (FSAs) or a Health Savings Account (HSA)

This brochure highlights some plan details and premiums for your 2018 benefits. More information can be found on the *2018 Benefits Guide* at:

- www.cuc.claremont.edu/benefits
- <https://www.pitzer.edu/human-resources/benefits/>
- <http://my.pomona.edu>

When to Enroll

Below are some guidelines for when you can enroll for benefits. For more information about how to enroll, see page 12.

During Open Enrollment

Each year, you will have the opportunity to review your benefit choices for the following year during Open Enrollment. Open Enrollment for your 2018 benefits is Monday, October 30 through Friday, November 17, 2017.

As a New Hire

If you're eligible, you must enroll within 31 days following your Benefits Seniority Date. If you enroll for benefits during this 31-day period, coverage will take effect as of your Benefits Seniority Date.

Enrolling During the Year

If you don't enroll for The Claremont Colleges benefits during the Open Enrollment period each fall, you can't enroll until the next enrollment period, unless you have a qualified family status change, such as a marriage or the birth of a child. In that case, you must change your coverage within 31 days of the event and provide necessary documentation, such as a marriage certificate or a birth certificate.





Who Is Eligible for Benefits

You are eligible to participate in The Claremont Colleges benefits if you are a regular employee scheduled to work at least 20 hours per week.

A benefits-eligible employee is defined as:

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

All other employees are not eligible for medical benefits, unless they meet the criteria for medical benefits under the Affordable Care Act defined in the Statement of Benefit Eligibility for Centrally Administered Employee Benefit Programs available at www.claremont.edu/benefits.

Eligible Dependents

If you enroll yourself in coverage under The Claremont Colleges benefit plans, you may also enroll your eligible dependents. Eligible dependents include your:

- Spouse
- Domestic partner
- Children up to age 26, and children of any age who are mentally or physically disabled and meet certain requirements
- Step-children or children of your domestic partner up to age 26

Qualifying Life Event¹

Qualifying life events allow you to make changes to your benefits mid-year. In order to be eligible you must have one of the following events and submit documentation to Benefits Administration within 31 days of the event:

- Birth/adoption
- Marriage/divorce
- Loss of coverage
- Dependent gains coverage elsewhere

¹ Please contact your benefits representative to discuss your life event.

Benefits at a Glance

The medical, dental and vision plans provide comprehensive coverage to allow you to choose the plan that works for your needs and your budget. For a Medical Plan comparison, see page 8. For comparisons of the Dental and Vision plans, see page 9.

Type of Benefit	Benefit Plans Available	Carrier Name	Quick Description
Medical (Includes prescription drug coverage)	Lumenos HDHP with HSA	Anthem Blue Cross	With the Lumenos HDHP plan, you have more control over how you spend your health care dollars.
	Blue Cross (CaliforniaCare) HMO	Kaiser Permanente	With the HMO plans, you must see an in-network provider, no out-of-network coverage is provided.
	HMO		
Health Savings Account (HSA)	Available only with the Lumenos HDHP	Benefit Wallet (Mellon Bank)	A personal savings account created from pre-tax employee contributions to be used for qualified medical expenses. Federal regulations limit HSAs to plans with a high deductible, like the Anthem Lumenos HDHP.
Dental	DHMO	Cigna	With the HMO you must see an in-network provider; no out-of-network coverage is provided.
	DPPO		With PPO coverage, you may use the dental provider of your choice, but you will receive discounted services by utilizing a Cigna network provider.
Vision	Core Plan	Anthem	With the Core Plan, you must see network providers; no out-of-network coverage is provided.
	Buy-up Plan		With the Buy-up Plan, you can see in-network or out-of-network providers, but will receive higher benefits when you stay in network.
Retirement	Academic Retirement Plan (ARP)	TIAA	Save for your future with the colleges' ARP plan. Employer contributions are made as a percentage of eligible compensation. Employee voluntary elective deferrals can be made on a pre-tax or Roth after-tax basis.

Benefits paid for by you and The Claremont Colleges

Continued →



Benefits at a Glance (continued)

	Type of Benefit	Benefit Plans Available	Carrier Name	Quick Description
Benefits fully paid for by you	Flexible Spending Accounts (FSAs)	Health Care FSA Limited Scope Health FSA Dependent Care FSA	PayFlex	FSAs help you make your money go further by letting you set aside pre-tax dollars to pay for certain out-of-pocket eligible expenses and dependent care costs.
	Voluntary Life Insurance	Employee Voluntary Life Spouse Voluntary Life Child(ren) Voluntary Life	The Standard	1-4 times your basic annual earnings (rounded to the next higher multiple of \$1,000), to a maximum of \$1 million. \$10,000 increments, to a maximum of \$250,000 or 50% of your combined Basic and Supplemental Life Insurance coverage. \$1,000 or \$5,000 depending on child's age at time of election.
	Voluntary Accidental Death & Dismemberment (AD&D) Insurance	Individual or Family Coverage	Zurich	Individual or family coverage in \$25,000 increments up to \$500,000. AD&D provides coverage in the event of your death or serious injury due to an accident.
	Voluntary Long-Term Care	Coverage is available for you, your spouse, your children, and other members of your extended family between the ages of 18 and 75	Genworth	In addition to conventional nursing home coverage, the policy covers services received in your own home; other types of care facilities may be covered. Contact Genworth for a price quote.
	Voluntary Pet Insurance	Coverage for your furry family members	Pet's Best	Pet insurance can help you pay medical treatment costs for your pet's accidents, illnesses and routine medical care.
Benefits paid 100% by The Claremont Colleges	Basic Life Insurance	Coverage for you, paid to your family in the event of your death	The Standard	All benefits eligible faculty and staff receive Basic Life Insurance with a benefit of 1 times their annual income or a minimum of \$20,000, to a maximum of \$50,000.
	Long-Term Disability	Coverage for you	The Standard	Benefits eligible faculty and staff who are scheduled to work 30 hours or more per week, are automatically enrolled for long-term disability coverage on their first day of employment. <i>Exception: Rancho Santa Ana Botanic Gardens staff may elect coverage and pay 50% of the premium.</i>
	Employee Assistance Program (EAP)	Coverage for you, your spouse, and your dependents	Optum Health	Confidential advice and counseling is available to faculty and staff at no cost through the EAP. Employees and their legal spouses, domestic partners and eligible dependents receive up to 5 counseling sessions with a licensed/certified therapist by phone or in-person, per family member, per issue, each calendar year. And, there are many other benefits available through the EAP, which are detailed in the Benefits Guide. Access to the EAP is available 24/7 year round.

Detailed information about all of the benefits above is available in your *2018 Benefits Guide*, which can be found at:

- www.cuc.claremont.edu/benefits
- <http://pitweb.pitzer.edu/human-resources/benefits/>
- <http://my.pomona.edu>

Important Information About Flexible Spending Accounts (FSAs)

Three reasons to consider an FSA:

1. **Reduce your taxable income.** By contributing to these accounts pre-tax, you reduce your taxable income.
2. **Save money.** You are already spending your hard-earned money on common out-of-pocket expenses like your deductible, copays and coinsurance, or your child care expenses. Why not pay for these expenses on a pre-tax basis?
3. **Save on your dependents' expenses too!** Your dependents' expenses are also eligible for reimbursement through these accounts, so be sure to make your dependents aware of how they can use your FSA to save money for the whole family.

• You Must Re-enroll for Flexible Spending Accounts (FSAs) Each Year

- Per IRS regulations, you are required to actively enroll in the Health Care, Limited Scope Health Care, or Dependent Care Flexible Spending Accounts (FSAs) each year. This means that if you are enrolled in an FSA for 2017, your 2017 elections will not roll over to 2018. Be sure to re-enroll for your FSAs each year before the enrollment deadline!

• Using your FSA to Pay for Medical and Dental Expenses

- When you open an FSA, you'll receive a debit card to pay for qualified health care expenses.
- **At the doctor's office:** Depending on the plan in which you are enrolled, you may have to pay a copay for some services when you see your doctor. You can simply present your FSA debit card at the time of service to pay for the copay and the funds will be automatically deducted from your account.
- **At the pharmacy:** If your doctor writes you a prescription, you can use Anthem's online tools to check prices and find an in-network pharmacy. Once you've submitted your prescription and the pharmacy notifies you it is ready for pick-up, use your FSA debit card to access the funds in your FSA to pay the pharmacy.
- **At the dentist:** If your dentist requires you to pay at the office, present your FSA debit card and funds will automatically be deducted from your account.

• Filing an FSA Claim Form

- Instead of using your FSA debit card, you may pay for eligible expenses with cash, check, or your personal credit card. Then, submit an online claim to PayFlex for reimbursement at www.payflex.com. Or, send a paper claim to PayFlex Systems USA, Inc., P.O. Box 91158, El Paso, TX 79998-1158. Fax: 855-703-5305.
- **Note:** When you submit a claim, your claim will only be approved if it contains an itemized receipt that includes the following information:
 - Provider name and address,
 - Patient name,
 - Description or type of service,
 - Date of service (not date of payment), and
 - Dollar amount charged for the expense.
- **Note:** If you use your Health Care FSA or Limited Scope FSA to pay for dental expenses before your insurance has processed the expense, the claim may result in requests for additional information. Visit www.payflex.com for more information on dental substantiation.



Dependent Care FSAs

The Dependent Care FSA may be used to pay for expenses that allow you (or your spouse, if married) to work by providing pre-tax funds to cover eligible child and elder care. In any calendar year, you can contribute, before tax, a minimum of \$300 and a maximum of \$5,000 (\$2,500 if married and filing separately).

¹ Domestic partners and dependents of domestic partners are not eligible for FSA reimbursement. Expenses for dependent children can be paid from the FSA until the child is age 27 at the end of your tax year.

4 TIPS: Make the most of your coverage

TIP #1: Stay healthy with preventive care

Make the most of your health care dollars by taking advantage of your plan's preventive care benefits. All of our medical plans pay 100% for covered preventive services.

Preventive Care: Smart Consumer

Our medical plans offer Health Coaching, available to help you make positive lifestyle choices, like adding exercise or strength training to your daily routine, managing your weight, eating better, and managing stress. The service is free, personalized and completely confidential. To find information to help you make smart choices, visit www.anthem.com or www.kp.org.

Using your preventive care benefits

Preventive care helps identify potential health risks early when they are easier and less costly to treat.

- 1. Use a network doctor.** Find one using the Find a Doctor tool on the Anthem website (www.anthem.com/ca), the Kaiser Permanente website (www.kp.org) or KP Mobile App (available for Android or Apple smartphones).
- 2. Know what's covered.** Network preventive care services, such as physical examinations, related laboratory and X-rays, Pap tests, mammograms, prostate and colorectal (including colonoscopy) screenings, and immunizations excluding travel vaccines, are covered at 100% under all of our medical plans (subject to certain age-appropriate and frequency guidelines). To find the full list of covered preventive services, review the Summary of Benefits and Coverage (SBC) for your plan, available in the *2018 Benefits Guide*.

Quick Question: What if I get billed for Preventive Care?

Network preventive care is covered at 100% (subject to certain guidelines), but what if your doctor labels a preventive care service as a diagnostic service? If you get a bill for a covered preventive service, contact your health plan administrator to get the issue corrected. **Note:** If, as part of your checkup, you receive a treatment, or screenings for a condition for which you have already been diagnosed—for example, a bone scan for diagnosed osteoporosis—that service may not be considered preventive, and the deductible and coinsurance may apply.

TIP #2: Pay less for prescription drugs

For non-preventive services and medications, you must pay the full deductible (for the Lumenos HDHP) before the medical plan pays any benefits, including benefits for prescription drugs. (However, note that certain preventive drugs are covered at 100% and aren't subject to the deductible.)

Here are a few ways to save on your prescription drug costs:

Go generic



Don't pay more for prescription drugs than you need to—ask your doctor if a generic is available. On average, generic drugs cost 30% - 70% less than their brand-name equivalents, but have the same active ingredients, quality, and strength.

Use mail order



Save money on maintenance medications (drugs you take regularly for chronic conditions like diabetes and high blood pressure) by ordering them through your medical plan's mail-order program. You'll get a larger supply at a lower cost.

Find out whether your medications are preventive



Certain preventive prescriptions aren't subject to the deductible. You can find the complete list on your medical plan's website.

TIP #3: Know where to go in an emergency

Need care now? The emergency room may not always be the best option. Consider using an urgent care facility for faster care and lower costs. If you're experiencing a true, life-threatening emergency, go directly to the emergency room (ER).

When to go to an urgent care facility	When to go to the ER
<ul style="list-style-type: none"> • Rash or other skin irritations • Broken bones • Minor burns or injuries • Minor animal bites • Objects in the eye, ear, or nose 	<ul style="list-style-type: none"> • Loss of consciousness • Severe or unexpected dizziness • Intense pain • Symptoms of a heart attack or stroke, such as chest pain • Severe breathing problems or shortness of breath

Quick Question: What is an Urgent Care Facility?

Urgent care facilities are medical facilities that have extended hours outside normal medical clinic hours and provide walk-in, nonemergency medical services. Services received at an urgent care facility generally cost much less than getting the same service at an emergency room. For the HMO plans, urgent care services are the same as an office visit copay.

TIP #4: Use your tools and resources

Your plan providers offer a number of health and wellness services that are covered for free under your medical plan:

Anthem Blue Cross HMO and Lumenos HDHP
<p>www.anthem.com/ca or 800-227-3771 (HMO)/ 866-207-9878 (Lumenos)</p> <ul style="list-style-type: none"> • Free preventive care (in-network only for Lumenos HDHP members) • Free immunizations such as the annual flu shot and pneumonia vaccine • 24/7 Nurseline provides an on-call nurse that you can call at any time, day or night • Future Moms is a no-cost resource for expecting mothers who want to access advice nurses and specialists, wellness info, and health screenings • Condition Care provides on-hand advice nurses and other resources to members affected by chronic and long-term health problems including asthma, diabetes, and heart failure. • LiveHealth Online (LHO) gives you quick and easy 24/7 access to doctors, including private video chats. LHO consultations are covered by your regular copay. • MyHealth Record is a feature of Anthem's website that stores your medical and immunization records all in one place. • 360°Health offers an online library of health-related information and tools to help members with anything from managing a condition to organizing health records • Discounts on eye care and eye care vendors for services like Premier LASIK • Discounts on health programs and fitness clubs, such as Weight Watchers and Gold's Gym

Kaiser Permanente HMO
<p>www.kp.org or Member Services at 800-464-4000</p> <ul style="list-style-type: none"> • Free preventive care • Free immunizations like the annual flu shot and pneumonia vaccine • Healthy Lifestyle Programs cover: Health assessment • Maternity and pregnancy • Pain management • Weight loss • Nutrition • Smoking cessation • Depression and stress management • Insomnia • Diabetes management • Chronic condition management • Wellness Coaching encourages members to focus on health and wellness improvement initiatives • ChooseHealthy is a website that offers discounts on fitness and health club membership rates and other health-improving resources such as health and fitness books, videos and personalized exercise and nutrition plans • Discounts on alternative care services for acupuncture or massage therapy

Medical Plans at a Glance

Benefit	Kaiser HMO	Anthem Blue Cross HMO (California Care)	Anthem Lumenos HDHP In-Network	Anthem Lumenos HDHP Out-of-Network
Calendar Year Deductible				
Employee-only	None	None	\$1,500	\$2,500
Family	None	None	\$3,000 ¹ <i>Individual Maximum: \$2,700</i>	\$5,000
Out-of-Pocket Maximum (per calendar year) Some benefits do not apply toward the out of pocket maximum.				
Employee-only	\$1,500	\$1,500	\$3,000	\$6,000
Family	\$3,000	\$3,000 (two-party) \$4,500 (family)	\$6,000 ¹ <i>Individual Maximum: \$3,000</i>	\$12,000
Inpatient Services				
Inpatient Hospital	\$200 copay per admission	\$300 copay per admission	Plan pays 80% after deductible	Plan pays 60% after deductible
X-ray, Laboratory	Plan pays 100%	Plan pays 100%	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Services				
Office Visits	PCP: \$20 copay Specialist: \$30 copay	PCP: \$25 copay Specialist: \$40 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Preventive Care	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 60% after deductible
Outpatient Surgery	\$30 copay	\$100 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Services				
Emergency room services and supplies	\$100 copay; waived if admitted	\$150 copay; waived if admitted	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient care	\$200 per admission	\$300 per admission	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient care	\$20 copay per visit/individual therapy \$10 copay per visit/group therapy	\$100 copay per visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Prescription Drugs—Retail (up to a 30-day supply)				
Generic	\$10 copay	\$10 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Brand Formulary	\$25 copay	\$30 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Brand Non-formulary	\$25 copay	\$50 copay	Plan pays 80% after deductible	Plan pays 60% after deductible
Prescription Drugs—Mail-order				
Generic	\$20 for up to 100 day supply	\$10 copay for 60 day supply	Plan pays 80% after deductible	Not Covered
Brand Formulary	\$50 for up to 100 day supply	\$60 copay for 60 day supply	Plan pays 80% after deductible	Not Covered
Brand Non-formulary	\$50 for up to 100 day supply	\$100 copay for 60 day supply	Plan pays 80% after deductible	Not Covered

¹ The family amount includes insured employee and one or more members of the employee's family. After one person reaches the in-network individual maximum deductible, that person will pay coinsurance for care; if they reach the individual out-of-pocket limit, the plan will pay 100% for that person for the rest of the year. All other family members will pay the full cost of care until the in-network family deductible is met and will pay coinsurance until the in-network family out-of-pocket maximum is met.

Dental Plans at a Glance

Benefit	Cigna Dental DHMO In-Network	Cigna Dental PPO	
		In-Network	Out-of-Network
Calendar Year Deductible	None	Individual: \$50/Family: \$150	Individual: \$50/Family: \$150
Calendar Year Maximum Benefit	Unlimited	Plan pays up to \$2,000 per person/year	Plan pays up to \$2,000 per person/year
For every year you get preventive dental care, \$200 will be added to next year's maximum annual benefit (up to an overall maximum benefit of \$2,600 after four years).			
Preventive/Diagnostic			
Routine Examination Cleaning once every 6 months	\$0 copay	Plan pays 100%; deductible does not apply	Plan pays 100%; deductible does not apply
General Services (Restorative)			
Fillings Amalgam Composite/Resin	\$0 to \$40 copay	Plan pays 80% after deductible	Plan pays 80% after deductible
Simple Extractions	\$5 copay	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services			
Caps, Crowns, Dentures	As listed in copay schedule	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontia			
Adults	\$0 to \$1,488 copay depending on the service performed	Plan pays 50% up to \$2,500 lifetime maximum benefit; after deductible	
Dependent Children (to age 19)	\$0 to \$984 copay depending on the service performed		
Retention	\$250 copay		

Vision Plans at a Glance

Benefit	Anthem Blue View Core Plan	Anthem Blue View Buy-Up Plan	
		In-Network	Out-of-Network
Eye Exam (Once every 12 months)			
	Plan pays 100% after \$10 copay	Plan pays 100% after \$10 copay	Plan pays up to \$79
Frames (Once every 12 months)			
	35% discount	Plan pays up to \$130 allowance; you receive a 20% discount on amounts over allowance	\$100 allowance
Lenses (Once every 12 months)			
Single Vision	\$50 copay	Plan pays 100% after \$15 copay	Plan pays up to \$36
Lined Bifocal	\$70 copay		Plan pays up to \$60
Lined Trifocal	\$105 copay		Plan pays up to \$79
Contact Lenses (Once every 12 months)			
	15% discount on conventional lenses	Plan pays up to \$130 allowance; you receive a 15% discount on doctor's professional fees. Materials are paid at usual and customary rates.	Plan pays up to \$115

2018 Employee Rates¹

Medical Plans	Kaiser Permanente HMO			Anthem Blue Cross HMO (California Care)			Anthem Lumenos HDHP		
	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly
Employee Only	\$46.18	\$21.31	\$23.09	\$53.34	\$24.62	\$26.67	\$65.82	\$30.38	\$32.91
Two Party	\$193.94	\$89.51	\$96.97	\$223.99	\$103.38	\$112.00	\$259.44	\$119.74	\$129.72
Family	\$415.60	\$191.82	\$207.80	\$479.54	\$221.33	\$239.77	\$545.05	\$251.56	\$272.53

For Faculty and Staff of Pitzer College

Medical Plans	Kaiser Permanente HMO		Anthem Blue Cross HMO (California Care)		Anthem Lumenos HDHP	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Under \$52,000						
Employee Only	\$36.94	\$17.05	\$42.67	\$19.69	\$65.82	\$30.38
Two Party	\$155.16	\$71.61	\$179.19	\$82.70	\$259.44	\$119.74
Family	\$332.48	\$153.45	\$383.63	\$177.06	\$545.05	\$251.56
Over \$52,000						
Employee Only	\$46.18	\$21.31	\$53.34	\$24.62	\$65.82	\$30.38
Two Party	\$193.94	\$89.51	\$223.99	\$103.38	\$259.44	\$119.74
Family	\$415.60	\$191.82	\$479.54	\$221.33	\$545.05	\$251.56

For Faculty and Staff of Pomona College

Medical Plans	Kaiser Permanente HMO		Anthem Blue Cross HMO (California Care)		Anthem Lumenos HDHP	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Under \$52,000						
Employee Only	\$46.18	\$23.09	\$53.34	\$26.67	\$65.82	\$32.91
Two Party	\$96.97	\$48.49	\$112.00	\$56.00	\$259.44	\$129.72
Family	\$138.53	\$69.27	\$159.85	\$79.93	\$545.05	\$272.53
Over \$52,000						
Employee Only	\$46.18	\$23.09	\$53.34	\$26.67	\$65.82	\$32.91
Two Party	\$193.94	\$96.97	\$223.99	\$112.00	\$259.44	\$129.72
Family	\$415.60	\$207.80	\$479.54	\$239.77	\$545.05	\$272.53

For hourly employees of Pomona College, deductions are made on a semi-monthly basis.

Dental Plans ²	Cigna Dental DHMO			Cigna Dental PPO		
	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly
Employee Only	\$4.18	\$1.93	\$2.09	\$36.37	\$16.79	\$18.19
Two Party	\$12.85	\$5.93	\$6.43	\$71.47	\$32.99	\$35.74
Family	\$27.15	\$12.53	\$13.58	\$141.08	\$65.11	\$70.54

Vision Plans	Vision Core			Vision Buy-Up		
	Monthly	Bi-Weekly	Semi-Monthly	Monthly	Bi-Weekly	Semi-Monthly
Employee Only	\$0.00	\$0.00	\$0.00	\$6.42	\$2.96	\$3.21
Two Party	\$1.36	\$0.63	\$0.68	\$10.83	\$5.00	\$5.42
Family	\$3.05	\$1.41	\$1.53	\$17.95	\$8.28	\$8.98

¹ Imputed income taxation applies when enrolling a domestic partner; please see your benefits representative for additional information.

² RSABG employees pay 100% of the premium for dental coverage.

Monthly Supplemental Life Insurance Rates

Rates for employees and spouse/domestic partner are based on the employee's age as of January 1, 2018.

Age	Monthly Rate (per \$1,000 of coverage)
Under 30	\$ 0.03
30-34	0.04
35-39	0.06
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.41
60-64	0.63
65-69	1.27
70 +	2.06

Dependent Child(ren) Life Insurance

Monthly Rate (for \$5,000 of coverage)
\$ 0.35

Monthly Accidental Death & Dismemberment Insurance (AD&D) Rates

Coverage amounts in excess of \$250,000 may not exceed 10 times annual base salary to a maximum of \$500,000. Principal sum amount cannot be increased after age 70. Coverage for children is 30% of the principal sum up to a maximum of \$50,000.

Principal Sum	Employee Only Coverage	Family Coverage
\$ 25,000	\$ 0.50	\$ 0.98
50,000	1.00	1.95
75,000	1.50	2.93
100,000	2.00	3.90
125,000	2.50	4.88
150,000	3.00	5.85
175,000	3.50	6.83
200,000	4.00	7.80
225,000	4.50	8.78
250,000	5.00	9.75
275,000	5.50	10.73
300,000	6.00	11.70
325,000	6.50	12.68
350,000	7.00	13.65
375,000	7.50	14.63
400,000	8.00	15.60
425,000	8.50	16.58
450,000	9.00	17.55
475,000	9.50	18.53
500,000	10.00	19.50



Affordable Care Act (ACA) Reporting

- As part of the ACA, the IRS requires employers with over 50 employees to provide an annual statement to the IRS describing the coverage offered to eligible employees. This statement is called the Form 1095-C.
- If you are eligible for coverage from The Claremont Colleges, you will receive a copy of Form 1095-C from The Claremont Colleges, this form includes information about eligibility and the cost of coverage from available plans.
- In addition, if you are enrolled for medical coverage, you will receive a Form 1095-B from your insurance carrier. This form will include information about your specific coverage, your coverage period, and who from your family was covered.
- Forms for 2017 coverage will be mailed to your home address in January 2018.
- **What it means for you:** The forms are used to verify on your tax return that you and your dependents have at least minimum qualifying health insurance coverage in 2017, as required by the ACA. If you didn't have health care coverage for any part of the year you may have to pay a tax penalty. The check boxes in Part IV of Form 1095-B will help you calculate the penalty that applies, if any.

How to Enroll

Sign into UltiPro using your individual user name and password. **Current employees:** Go to "Myself" on the menu bar and click on "Open Enrollment." **New employees:** Go to "Myself" on the menu bar and click on "Life Events" and then on "Choose Event." Make your elections and click on the "Submit" button on the Confirmation page to complete your 2018 elections.

For your UltiPro user name and password assistance, please contact your Human Resources Department.

CGU: ADP Instructions

Login to ADP by going to <https://workforcenow.adp.com/public/index.htm>. Select User Login, enter your User Name and Password. For user name and password assistance please contact Human Resources. CGU will allow a PASSIVE enrollment for 2018. This means if you do nothing, your 2017 elections will carry over. PLEASE NOTE: FSA and HSA accounts require re-enrollment. These will not carry over to 2018.

Benefits Administration Contacts

Claremont University Consortium

Carol Saldivar (909) 607-3195 carol_saldivar@cuc.claremont.edu
Monica Villanueva (909) 607-3684 monica_villanueva@cuc.claremont.edu
Claudia Garcia (909) 607-9493 claudia_garcia@cuc.claremont.edu
Alicia Silva (909) 621-8049 alicia_silva@cuc.claremont.edu
Cristal Hernandez (909) 607-4130 cristal_hernandez@cuc.claremont.edu

For more information, please view the *2018 Benefits Guide* at:

- www.cuc.claremont.edu/benefits
- <http://pitweb.pitzer.edu/human-resources/benefits/>
- <http://my.pomona.edu>

If you need assistance, please email BENREPS@cuc.claremont.edu.



Legal Notices

Important notice from The Claremont Colleges about creditable prescription drug coverage and Medicare

Date of this notice: October 2017

The purpose of this notice is to advise you that the prescription drug coverage listed below under The Claremont Colleges medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2018. This is known as “creditable coverage.”

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2018 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty—as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Notice of creditable coverage

Please read the notice below carefully. It has information about prescription drug coverage with Claremont and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Claremont prescription drug plans listed below, you'll be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2018. This is called creditable coverage. Coverage under the plans listed below will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan:

- Kaiser HMO
- Anthem Blue Cross HMO
- Anthem Lumenos HSA

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Claremont coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Claremont plan.

You should know that if you waive or leave coverage with Claremont and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future—such as before the next period you can enroll in Medicare prescription drug coverage, if this Claremont coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

The Claremont Colleges
CUC Benefits Administration
101 S. Mills Avenue
Claremont, CA 91711
909-621-8151

Privacy Notice

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by employer health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan—whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Health Care Flexible Spending Arrangement (FSA) benefits. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not The Claremont Colleges as an employer – that's the way the HIPAA rules work. Different policies may apply to the other Claremont Colleges' programs or to data unrelated to these Plans.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan may share your health information with physicians who are treating you.*
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.*
- **Health care operations** include activities by this Plan (and in limited circumstances by other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors, engaging in credentialing, training, and accreditation activities, performing underwriting or, premium rating, arranging for medical review and audit activities, and conducting business planning and development. *For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.*

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses Protected Health Information (PHI) for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with The Claremont Colleges

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to The Claremont Colleges for plan administration purposes. The Claremont Colleges may need your health information to administer benefits under the Plan. The Claremont Colleges agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. The benefits staff, payroll and finance are the only employees of The Claremont Colleges employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and **The Claremont Colleges**, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to The Claremont Colleges if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to The Claremont Colleges information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that The Claremont Colleges cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by The Claremont Colleges from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made—for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death

Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death – or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with one of these responses:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

If the Plan keeps your records in electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- make the amendment as requested;
- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- for treatment, payment, or health care operations;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on September 1, 2017. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice through your Human Resources Department via mail or e-mail as appropriate.

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint,

The Claremont Colleges' Plan Administrator
c/o Claremont University Consortium Benefit Administration
101 S. Mills Avenue
Claremont, CA 91711

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact

The Claremont Colleges' Plan Administrator
c/o Claremont University Consortium Benefits Administration
101 S. Mills Avenue
Claremont, CA 91711

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Federal law requires certain employers sponsoring group health plan coverage to offer their employees (and his or her enrolled family members) the opportunity to elect to extend health coverage should a loss of plan coverage occur due to a qualifying event. You are receiving this notice because you have either (1) recently been hired by The Claremont Colleges, and are enrolled in The Claremont Colleges Group Health Plan or (2) you recently added a newly eligible dependent to your plan. This notice contains important information about the right you and your covered dependents have under COBRA continuation coverage.

Both you (the employee) and your enrolled dependents (if applicable) should read this notice carefully and keep it with your records.

Introduction

You are receiving this notice because you have recently become covered under The Claremont Colleges (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The Claremont Colleges and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator, in writing, within 60 days after the qualifying event occurs. You must send this notice to:

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify PayFlex of that fact within 60 days of the later of 1) the SSA's determination of disability (the date of the SSA award letter); 2) the date of your qualifying event; 3) the date of your loss of coverage; or 4) the date you were notified of the requirement (the date of your qualifying event letter). The notification must also be provided before the end of the first 18 months of continuation coverage. Also, you are required to notify the Plan Administrator of any change in your disabled status. This notice should be sent to:

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:**

The Claremont Colleges' Plan Administrator
c/o Claremont University Consortium Benefit Administration
101 S. Mills Avenue
Claremont, CA 91711

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at <http://www.dol.gov/ebsa>. For more information about the Marketplace, visit www.HeathCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The Claremont Colleges
101 South Mills Avenue
Claremont, CA 91711
(909) 621-8151

October 2017

Participant and family, if applicable

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions are as follows:

1. Under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to various requirements. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined by the Social Security Administration, under the Social Security Act, to have been disabled at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.

Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements in a timely fashion.

2. A child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.
3. Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan.

If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact The Claremont Colleges Benefits Administration department at (909) 621-8151.

THE CLAREMONT COLLEGES 2018 OPEN ENROLLMENT

Your Annual Open Enrollment Period for Medical, Dental, Vision,
and Flexible Spending Accounts Coverage is here.

October 30 – November 17, 2017

Open Enrollment Meetings

These meetings include a review of benefit offerings and changes for 2018 as well as an opportunity to ask questions and speak to a Benefits Representative from CUC Benefits Administration.

Meetings

Wed., Nov. 1, 2017	2 – 3 p.m.
Tues., Nov. 7, 2017	9:30 – 10:30 a.m.
Mon., Nov. 13, 2017	10 – 11 a.m.

*Held at the Administrative Campus Center
(101 S. Mills Ave., Claremont, CA 91711) in the Board Room*

To watch a recorded presentation go to:
<https://www.cuc.claremont.edu/benefits/youtube/>

Enrollment Assistance

Come by ACC M-F 8: 30 a.m. – 5 p.m. for enrollment assistance, no appointment needed.

Have questions?

Email us at BENREPS@cuc.claremont.edu

or call us at 909-621-8151

