EMPLOYEE BENEFITS

Barnard College

Administrators & Faculty

2025 Benefits Enrollment Guide

MARSHALL + STERLING

Secure your Success

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Please Note: This enrollment guide is a summary of the benefits provided to benefit eligible employees. Barnard 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.

3009 Broadway
New York, NY 10027
Phone Number: (646) 745-8352

Dear Valued Employee:

Welcome to Barnard College's January 1st, 2025, to December 31st, 2025 plan year. Barnard College acknowledges and affirms that its employees are among its greatest assets. To that end, the College seeks to recruit and support top-tier employees who will continue to secure Barnard's reputation as a premier institution, support the College's commitment to the liberal arts and women's education, and its affiliation with Columbia University. To meet these needs and priorities, Barnard offers employees competitive total rewards within a culture that promotes diversity, using its unique location in the cosmopolitan urban environment of New York City as a platform.

Barnard College (known throughout as "the College") offers a comprehensive and competitive benefits program as part of your total compensation package. We are committed to improving your healthcare, financial and work life needs as well as those of your family. This guide serves as a reference book for the College's benefits program should you need help making your enrollment decisions.

Take time to read the detailed information about each of our programs as the choices you make are binding. You cannot change your elections until the next open enrollment period, which will be for benefits effective January 1, 2026, unless you experience a midyear qualifying life event. If you wish to change your benefit election due to a qualifying life event, you must provide supporting documentation of the change (marriage certificate, birth certificate, etc.) within 30 days of the event. **No exceptions will be made**.

We want to make it as simple as possible for you to select the right benefit coverage for you and your family. We strive to make it easy to view and update your personal and benefits information via Workday.
We hope you find all the information you need within this guide, but please know the benefits and wellness team in the Office of Human Resources is available to answer any questions you might have. You can contact the Human Resources team at benefits@barnard.edu, our benefits broker team at barnard@marshallsterling.com, or call your benefits and wellness team members directly.

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 Barnard College?
- Verify that your enrolled dependents meet the definition of an eligible dependent. Medical coverage is provided for dependent children up to the end of the month of 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. 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.

Eligibility & Enrollments

How It Works

The College pays a portion of the cost of your benefit plans which is considered part of your "total compensation" package. Your contributions for most benefits are made with pre-tax dollars. The cost of the option you choose is deducted from your pay before taxes are computed. Because your annual income is reduced by the amount of your deductions for elected benefits, you pay less in taxes. Details on whether contributions are deducted from your pay on a pre-tax or post-tax basis for a benefit option are identified throughout this guide.

Eligibility

All active Faculty and Administrative employees who are regularly scheduled to work at least 30 hours a week are eligible to participate in the Barnard College's Benefits Program. If you enroll in coverage, you may also enroll your "eligible dependents" into the following plans: medical, dental, and vision insurance. Effective January 1st, 2025, proof of dependent relationship is required for all dependents (marriage, birth certificate or signed Domestic Partner Affidavit).

Additionally, Variable Part Time employee's who meet the full-time definition defined by the Affordable Care Act (ACA), are eligible to participate in the medical plan(s). If eligible, you may also enroll your "eligible dependents" into a medical plan.

Eligible Dependents:

- Your same or opposite sex legal spouse or domestic partner* (must be a U.S. citizen or legal resident)
    - Certain provisions apply to spouses/domestic partners with access to medical coverage under another employer plan. See medical plan page for details.
- Any of your dependent children to the end of the month of their 26th birthday
- Any of your spouse's or domestic partner's dependent children to the end of the month of their 26th birthday
- The term "child" includes any of the following:
    - A natural child or stepchild
    - A legally adopted child or a child placed for adoption
    - A child for whom you or your spouse/domestic partner are the legal guardian
    - Unmarried/married dependent children (not their spouse or dependents) of any age who are physically or mentally disabled

    For Medical coverage only:
    - A dependent includes any dependent child to the end of the month in which the child turns age 26 regardless of full-time student, residence or marital status.

    For Dental and Vision coverage:
    - A dependent includes any dependent child to the end of the month in which the child turns age 26 regardless of full-time student status or residence.

You cannot change your selections until the next open enrollment period for benefits to be effective January 1, 2026, unless you experience a "qualifying life event." A "qualifying life event" means you've experienced a personal change that may allow you to change your benefit selections. Examples of qualifying life events include, but are not limited to: change in legal marriage status, change in number of dependents, change in employment status, gain or loss of other coverage, a child satisfying or ceasing to meet an eligibility requirement, etc.

You may waive medical, dental, vision and/or FSA coverage. Your next opportunity to enroll in these plans will be the next annual enrollment period in the fall of 2025, for benefits effective January 1st, 2026, unless you experience a qualifying life event.

Eligibility & Enrollments *Continued*

***Important Note About Domestic Partnership Taxability**
Your medical, dental and vision contributions made towards coverage for your domestic partner will be deducted from your pay on a post- tax basis. Employer contributions towards medical and dental coverage for your domestic partner are considered imputed income. You will be responsible to pay taxes on the value of the College's contribution towards the cost of coverage for your domestic partner.

If you want to cover an eligible domestic partner for benefits and that person is your dependent for tax purposes, you must complete the Section 152 form (Certification for Tax Dependents Form) annually to be exempt from post-tax contributions and imputed income. The Certification for Tax Dependents form must be returned to the benefits and wellness team in the Office of Human Resources within 30 days of the date your benefits go into effect. Forms received will be processed on a prospective basis; no retroactive adjustments will be made.

If you have any questions or wish to request a form, please contact the benefits and wellness team in the Office of Human Resources.

It is your responsibility to make sure all dependents you enroll are eligible for coverage. Dependent children who no longer qualify for benefits under the College's plan may continue coverage under COBRA. Notify the benefits and wellness team in the Office of Human Resources if your dependent does not receive a COBRA packet within 30 days following the loss of coverage.

New Hires

New hires and newly eligible employees may enroll in the Health and Welfare plans when they first join Barnard College. New hires must elect benefits within 30 days of their date of hire; otherwise, they will have to wait until the next Open Enrollment period to elect benefits. The following provides an overview of benefit election requirements and effective dates.

Benefit	Action Required	Benefit Effective Date
Medical, Dental, Vision, Flexible Spending Account, Parking & Transit, Supplementary Benefits	Eligible associate must actively elect these benefits	Benefits go into effect the date of hire
Health Savings Account	Eligible associate must actively elect these benefits	Benefits go into effect the first of the month following date of hire
Basic Life, Accidental Death and Dismemberment, Employee Assistance Program	Eligible associates are automatically enrolled in this benefit	Benefits go into effect on the date of hire
Short Term Disability	Eligible associates are automatically enrolled in this benefit	Benefits go into effect on the 1st of the month following 30 days of service
Long Term Disability	Eligible associates are automatically enrolled in this benefit	Benefits go into effect the 1st of the month following 1 year of service

Medicare Eligible

If you are actively working and you or your spouse is eligible for Medicare benefits, please see the outline below:

Medicare Eligibility Reason	Primary Payor	Secondary Payor
Over 65 years of age	Cigna	Medicare
Due to disability	Cigna	Medicare

Termination of Benefits Coverage

Your benefits coverage ends as follows:
Medical, Dental, Vision, Flexible Spending Account, voluntary benefits, EAP, Basic Life, AD&D, and disability benefits terminate on the day of termination.

Medical and Prescription Drug Plan

The College offers a choice of three medical and prescription drug plans, insured by Cigna, which includes access to a nationwide network of providers through Cigna's Open Access Plus (OAP) network. The cost of this plan is shared by you and the College. Your contribution to the cost of coverage is deducted from your pay on a pre-tax basis.

Choice

You have the choice of seeing any provider without needing a referral for specialist visits. Claim forms are not required when utilizing network participating providers. Providers who participate in Cigna's network accept negotiated rates which reduce your claim costs and out-of- pocket expenses.

You have the option to use providers who participate in the Cigna OAP network and you have the option to utilize Cigna's participating labs or a non-participating lab. If you use a provider who is not in Cigna's network, services rendered are subject to the plan's annual deductible and coinsurance. An out-of-network provider may require payment at time of service, in which case, you will need to file a claim to receive reimbursement up to the allowable charge for that service in your geographic area. The provider has the right to balance bill you for amounts in excess of the allowable charge.

How the In-Network Deductible Works (Plans A & B)

All in-network facility, lab, x-ray and advanced radiology services are subject to the plan's in-network deductible. Once the deductible is satisfied, the plan will pay a percentage of the negotiated rate, referred to as coinsurance. Office visits, emergency room visits, and urgent care visits are not subject to the plan's deductible.

How The Family Deductible Works (Plans A & B)

After each family member meets the individual deductible, the plan will pay their claims (up to the allowable charge, if out-of- network) less any copayment or coinsurance amounts. After the total family deductible has been met, each individual's claim will be paid by the plan (up to the allowable charge, if out of network)less any copayment and coinsurance amounts. No one family member will ever be charged more than the individual deductible. Every dollar that is applied to any one family member's individual deductible is also applied to the overall family deductible.

How the In-Network Deductible Works (Plan C)

All in-network services, including prescription drug expenses, are subject to the plan's in-network deductible. Once the deductible is satisfied, the plan will pay a percentage of the negotiated rate, referred to as coinsurance, for all services except prescription drugs. Following satisfaction of the deductible, prescription drug copays apply.

How The Family Deductible Works (Plan C)

For individuals in a family, the family deductible is not satisfied for any one individual until the entire family deductible is met. All family members contribute towards the family deductible. Once the family deductible is satisfied, the plan will pay a percentage of the negotiated rate for all covered family members for all services except prescription drugs. Following satisfaction of the family deductible, prescription drug copays apply.

Prescription Drugs

Our plan utilizes the Cigna Standard Formulary.
For information on quantity limits, step therapy and/or pre-certification requirements for certain prescription drugs, please contact Cigna by calling the member services number on the back of your Member ID card or visit www.mycigna.com once you are enrolled.

Mail Order Program

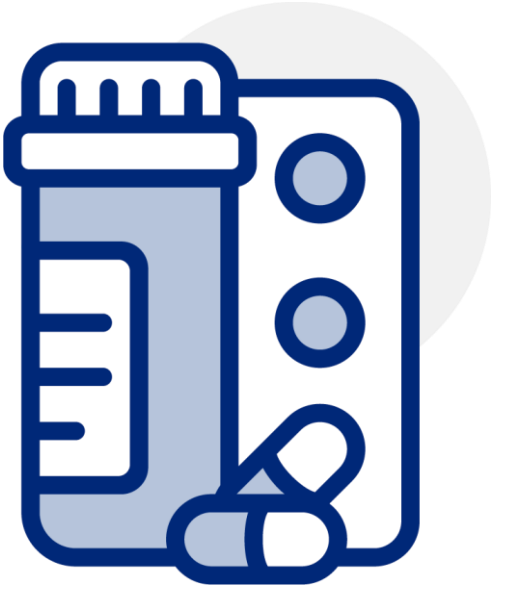
The mail order program benefits members who are on maintenance medications for chronic conditions such as diabetes, asthma and high blood pressure (or any medication you take on a regular basis). By ordering prescriptions by mail, you can receive a 3-month supply of prescriptions delivered directly to your home for 2.5 times the retail pharmacy copayment under Plans A & B. Once you are enrolled, visit www.mycigna.com to learn how to transition your medication to the mail order program.

ID Cards

You should typically receive your ID card(s) within 10–15 business days after you make your benefit elections. Digital ID cards are also available on your online member portal(s.)

How to Enroll

Complete your benefits event in Workday within your eligible benefit enrollment window.



Medical

The OAP (Open Access Plus) medical plans, through the Cigna network, delivers in-network and out-of-network benefits. Members are encouraged to 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 they are seeing participate in the network.**

Plan Features	Cigna OAP Plan A	
	In-Network	Out-of-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)	
Plan Year Deductibles (Indiv / Family)	$750/$1,500	$1,000 / $2,000
Deductible Type	Embedded	Embedded
Dependent Age Limit	Up to the end of the month of your dependent child's 26th birthday	
Plan Year Out-of-Pocket Max (Indiv / Family)	$4,000 / $8,000	$8,500 / $17,000
Out-of-Pocket Type	Embedded	Embedded
Medicare Part D Coverage	Creditable	
Referral Needed	No	
Network	National OAP	N/A
Preventive Care	Covered in Full	30% Coinsurance after Deductible
Primary Care Visit	$50 Copay, then Covered in Full	30% Coinsurance after Deductible
Telemedicine Visit	$50 Copay, then Covered in Full	30% Coinsurance after Deductible
Specialist Visit	$50 Copay, then Covered in Full	30% Coinsurance after Deductible
Diagnostic Lab	Covered in Full after Deductible	30% Coinsurance after Deductible
X-Rays		30% Coinsurance after Deductible
Complex Images		Covered in Full after Deductible
Prenatal Office Visit	Covered in Full after Deductible	30% Coinsurance after Deductible
Delivery (Maternity)	Covered in Full after Deductible	30% Coinsurance after Deductible
Inpatient Services (Maternity)	Covered in Full after Deductible	30% Coinsurance after Deductible
Hospital Outpatient Services	Covered in Full after Deductible	30% Coinsurance after Deductible
Hospital Inpatient Services	Covered in Full after Deductible	30% Coinsurance after Deductible
Mental Health Outpatient Services	$50 Copay, then Covered in Full	30% Coinsurance after Deductible
Emergency Room	$100 Copay, then Covered in Full	
Land/Air Ambulance	Covered in Full after Deductible	
Urgent Care	$50 Copay, then Covered in Full	
Retail Pharmacy / RX (30 Day Supply)	$30 / $40 / $65 Copay	Not Covered
Mail Order Pharmacy / RX (90 Day Supply)	$75 / $100/ $162 Copay	Not Covered

- Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.
- Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 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.

Medical

The OAP (Open Access Plus) medical plans, through the Cigna network, delivers in-network and out-of-network benefits. Members are encouraged to 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 they are seeing participate in the network.**

Plan Features	Cigna OAP Plan B	
	In-Network	Out-of-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)	
Plan Year Deductibles (Indiv / Family)	$600 / $1,200	$600 / $1,200
Deductible Type	Embedded	Embedded
Dependent Age Limit	Up to the end of the month of your dependent child's 26th birthday	
Plan Year Out-of-Pocket Max (Indiv / Family)	$2,500 / $5,000	$2,500 / $5,000
Out-of-Pocket Type	Embedded	Embedded
Medicare Part D Coverage	Creditable	
Referral Needed	No	
Network	National OAP	N/A
Preventive Care	Covered in Full	20% Coinsurance after Deductible
Primary Care Visit	$50 Copay, then Covered in Full	20% Coinsurance after Deductible
Telemedicine Visit	$50 Copay, then Covered in Full	20% Coinsurance after Deductible
Specialist Visit	$50 Copay, then Covered in Full	20% Coinsurance after Deductible
Diagnostic Lab	Covered in Full after Deductible	20% Coinsurance after Deductible
X-Rays		
Complex Images		Covered in Full after Deductible
Prenatal Office Visit	Covered in Full after Deductible	20% Coinsurance after Deductible
Delivery (Maternity)	Covered in Full after Deductible	20% Coinsurance after Deductible
Inpatient Services (Maternity)	Covered in Full after Deductible	20% Coinsurance after Deductible
Hospital Outpatient Services	Covered in Full after Deductible	20% Coinsurance after Deductible
Hospital Inpatient Services	Covered in Full after Deductible	20% Coinsurance after Deductible
Mental Health Outpatient Services	$50 Copay, then Covered in Full	20% Coinsurance after Deductible
Emergency Room	$100 Copay, then Covered in Full	
Land/Air Ambulance	Covered in Full after Deductible	
Urgent Care	$50 Copay, then Covered in Full	
Retail Pharmacy / RX (30 Day Supply)	$30 / $40 / $65 Copay	Not Covered
Mail Order Pharmacy / RX (90 Day Supply)	$75 / $100 / $162 Copay	Not Covered

- Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.
- Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 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.

Medical

The OAP (Open Access Plus) medical plans, through the Cigna network, delivers in-network and out-of-network benefits. Members are encouraged to 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 they are seeing participate in the network.**

Plan Features	Cigna OAP Plan C with HSA	
	In-Network	Out-of-Network
Deductible / Maximum Period	Calendar Year (1/1-12/31)	
Plan Year Deductibles (Indiv / Family)	$1,650 / $3,300	$2,000 / $4,000
Deductible Type	Aggregate	Aggregate
Dependent Age Limit	Up to the end of the month of your dependent child's 26th birthday	
Plan Year Out-of-Pocket Max (Indiv / Family)	$3,500 / $6,850	$4,000 / $8,000
Out-of-Pocket Type	Aggregate	Aggregate
Medicare Part D Coverage	Creditable	
Referral Needed	No	
Network	National OAP	N/A
HSA Funding	**$1,650/$3,300 – Please See HSA Page for Further Details**	
Preventive Care	Covered in Full	30% Coinsurance after Deductible
Primary Care Visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Telemedicine Visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Specialist Visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Lab	Physicians Services/Office Visit: Covered in Full after Deductible Independent Lab/Outpatient Facility: 20% Coinsurance after Deductible	Physicians Services/Office Visit: 30% Coinsurance after Deductible Independent Lab/Outpatient Facility: 40% Coinsurance after Deductible
X-Rays		
Complex Images	Covered in Full after Deductible	Physicians' Services/Office Visit: 30% Coinsurance after Deductible Outpatient Facility: Covered after Deductible
Prenatal Office Visit	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Delivery (Maternity)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services (Maternity)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospital Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospital Inpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency Room	20% Coinsurance after Deductible	
Land/Air Ambulance		
Urgent Care		
Retail Pharmacy / RX (30 Day Supply)	$10 / $25 / $50 Copay after Deductible	Not Covered
Mail Order Pharmacy / RX (90 Day Supply)	$25 / $62 / $125 Copay after Deductible	Not Covered

- Aggregate Deductible: The entire family deductible must be met before copay or coinsurance is applied for any individual family member.
- Embedded Deductible: Each covered family member only needs to satisfy his/her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 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.

For BARNARD COLLEGE plan participants and their covered family members

Take control of your health.

Get the most from the benefits offered through your employer.

As part of your employer's health plan, you get access to a variety of programs and services to help make your life easier — and healthier.

Cigna One Guide®

Make getting and staying healthy as easy as possible with Cigna One Guide. Our personal guides can help give you health and money-saving tips. This personalized support comes with your medical plan.

During the enrollment period, you can call the One Guide team at **800.244.6224** for help with plans and coverage. After enrollment, One Guide offers ongoing support to help you:

Understand your plan

- Know your coverage and how it works.
- Get answers to health care or plan questions.

Get care

- Find an in-network provider, lab or urgent care center.
- Connect with health coaches and more.
- Stay on track with appointments and preventive care.
- Get support for complex health situations.

Save and earn

- Maximize your benefits.
- Get cost estimates and service comparisons to avoid surprises.
- Check account balances and claim activity.

Once you have enrolled, start using the Cigna One Guide support service by going to the the **myCigna**® app[1] or **myCigna.com**®.

1. The downloading and use of the myCigna App is subject to the terms and conditions of the app and the online store from which it is downloaded. Standard mobile phone carrier and data usage charges apply. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.

myCigna

Your health is most important. That's why there's **myCigna** — your online home for assessment tools, medical updates and more.[1]

On the **myCigna**® app or **myCigna.com**® you can:

- Find in-network providers.
- View, print or email your ID card information.
- Review coverage, manage and track claims.
- Compare prescription drug prices.[2]
- Compare provider and hospital cost and quality.
- Get health and wellness tools and resources.
- Sign up for new plan document alerts.
- Track your account balances and deductible.

1. App/online store terms and mobile phone carrier/data charges apply. Please refer to your phone's manufacturer for your phone's specific capabilities. Actual myCigna features may vary depending on your plan and individual security profile.

2. Prices shown on myCigna are not guaranteed and coverage is subject to your plan terms and conditions. Visit myCigna for more information.

cigna healthcare

Offered by: Cigna Health and Life Insurance Company or their affiliates.

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24/7 customer service

Anytime you need us, feel free to call the toll-free number on your ID card.

- You can reach us 24 hours a day, seven days a week.
- You can get answers to your health, claims and benefit questions.
- Ask for a Spanish-speaking service representative or someone who can translate one of 200 languages.

24/7 customer assistance is available for medical and dental plan customers only.

Health Information Line

Once your health coverage begins, you can call the Health Information Line, available 24 hours a day, seven days a week. Speak with a personal nurse advocate[1] via chat or phone. They're here to confidentially answer your health questions. This toll-free number is **800.Cigna24 (800.244.6224)**.

- Get information to help you decide where and when you should get treatment for your immediate care needs.
- Call if you need general health information or have a specific health concern.
- Chat is available Monday–Friday, 9:00 a.m.–8:00 p.m. ET, excluding holidays, via the myCigna® website or app.
- Listen to hundreds of podcasts to help you stay informed about your health.

1. These health advocates hold current nursing licensure in a minimum of one state, but are not practicing nursing or providing medical advice in any capacity as a health advocate.

Virtual care available 24/7/365

MDLIVE® offers virtual care by phone or video, whenever it's convenient for you.[1] MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists provide personalized care for many health needs in the privacy of your home, including:

- Preventive care, routine care and specialist referrals.
- On-demand urgent care for minor medical conditions.
- Prescription needs, if appropriate.
- Behavioral care for issues such as anxiety, stress, grief and depression.
- Dermatology care for common skin, hair and nail conditions.

Access MDLIVE by logging in to **myCigna.com**® and selecting "Talk to a doctor."

1. Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Not all services are eligible or may be covered under your specific medical plan. The following services are generally not covered: services that aren't medically necessary; experimental, investigational or unproven services; services for an injury or illness that occurs while working for pay or profit, including services covered by Worker's Compensation benefits; treatment of sexual dysfunction. This is a summary only and the terms of your specific medical plan may vary. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan. Virtual primary care through MDLIVE is only available for Cigna Healthcare medical members aged 18 and older. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

Cigna Healthy Pregnancies, Healthy Babies®

Enrolling in the Cigna Healthy Pregnancies, Healthy Babies program is an important first step toward a healthy future for you and your baby. To support you along your journey, you'll get:

- Helpful guidance and support on everything from infertility and preconception planning to post-delivery information.
- A guide to help you learn about pregnancy and babies, including topics like prenatal care, exercise, stress, depression and more.
- Support from a maternity specialist, who has nursing experience and can help you with everything from tips on how to handle your discomfort during pregnancy to birthing classes and maternity benefits.
- Access to an audio library of health topics.

You'll also have easy access to a wealth of information on the **myCigna**® website from trusted sources like WebMD® and Healthwise®. You'll learn how to make a plan for a healthy pregnancy, monitor your pregnancy week by week, prepare for labor and delivery, care for your baby and more.

Cigna Lifestyle Management programs

If weight, tobacco or stress is affecting your health or your ability to live an active life, it may be time to make some changes. A health coach can provide you with personalized support to help you:

- Learn to manage your weight using a non-diet approach that helps you build confidence, change habits, eat healthier and become more active.
- Develop a personal quit plan to become and remain tobacco-free.
- Understand the sources of your stress, and learn coping techniques to better manage stress, both on and off the job.

You can use an online or telephone coaching program — or both — for the support you need.

Health assessment

Taking a health assessment is a quick and easy way to learn more about your health today, and to figure out how you can improve your health in the future. After all, when you're healthy, you have the strength and confidence to be your true self. After completing the health assessment, you'll get a wellness score and recommendations to help you get started on a path to better health. Share your report with your health care provider at your next visit.

Cigna Healthy Rewards®

Get discounts on the health products and programs[1] you use every day for:

- Meal delivery
- Gyms and virtual workouts
- Mind/body programs and equipment
- Vision and hearing care
- Alternative medicine

Log in to **myCigna.com**® and navigate to Healthy Rewards® to learn more.

1. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. A discount program is NOT insurance and you must pay the entire discounted charge.

Preventive care

Getting and staying healthy is important. That's why most health plans include coverage for eligible preventive care services at no additional cost to you, when you receive them from a provider who participates in your plan's network.

This means no out-of-pocket costs to you. Covered preventive care services can include, but are not limited to:[1]

- Blood pressure screenings
- Cholesterol screenings
- Diabetes screenings
- Screenings for colon/rectal cancer
- Clinical breast exams
- Pap tests
- Mammograms

1. Plans may vary and not all preventive care services are covered. For example, immunizations for travel are generally not covered. See your plan materials for a complete list of covered preventive care services.

Cigna Health Matters® Care Management

If you're faced with a medical condition, a personal nurse advocate[1] can offer support — at no added cost to you. This support helps coordinate your care and benefits to help you get the right care, at the right time, at the right price. A personal nurse advocate can help you:

- Better understand your condition, treatment options (as identified by your doctor) and medications.
- Understand inpatient and outpatient hospital coverage, in-network benefits, out-of-pocket costs and prescription drug costs.
- Work with your health care providers to manage your overall care plan.
- Coordinate referrals, home care, durable medical equipment, caregiver respite services and more.
- Access resources that go beyond medical treatment, including transportation to appointments, financial assistance programs and other cost-saving opportunities.
- Benefit from one-on-one emotional support.

1. These health advocates hold current nursing licensure in a minimum of one state, but are not practicing nursing or providing medical advice in any capacity as a health advocate.

Omada® for Cigna Healthcare℠

If you're ready to lose weight, gain energy and reduce the risks of type 2 diabetes and heart disease, Omada can help you build healthy habits that last.[1] This digital lifestyle program surrounds you with the tools and support you need to make meaningful changes to the way you eat, move, sleep and manage stress — one small step at a time. Omada is offered at no additional cost if you or your covered adult dependents are at risk for type 2 diabetes or heart disease, and are accepted into the program.

1. The Omada program is administered by Omada Health, Inc., an independent third-party service provider. Cigna Healthcare does not endorse or guarantee the products or services of any third parties and assumes no liability with respect to any such products or services.

Cigna Total Behavioral Health®

When you or a family member need help taking care of your emotional well-being, Cigna Healthcare℠ provides access to a wide range of behavioral experts, programs and resources to help you take control of your whole health — mind and body.

Cigna Healthcare's behavioral health network includes licensed therapists, psychiatrists and nurse practitioners, behavioral facilities and programs, and more. Our Fast Access guarantees appointments with psychiatrists or psychiatric nurse practitioners within 15 business days.

Cigna Healthcare's behavioral health benefits also include:

- Virtual care, which lets you receive quality, behavioral health care without leaving home. Simply connect via your phone, computer or tablet and you can schedule online appointments with licensed counselors or psychiatrists through MDLIVE®.[1]
- Online tools that help you find in-network providers and facilities, stress management tools, and a variety of health and well-being information. You'll also have access to online, on-demand seminars, as well as a wide range of referrals to community resources.
- Programs that give you access to behavioral experts with extensive experience. Our experts can help you and your family address challenges such as autism spectrum disorder, eating disorders, opioid and pain management and substance use.
- Seminars that are offered monthly on topics such as autism, eating disorders, substance use and behavioral health awareness for children and families. These seminars are taught by industry experts and offer tips, tools and helpful information.

1. Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna Healthcare medical members aged 18 and older. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

Know before you go

Here's an at-a-glance view of your options when you need medical care.[1]

	Cost	Wait time	Severity
Virtual care[1]	$		
Convenience care clinic	$$		
Primary care provider	$$$		
Urgent care center	$$$$		
Emergency room	$$$$		

For illustrative purposes only. Actual covered benefits, costs and wait times may vary. Always consult with your doctor for medical advice, including prior to selecting another provider for care.

1. Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna Healthcare medical members aged 18 and older. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

Pharmacy home delivery

Home delivery with Express Scripts® Pharmacy is a convenient choice when you take a medication regularly.[1] It's easy, safe — and saves you trips to the pharmacy. By choosing home delivery, you can:

- Manage your medications from your phone or online — order, track, pay and more.
- Get standard shipping at no extra cost.[2]
- Fill up to a 90-day supply at one time.[3]
- Talk with helpful pharmacists 24/7.
- Get automatic refills[4] or refill reminders so you don't miss a dose.
- Use a payment plan to split your bill into three smaller monthly payments.

1. Cigna Healthcare maintains an ownership interest in Express Scripts Pharmacy's home delivery services. However, you have the right to fill prescriptions at any pharmacy in your plan's network. You won't be penalized regardless of where you fill your prescriptions.
2. Standard shipping costs are included as part of your prescription plan.
3. Certain medications may only be packaged in less than a 90-day supply. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.
4. Express Scripts Pharmacy can automatically refill certain medications. Once enrolled, you can log in to the myCigna App or myCigna.com sign up. You can sign up to get emails and/or texts from Express Scripts Pharmacy. To get text messages, you'll have to sign up for Express Scripts' texting service. You can do this online or over the phone. Once you sign up, simply reply to their welcome text to get started. Standard text messaging rates apply.

Specialty medications

Managing a complex health condition can be, well, complex. That's true whether you've had it for years or just got diagnosed. Accredo® supports patients with conditions like yours.[1] Its team of specialty-trained pharmacists, nurses and clinicians helps you manage your therapy. Accredo also delivers your medication to your home, workplace or doctor's office.[2] That way, you don't miss a dose. With Accredo, you can:

- Get personalized care services.
- Talk with a specialty-trained pharmacist, nurse or clinician, 24/7.
- Learn how to work through side effects.
- Find ways to help pay for your medications, if needed.
- Get standard shipping, at no extra cost.[3]
- Sign up for free refill reminders.
- Manage your medications by phone or online.[4]

1. Cigna Healthcare maintains an ownership interest in Accredo's specialty pharmacy services. However, you have the right to fill prescriptions at any pharmacy in your plan's network. You won't be penalized regardless of where you fill your prescriptions.
2. As allowable by law. For medications administered by a health care provider, Accredo will ship the medication directly to your doctor's office.
3. Standard shipping costs are included as part of your prescription plan.
4. You'll see your first order in the myCigna App or myCigna.com as soon as Accredo ships it.

Have your ID card handy?

With myCigna, the answer is always yes

Big news: You never have to worry about misplacing your ID card. It's always right there on myCigna®, whenever and wherever you need it.[1]

Accessing your digital ID cards is easy.

- Log in to **myCigna.com**® or the **myCigna App**.[2]
- Click or tap "ID Cards."
- View your card(s) as well as any dependents' cards
- Email cards directly to doctors.
- Save your digital ID cards in your Apple Wallet.

Not registered on myCigna yet?
It's quick and easy.

Visit **myCigna.com** or scan the QR code to download the **myCigna App** and register now.

cigna healthcare

All disclosures appear at the end of this document

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Unlock the full value of your health plan with myCigna®.

From programs that help you improve your health to tools that help you manage your health spending, there's so much you can do on **myCigna.com** and the **myCigna App**.[3]

Find in-network doctors, hospitals and medical services.

Manage and track claims.

See cost estimates for medical procedures.

Use the click-to-chat feature to connect with a live Cigna Healthcare℠ representative.

Compare quality-of-care information, including patient reviews.

Access a variety of health and wellness tools and resources, including an interactive health assessment.

New to Cigna Healthcare?

As a new customer, you can access your digital ID card before the plan effective date. Simply log in to **myCigna** and enter the required information.[4]

1. Digital ID cards do not apply to the following: all insured medical clients sitused in Texas, New York, Florida and Colorado (ASO will be included); all medical clients sitused in Minnesota regardless of funding type; all D HMO plans sitused in Texas; all D HMO and D PPO plans sitused in Georgia and Minnesota; all vision plans sitused in Georgia, Minnesota and Texas.
2. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
3. Actual myCigna features may vary depending on your plan and customer profile.
4. Access to digital ID cards prior to plan effective is available when Cigna Healthcare has received customer information from employers. Access to digital ID cards is not available on the myCigna App until after the plan effective date.

cigna healthcare

HARD WORK PAYS OFF.

Get reimbursed for health club membership dues or exercise class fees.

As a participant in your Cigna HealthCare medical plan, you can be reimbused up to $400 per employee/ $200 per spouse annually in gym / health club membership dues or exercise class fees. To be eligible for this reimbursement, you must complete a minimum of 12 visits each quarter. Employee must be actively employed at time of payment.

Follow the steps below to claim reimbursement for health club membership dues or group fitness classes with a credentialed instructor.**

Complete the form on the next page and return it with your supporting documents.

- Complete the Fitness Benefit Form following the reimbursement schedule below.
- Supply dated, original receipts from your health club. Or if you pay by electronic funds transfer, supply copies of bank or credit card statements, showing:
  - Member's name
  - Individual charges for each health club membership or class
- Supply proof of qualifying visits.
  - A usage report from your gym
  - Receipts that indicate each time you have visited the health club
  - Or verification from your employer that shows your use of the employer health club
- Supply a copy of your health club agreement or contract, showing the name and address of the health club, which includes beginning and ending dates of the membership.
- Sign and date the completed Fitness Benefit Form, then email all of the above to:
  - BCGYMReimbursement@cignahealthcare.com
  -

Reimbursement schedule

Benefit period	Submission dates	Processing and processing dates	Maximum reimbursement
Quarterly	Apr/Jul/Oct/Jan	May/Aug/Nov/Feb	$100/$50 per quarter
(Jan-Mar / Apr-Jun)			
(Jul-Sep / Oct-Dec)			Yearly total: $400/$200

If you are unable to participate in or meet the requirements of the gym membership reimbursement program due to a disability or other reason, you may be entitled to a reasonable accommodation for participation, or an alternative standard for rewards. Please contact Cigna for more information.

Together, all the way.®

Cigna®

Submit form to: BCGYMReimbursement@cignahealthcare.com
NOTE: You will receive an automatic response if you submitted to the correct email address. RETAIN ORIGINAL EMAILS YOU SEND IN FOR YOUR FILES.

FITNESS BENEFIT FORM

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber's Last Name	First Name	Middle Initial	
Address – Number, Street and Apt	City	State	Zip Code
Employer's Name Barnard College #3339306	Subscriber's Email Address	Claimant is: ☐ Subscriber ☐ Spouse	
Date of Birth	Sex ☐ Male ☐ Female	Cigna ID # or SSN	

When to submit:

By April 30th for reimbursement in May / By July 31st for reimbursement in August,
By October 31st for reimbursement in November / By January 31st for reimbursement in February

LATE SUBMISSIONS WILL NOT BE PROCESSED!-MUST BE EMPLOYED AT THE TIME OF REIMBURSEMENT!

CLUB/CLASS INFORMATION REQUIRED

Submit dated, original receipts from your health club, copy of pay stubs, bank or credit card statements FOR EACH MONTH. Supply a computer printout report showing 12+ visits and a copy of your health club contract. Other types of facilities that qualify are Peloton visits, CrossFit, Kickboxing, Martial Arts, Pilates, Spinning, Yoga and Zumba. Facilities, such as fees paid for attending aerobic/fitness classes at a qualified health club without an annual membership, will also be covered but make sure you obtain full documentation from the club.

Name and address of health club*	Benefit year	Amount charged	For office use only

TOTAL NUMBER OF RECEIPTS_____ ATTACHED: TOTAL CHARGES: $_____

*Cigna reserves the right to verify all submitted information directly with the health club.

All Fitness Benefit payments will be sent to the subscriber's address on this form.

CERTIFICATION AND AUTHORIZATION (This form must be signed and dated below.)

I authorize the release of any information to Cigna about my health club membership. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services.

Subscriber signature_____Date_____

* The facility you choose must have a vast array of cardiovascular and strength training exercise equipment, such as traditional health clubs, or Y's. Health clubs that do not qualify include gymnastics facilities, country clubs, pool-only facilities, social clubs or sports teams and leagues. Dues or fees for participation in aerobic/fitness activities in facilities that are not a qualified health club, as well as fees for personal training, lessons, coaching, and exercise equipment or clothing purchases, are not eligible for reimbursement.

** Group exercise instructors must be professionally trained and certified through industry-approved organizations such as ACE, Spinning, MOSSA programs, NSCA, ACSM and various martial arts disciplines such as Taekwondo.

Incentive rewards received through the gym membership reimbursement program may be considered taxable income. Contact your employer or your professional tax advisor for help understanding your specific program details. Always consult your doctor prior to beginning a new exercise program.

Rx Discount Programs

Purchases through a discount program will not apply toward your annual deductible or the annual out-of-pocket max.

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Same Medication, Same Pharmacy, Lower Price

No matter if you are insured, uninsured or something in between, we offer some of the lowest prices on over 15,000 medications. Simply pay online before you pick up at your pharmacy to save up to 95%. No membership fees. Fully refundable.

- **Search for Your Prescription**
  Find savings of up to 95% on over 15,000 medications
- **Pay For It Online or Through The App**
  You'll get a Blink Card – that's your proof of purchase. You can print it out. We'll also text it to you.
- **Pick Up At Your Pharmacy**
  When your pharmacist asks for payment, show them your Blink Card. You'll pay nothing at the pharmacy.

GoodRx

www.goodrx.com

Stop Paying Too Much For Your Prescriptions!

Every GoodRx collects millions of prices and discounts from pharmacies, drug manufacturers and other sources.
Here's how you can use it to save:

- **Use GoodRx's Drug Price Search to Compare Prices**
  See which pharmacy near you offers the best price. We don't sell the Medications, we tell you where you can get the best deal on them.
- **GoodRx Will Show You Prices, Coupons, Discounts & Savings Tips**
  Get your prescriptions cheaper with deals at pharmacies near you.
- **Download GoodRx's iPhone or Android App**
  Get drug prices and coupons on the go.
- **Receive A Discount Savings Card**
  Keep your GoodRx card in your wallet for easy access when you need it.

Health Savings Account

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is used in conjunction with an HSA-qualified health plan like the **Cigna OAP Plan C.**. This unique account allows you to save for medical, dental, and/or vision expenses tax-free, or to save those funds for use in the future.

HSAs offer a **triple tax advantage**. They allow you to:

- Save money – tax-free!
- Accumulate interest and earnings – tax-free!
- Spend on qualified healthcare expenses – tax-free!

You own the money in your HSA! The account is yours, just like a checking or savings account. Any money left over at the end of the year is yours to keep and rolls forward to be used in the future. You keep the account even if you change medical plans, stop working, or retire.

Contributing to your HSA

There are certain criteria you must meet to be eligible to contribute to an HSA:

- You must be enrolled in an HSA-qualified medical plan like the Cigna Plan C $1,650/$3,300 offered by Barnard College, and you cannot be covered by any other medical plan that is not HSA-qualified.
- You cannot be covered under Medicare; TRICARE or receiving VA benefits.
- You cannot be eligible to be claimed as a dependent on another individual's tax return.
- You must be 18 years or older.
- You must be a U.S. resident.

You can put money (or "make contributions") into your HSA a few ways:

- **Pre-tax payroll contributions.** You can elect to have an amount regularly deducted from your paycheck.
- **Post-tax contributions.** You can initiate an online transfer, which moves money directly into your HSA from your personal savings or checking account.
- **Transfers from an existing IRA.** You can irrevocably elect to make a once-in-a-lifetime, tax-free, direct trustee-to-trustee transfer of a "qualified HSA funding distribution" from your IRA (traditional or ROTH) into your HSA.

Does Barnard College contribute to your HSA?

Yes, participants enrolled in the Barnard College-sponsored Cigna OAP Plan C health plan will receive a contribution from Barnard College of up to $1,650 / $3,300 annually. This contribution is deposited in quarterly increments. Barnard College's contributions are added to your contributions and will count toward the annual limits set by the IRS. Barnard's contribution to your HSA is pro-rated monthly based on your enrollment date, as shown in the chart below.

HSA Employer Contribution	1/31/2025	4/30/2025	7/31/2025	10/31/2025
Single ($1,650 Annually)	$412.50	$412.50	$412.50	$412.50
Family ($3,300 Annually)	$825.00	$825.00	$825.00	$825.00

MONTH	INDIVIDUAL	FAMILY
JANUARY 1	$412.50	$825.00
FEBRUARY 1	$275.00	$550.00
MARCH 1	$137.50	$275.00
APRIL 1	$412.50	$825.00
MAY 1	$275.00	$550.00
JUNE 1	$137.50	$275.00
JULY 1	$412.50	$825.00
AUGUST 1	$275.00	$550.00
SEPTEMBER 1	$137.50	$275.00
OCTOBER 1	$412.50	$825.00
NOVEMBER 1	$275.00	$550.00
DECEMBER 1	$137.50	$275.00

Health Savings Account *(continued)*

The IRS limits the total amount that can be contributed to an HSA each year, based on your age and coverage level (note these limits include the contribution made by Barnard College on your behalf)**:**

	2024		2025	
	Single	Family	Single	Family
Contribution Limit	$4,150	$8,300	$4,300	$8,550
"Catch-up" contribution for age 55+	$1,000		$1,000	

"Catch-Up contributions" provide an opportunity for those age 55+ to put an additional $1,000 into an HSA. If you have high deductible health plan (HDHP) coverage for the full year, you can make the full 55+ contribution regardless of when your 55th birthday falls during the year. If you did not have HDHP coverage for the full year, you must pro-rate your contribution for the number of full months you were "eligible", i.e., had HDHP coverage. However, if you are covered on December 1st, you are treated as if you had HDHP coverage for the entire year and can make the full contribution amount. You may also contribute an additional $1,000 if your spouse is over age 55, but the contributions go into a separate HSA under his or her name and social security number with a separate debit card per IRS guidelines.

Do you already have an HSA? Roll your old plan into your new HSA to keep everything organized in one place. Any money you roll from one HSA to another does not count towards the annual contribution limits. Combining your accounts could save you money since there are no fees to use your new account! Just download the HSA Transfer Form from your WEX Health Portal and send it to your current custodian to get the process started!

How your account works

There are two parts to your HSA account: a **Cash Account** and an **Investment Account**. Initially, your money will be held in an interest-bearing cash account that is FDIC insured. Once your balance has reached $1,000 (or another limit you specify), you can choose to use the Investment Account feature to invest the funds in the many mutual funds offered. Any interest or earnings on the account will be added to your account balance and continue to grow tax-free. You control all the investment decisions made for your account. You **can view and manage your account balances easily on your portal or through the mobile app.**

Using your HSA

You can use your money (or "make distributions") to pay for qualified expenses in two main ways:

- **By making purchases using your Flex Debit Card** Your Flex Debit Card is the easiest way to access the money in your HSA. The card links to the available funds in your HSA. When you use the card, payments are automatically withdrawn from your account. It's that easy!
- **By requesting reimbursement for payments you've made** You can also pay for expenses out-of-pocket and be reimbursed for the expense after the fact by requesting a distribution from your HSA.

If you receive a bill in the mail, you can still pay with your Flex Debit Card by inputting the debit card information in the credit card payment section or you can pay with your own money and be reimbursed for the expense from your account at a later date by requesting a distribution from your HSA.
Keep in mind, you can only use your Flex Debit Card if you have enough money in the account to cover the payment amount. If you do not have enough funds in your HSA to cover an eligible expense, there are a few options. As long as the account was open when the expense was incurred, you could:

- Pay for the expense out of pocket and then reimburse yourself from your HSA when your account balance has grown.
- Pay for the expense out of your pocket and then change your elected HSA contribution amount to increase your balance faster. When you have enough money in your account you can submit for reimbursement of the expense.
- Make an additional contribution to the account online via WEX Health - or by completing an HSA Contribution Form and submitting it, along with a check, to Marshall+Sterling Employee Benefits - Flex.

Health Savings Account *(continued)*

HSA FAQ's

Is an HSA the same as an FSA?

No! Although HSAs (Health Savings Accounts) and FSAs (Flexible Spending Accounts) both use pretax dollars to pay for eligible medical expenses, there are important differences.

- Any HSA money you don't use in one calendar year carries over to the next, while there are limits to the amount of FSA money you can carry with you into a new year.
- You can only use the HSA funds after they have been deposited into your account, while elected FSA funds are available for use *prior* to contributions being made.
- HSA funds can be used to pay for healthcare costs in retirement, including some medical care premiums. *See the HSA Guide for more information.*

What happens if I leave Barnard College?

Your HSA is **portable**, which means it is yours to keep should you change employment. You may choose to roll the funds over to another HSA if offered through your new employer, or you can leave them with Marshall+Sterling Employee Benefits - Flex for a cost of $30 annually.

What happens when I die?

You will assign a beneficiary to your HSA who becomes the account owner if you die. Your HSA can transfer to your spouse tax free upon your death. If you name a non-spouse beneficiary, such as your estate or other entity, the value of the HSA is taxable to them upon your death.

Can I be enrolled in Medicare and have an HSA?

You are not eligible to *contribute* to a health savings account if you are enrolled in Medicare health insurance or are age 65 and collecting, or beginning to collect, Social Security benefits (which automatically triggers your enrollment in Medicare Part A). However, if you have an HSA balance from your previous coverage, you can continue to use those funds to pay for qualified expenses tax-free.

My spouse has a Medical FSA or Health Reimbursement Arrangement (HRA) through his/her employer. Can I still have an HSA?

If your spouse participates in a Health FSA or HRA and those benefits cover your healthcare expenses, then you are not eligible to contribute to an HSA. You can still enroll in Barnard College's HSA-qualified health plan, but you cannot open or contribute to an HSA. However, if your spouse has a "limited-purpose" FSA or HRA that covers vision and dental care expenses only then you may participate in an HSA.

What do I do if I have an existing HSA with HSA Bank through Cigna?

If you have an HSA balance with HSA Bank, you have 2 options. 1) You can leave your existing HSA balance with HSA Bank for a $2.50 monthly administrative fee. 2) You can transfer your existing balance to Marshall+Sterling WEX at no cost.

Need more information?

Find more information about HSAs, as well as tools, calculators, and other resources on the **WEX Health portal** (https://msflex.LH1ondemand.com).

Employee Maximum Out-Of-Pocket Exposure Details

The charts on the following pages provide a detailed breakdown of your maximum financial exposure on each of the three available medical plans when utilizing in-network providers.

Plan A

EMPLOYEE ONLY	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$1,075.49	$4,000	$5,075.49
$50K-$74,999	$1,254.89	$4,000	$5,254.89
$75K-$99,9999	$1,613.15	$4,000	$5,613.15
$100K-$124,9999	$1,971.59	$4,000	$5,971.59
$125K-$149,999	$2,330.56	$4,000	$6,330.56
$150K	$2,698.74	$4,000	$6,698.74

EMPLOYEE + SPOUSE	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$5,019.50	$8,000	$13,019.50
$50K-$74,999	$6,372.24	$8,000	$14,372.24
$75K-$99,9999	$7,527.07	$8,000	$15,527.07
$100K-$124,9999	$9,038.40	$8,000	$17,038.40
$125K-$149,999	$10,887.58	$8,000	$18,887.58
$150K	$11,701.37	$8,000	$19,701.37

EMPLOYEE + CHILD(REN)	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$4,517.69	$8,000	$12,517.69
$50K-$74,999	$5,734.85	$8,000	$13,734.85
$75K-$99,9999	$6,774.60	$8,000	$14,774.60
$100K-$124,9999	$8,134.56	$8,000	$16,134.56
$125K-$149,999	$9,798.60	$8,000	$17,798.60
$150K	$10,531.08	$8,000	$18,531.08

EMPLOYEE + FAMILY	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$7,275.10	$8,000	$15,275.10
$50K-$74,999	$9,235.30	$8,000	$17,235.30
$75K-$99,9999	$10,909.24	$8,000	$18,909.24
$100K-$124,9999	$13,099.48	$8,000	$21,099.48
$125K-$149,999	$15,779.29	$8,000	$23,779.29
$150K	$16.958.81	$8,000	$24,958.81

Plan B

EMPLOYEE ONLY	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$2,771.99	$2,500	$5,271.99
$50K-$74,999	$2,951.04	$2,500	$5,451.04
$75K-$99,9999	$3,308.78	$2,500	$5,808.78
$100K-$124,9999	$3,666.35	$2,500	$6,166.35
$125K-$149,999	$4,024.79	$2,500	$6,524.79
$150K	$4,392.11	$2,500	$6,892.11

EMPLOYEE + SPOUSE	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$8,876.95	$5,000	$13,876.95
$50K-$74,999	$10,294.70	$5,000	$15,294.70
$75K-$99,9999	$11,504.98	$5,000	$16,504.98
$100K-$124,9999	$13,089.05	$5,000	$18,089.05
$125K-$149,999	$15,026.93	$5,000	$20,026.93
$150K	$15,879.86	$5,000	$20,879.86

EMPLOYEE + CHILD(REN)	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$8,006.71	$5,000	$13,006.71
$50K-$74,999	$9,282.34	$5,000	$14,282.34
$75K-$99,9999	$10,371.98	$5,000	$15,371.98
$100K-$124,9999	$11,797.30	$5,000	$16,797.30
$125K-$149,999	$13,541.47	$5,000	$18,541.47
$150K	$14,309.06	$5,000	$19,309.06

EMPLOYEE + FAMILY	ANNUAL PAYROLL	IN NETWORK OOPM	TOTAL IN NETWORK EXPOSURE
<$50k	$12,605.87	$5,000	$17,605.87
$50K-$74,999	$14,660.35	$5,000	$19,660.35
$75K-$99,9999	$16,414.81	$5,000	$21,414.81
$100K-$124,9999	$18,710.19	$5,000	$23,710.19
$125K-$149,999	$21,518.78	$5,000	$26,518.78
$150K	$22,755.01	$5,000	$27,755.01

Plan C

EMPLOYEE ONLY	ANNUAL PAYROLL	IN NETWORK OOPM	HSA FUNDING	TOTAL IN NETWORK EXPOSURE
<$50k	$217.08	$3,500	$1,650	$2,067.08
$50K-$74,999	$260.40	$3,500	$1,650	$2,110.40
$75K-$99,9999	$325.56	$3,500	$1,650	$2,175.56
$100K-$124,9999	$390.72	$3,500	$1,650	$2,240.72
$125K-$149,999	$434.28	$3,500	$1,650	$2,284.28
$150K	$553.20	$3,500	$1,650	$2,403.20

EMPLOYEE + SPOUSE	ANNUAL PAYROLL	IN NETWORK OOPM	HSA FUNDING	TOTAL IN NETWORK EXPOSURE
<$50k	$436.16	$6,850	$3,300	$3,984.16
$50K-$74,999	$953.64	$6,850	$3,300	$4,503.64
$75K-$99,9999	$1,968.72	$6,850	$3,300	$5,518.72
$100K-$124,9999	$2,626.08	$6,850	$3,300	$6,176.08
$125K-$149,999	$3,622.08	$6,850	$3,300	$7,172.08
$150K	$4,467.96	$6,850	$3,300	$8,017.96

EMPLOYEE + CHILD(REN)	ANNUAL PAYROLL	IN NETWORK OOPM	HSA FUNDING	TOTAL IN NETWORK EXPOSURE
<$50k	$390.84	$6,850	$3,300	$3,940.84
$50K-$74,999	$858.24	$6,850	$3,300	$4,408.24
$75K-$99,9999	$1,771.92	$6,850	$3,300	$5,321.92
$100K-$124,9999	$2,363.40	$6,850	$3,300	$5,913.40
$125K-$149,999	$3,259.80	$6,850	$3,300	$6,809.80
$150K	$4,021.20	$6,850	$3,300	$7,571.20

EMPLOYEE + FAMILY	ANNUAL PAYROLL	IN NETWORK OOPM	HSA FUNDING	TOTAL IN NETWORK EXPOSURE
<$50k	$652.44	$6,850	$3,300	$4,202.44
$50K-$74,999	$1,433.16	$6,850	$3,300	$4,983.16
$75K-$99,9999	$2,958.96	$6,850	$3,300	$6,508.96
$100K-$124,9999	$3,946.68	$6,850	$3,300	$7,496.68
$125K-$149,999	$5,444.04	$6,850	$3,300	$8,994.04
$150K	$6,715.32	$6,850	$3,300	$10,265.32

Plan C with Health Savings Account Scenarios

The following pages provide an overview of how, when paired with a Health Savings Account (HSA) funded by Barnard, the Cigna Plan C functions in everyday situations, including routine care as well as unexpected medical expenses and emergencies.

HSA Example One

Meet Sarah:

- Sarah is an employee enrolled in an HDHP through her company.
- She has a **$1,650 deductible**, a **$3,500 out-of-pocket maximum**, and her employer contributes to a Health Savings Account (HSA) that she can use for qualified medical expenses.

Monthly Premiums:

- Sarah pays **$27.13 per month** for her HDHP coverage.
- If she had chosen a traditional plan, her premium would be **$190.16 per month**.

Sarah's Yearly Routine Care:

- Sarah has her annual wellness check, which is **covered at 100%** by the HDHP. She doesn't have to pay anything for this visit.

Unexpected Medical Expense:

- Unfortunately, Sarah falls and injures her ankle, requiring an X-ray and a visit to a specialist. The total bill for this care is **$1,650**.

How Costs Are Paid:

1. Since Sarah hasn't met her deductible yet, she will pay the full **$1,650** bill out-of-pocket.
2. Fortunately, Sarah has an HSA, so she can use the **$500** she's saved in her HSA to cover part of the cost, and she pays the remaining **$1,150** out-of-pocket. Once she builds up enough money in the HSA account, she can reimburse herself the $**1,150**.

Future Medical Expenses:

- Later in the year, Sarah needs a minor surgery, which costs **$2,500**.
- She's already paid **$1,650** toward her deductible.
- After that, Sarah's insurance will begin covering **80%** of the remaining costs. For the surgery, her insurance covers **80% of $2,500**, which is **$2,000**, and Sarah pays the other **$500**.

Reaching the Out-of-Pocket Maximum:

- If Sarah has more medical expenses and reaches her **$3,500 out-of-pocket maximum**, the insurance will cover **100%** of her medical costs for the rest of the year.

Summary:

- An HDHP helps you save money on premiums, but you pay more upfront for care until you reach your deductible.
- You can use an HSA to set aside pre-tax money to pay for qualified medical expenses, which can reduce the financial burden.
- Once you hit your out-of-pocket maximum, the plan covers all remaining healthcare costs for the rest of the year.

HSA Example Two

Meet John:

- John is enrolled in an HDHP through his employer with a **$1,650 deductible** and a **$3,500 out-of-pocket maximum**.
- His employer also contributes to a Health Savings Account (HSA), which John uses to pay for medical expenses.

Monthly Premiums:

- John pays **$27.13 per month** for his HDHP.
- For comparison, a traditional plan would have cost him **$190.16 per month** in premiums.

Unexpected Medical Emergency:

- Midway through the year, John has a medical emergency and needs surgery, which costs **$20,000**.

How Costs Are Paid:

1. **John Pays His Deductible:**
   - John has not used any healthcare services yet this year, so he will pay the full **$1,650 deductible** before his insurance starts to pay.
   - He can use the **$1,000** saved in his HSA to help cover some of the deductible, leaving him to pay **$650** out-of-pocket.

2. **Insurance Kicks In:**
   - After John meets the deductible, his insurance starts covering **80%** of the remaining costs.
   - The remaining cost after the deductible is **$18,350**.
   - John's insurance covers **80%** of this amount, which is **$14,680**, and John is responsible for **20%**, which is **$1,850**. That puts him at his $3,500 out-of-pocket maximum.

3. **Reaching the Out-of-Pocket Maximum (OOPM):**
   - By now, John has already paid **$1,650** (the deductible) + **$1,850** (his 20% share), totaling **$3,500**.
   - Since his out-of-pocket maximum is **$3,500**, John will not have to pay any more toward his medical expenses.

Insurance Covers the Rest:

- If John has more medical expenses and reaches his $3,500 out-of-pocket maximum, the insurance will cover 100% of his medical costs for the rest of the year.

Summary:

- John pays his full **$1,650 deductible** and a portion of his medical bills until he reaches his **$3,500 out-of-pocket maximum**.
- After reaching the OOPM, his insurance covers **100%** of any additional healthcare costs for the rest of the year.
- The HDHP helped John save on monthly premiums, and using his HSA reduced his upfront costs for the surgery.

This example shows how an HDHP works in the case of a major, unexpected medical event and how the out-of-pocket maximum serves as a financial safety net.

HSA Example Three

Meet Lisa:

- Lisa is enrolled in an HDHP through her employer with a **$1,650 deductible** and a **$3,500 out-of-pocket maximum**.
- She has a chronic condition that requires a specialty medication costing **$3,500 per month**.
- Lisa's employer also contributes to her Health Savings Account (HSA), which she uses for qualified medical expenses.

Monthly Premiums:

- Lisa pays **$27.13 per month** for her HDHP coverage.
- A traditional plan with lower deductibles and copays would have cost her **$190.16 per month**.

Specialty Medication Costs:

- In January, Lisa picks up her first prescription of the year, and the pharmacy charges her **$3,500** for the month's supply of medication.

How Costs Are Paid:

1. **Meeting the Deductible:**
   - Since Lisa hasn't met her deductible yet, she will need to pay the first **$1,650** out-of-pocket for her medication in January.
   - Lisa uses her HSA, where she has **$1,200 saved**, to pay a portion of this cost, leaving her to pay **$450** out-of-pocket.
2. **Insurance Covers a Percentage After Deductible:**
   - After Lisa meets her **$1,650 deductible**, her insurance begins covering **80%** of her medication costs.
   - For the rest of January's medication cost, the remaining amount is **$1,850**.
   - Insurance covers **80%** of this, which is **$1,480**, and Lisa is responsible for **20%**, which is **$370**.
3. **February's Medication:**
   - In February, Lisa picks up her next refill, again costing **$3,500**.
   - Now that her deductible is met, she only pays her **20% coinsurance** on the total
   - cost of **$3,500**.
   - Insurance covers **80%** of the medication cost, which is **$2,800**, and Lisa pays **$700**.
4. **Reaching the Out-of-Pocket Maximum (OOPM):**
   - After her February medication refill, Lisa has paid **$1,650** toward the deductible and **$1,070** (from January and February) in coinsurance, totaling **$2,720**.
   - In March, Lisa will pay **$700** for her next refill, bringing her total out-of-pocket spending to **$3,420**.
   - By April, Lisa will hit her **$3,500 out-of-pocket maximum** after paying another **$80** in coinsurance for the month's refill.
5. **Insurance Covers All Remaining Costs:**
   - After reaching the **$3,500 out-of-pocket maximum**, insurance will cover **100%** of Lisa's medication and any other healthcare costs for the rest of the year. For the remainder of the year, Lisa can get her medication at **no additional cost** to her.

Summary:

- Lisa pays her **$1,650 deductible** early in the year and then **20% coinsurance** on her specialty medication until she reaches her **$3,500 out-of-pocket maximum**.
- Once the out-of-pocket maximum is met, her insurance covers **100%** of her medication costs and any other healthcare expenses for the rest of the year.
- Her HSA helps her cover part of these costs with pre-tax money, reducing her financial burden.

This example shows how an HDHP handles the costs of an ongoing, expensive specialty medication and how the out-of-pocket maximum protects against unlimited spending.

Flexible Spending Accounts

What are Flexible Spending Accounts?

Flexible Spending Accounts are tax-advantaged plans that help you pay for out-of-pocket costs not covered by your insurance. You elect the amount of money you want to contribute, and those funds are taken from your pay in equal installments throughout the year, reducing the amount of your income subject to taxes.

Barnard College offers you a few types of Flexible Spending Accounts to choose from:

	Medical Flexible Spending Account (MFSA)	Limited Purpose Flexible Spending Account (LPMFSA)	Dependent Care Assistance Program (DCAP)
This might be for you if:	You are not enrolled in an HSA-Qualified health plan	You or your spouse are enrolled in an HSA-Qualified health plan and contribute to an HSA	You expect to incur qualified dependent care expenses
The money can be used to pay for:	Eligible healthcare expenses, as defined by IRC Section 213(d)	Qualified Vision, Dental, Post-Deductible or Preventative Care expenses	• Child or adult dependent care • An individual to provide care either in or out of your house • Nursery Schools and preschools (excluding kindergarten)
You can contribute up to:	$3,300 in 2025		$5,000 (or $2,500 if married and filing separately) per calendar year
You should also know that:	Barnard College has adopted a provision that allows you to carry forward up to $660 of unused funds into the next plan year instead of forfeiting those funds!		Dependent care services must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse (if applicable) can go to work. Care must be given during normal working hours (i.e., Saturday night babysitting does not qualify), and cannot be provided by another of your dependents.
When am I eligible?	Employees are eligible to participate as of their date or hire. The plan year runs from 1/1/2025 – 12/31/2025, which means that expenses can be incurred between those dates. The deadline for filing reimbursement requests is 3/31/2026.		
What if my employment or eligibility terminates before the end of the Plan Year?	COBRA provisions generally allow you the option to continue your coverage after termination. Details will be provided to you if you experience a qualifying event that affects your FSA coverage.		There is no COBRA provision for DCAP accounts so your participation in the plan will not continue.

FSA/HSA Eligible Health Care Expenses

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

- Acne medications and treatments
- Acupuncture
- Alcoholism treatment
- Allergy and sinus, cold, flu and cough remedies (antihistamines, decongestants, cough syrups, cough drops, nasal sprays, medicated rubs, etc.)
- Allergy shots and testing
- Ambulance (ground or air)
- Antacids and acid controllers (tablets, liquids, capsules)
- Antibiotic and antiseptic sprays, creams and ointments
- Anti-itch and insect bite remedies
- Antifungals
- Antidiarrheals
- Anti-gas and stomach remedies
- Artificial limbs
- Baby care (diaper rash ointments, etc.)
- Blind services and equipment
- Braces and supports
- Breast pumps for nursing mothers
- Chiropractor services
- Coinsurance and deductibles
- Contact lenses
- Contact lens solution
- Contraceptives (condoms, gels, foams, suppositories, etc.)
- Crutches, wheelchairs, walkers
- Deaf services -- hearing aid/batteries, hearing aid animal & care, lip reading expenses, modified telephone, etc.
- Dental care (non-cosmetic)
- Dentures
- Diabetic testing supplies/equipment
- Diagnostic tests & products
- Digestive aids
- Doctor's fees
- Drug addiction treatment & facilities
- Drugs (prescription Eye examinations and eyeglasses)
- Durable medical equipment (power chairs, walkers, wheelchairs, CPAP equipment and supplies, etc.)
- Eye drops, ear drops, nasal sprays
- Eczema and psoriasis remedies
- First aid kits
- Hemorrhoidal preparations
- Home diagnostic (pregnancy tests, thermometers, blood pressure monitors)
- Home health and/or hospice care
- Hospital services
- Insulin
- Laboratory fees
- LASIK eye surgery
- Laxatives
- Medicated band aids and dressings
- Menstrual products
- Medical alert (bracelet, necklace)
- Medical monitoring and testing devices
- Motion sickness remedies
- Nicotine medications (smoking cessation aids)
- Non-medicated band aids, rolled bandages and dressings
- Nursing services
- Obstetrical expenses
- Occlusal guards
- Operations and surgeries (legal & non-cosmetic)
- Optometrists
- Orthodontia
- Orthopedic services
- Osteopaths
- Over the counter medications
- Oxygen/oxygen equipment
- Pain relievers (aspirin, ibuprofen, acetaminophen, naproxen, etc.)
- Physical exams (except for employment-related physicals)
- Physical therapy
- Psychiatric care,
- PPE (masks, hand sanitizer, and sanitizing wipes)
- Radial keratotomy
- Reading glasses
- Sleep aids and sedatives
- Smoking cessation
- Surgery (non-cosmetic)
- Telephone for the hearing impaired
- Transportation (essentially and primarily for medical care; limits apply)
- Vaccinations
- Wart removal remedies, corn patches
- X-rays

FSA/HSA Eligible Health Care Expenses - *Medical Necessity or Prescription Required*

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

- Antiparasitic
- Birthing Classes
- Car Modifications
- Hydrogen peroxide
- Massage Therapy
- Psychologists, psychotherapists
- Schools and education (special and residential)
- Sexual dysfunction treatment
- Therapy treatments
- Vitamins and Nutritional supplements
- Weight loss programs

Commuter Benefits

Parking

Why Choose Parking Benefits?

Parking Benefits allow you to put money from your paycheck aside each month, before taxes are taken out, for qualified parking expenses incurred by you during your work commute.

+ **Fast savings.** You can save 40 percent or more on your costs for parking at or near your place of employment.
+ **Contribution Limits.** The IRS sets the maximum dollar amount you can set aside each month as a part of your Parking Benefits. The 2025 monthly pre-tax contribution limit is: **$325.**

Any money contributed to your parking benefits rolls over every month until it is used, or you are no longer eligible.

What Does It Cover?

Parking funds can be used on a variety of expenses that allow you to park at or near your office or a transit station you use to commute to work.

+ Parking paid directly to provider
+ Parking vouchers or prepaid cards

These funds can be used to cover your expenses only and cannot be used for costs incurred by a spouse or other dependent.

IRS Regulations

+ **Availability of funds.** Your funds become available as you contribute to the plan.
+ **Contribution changes.** You can adjust the amount you contribute to the plan each month at any time. No qualifying event is needed.
+ **Rollovers and use-or-lose.** The parking plan is flexible, and your funds will continue to roll over month-to-month until the funds are used. **However, your funds will no longer be available if you terminate employment and are forfeited.**

Commuter Benefits

Transit

Why choose transit benefits?

Transit Benefits allow you to put money from your paycheck aside each month, before taxes are taken out, for qualified mass transit expenses to and from work.

+ **Fast savings.** You can save 40 percent or more on your costs commuting to and from work.
+ **Get hours back in your day.** The average one-way commute to work is nearly 30 minutes! By using public transit, you can use that time to read news, text friends or get a start on your day.
+ **Improve your health.** Studies have shown that people who commute to and from work in a method other than a private vehicle are less stressed.
+ **Environmental impact.** Do your part to reduce traffic congestion and reduce air pollution.
+ **Commuter Contribution Limits**. The IRS sets the maximum dollar amount you can set aside each month as a part of your Commuter Benefits. The 2025 monthly pre-tax contribution limit is: **$325**

Money contributed to your transit benefits rolls over every month until it is used, or you are no longer eligible.

What does it cover?

Commuter funds can be used on a variety of transportation expenses that allow you to travel to and from work.

Eligible modes of transportation include but aren't limited to:

+ Train
+ Bus
+ Subway
+ Ferry
+ Vanpool *(must seat at least 6 adults)*

These funds can be used to cover your expenses only and cannot be used for costs incurred by a spouse or other dependent.

IRS Regulations

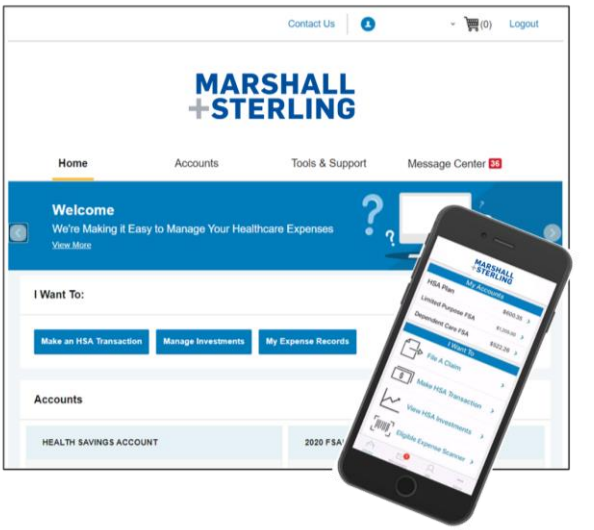
Availability of funds. Your funds become available as you contribute to the plan.

Contribution changes. You can adjust the amount you contribute to the plan each month at any time. No qualifying event is needed.

Rollovers and use-or-lose. The commuter plan is flexible, and your funds will continue to roll over month-to-month until the funds are used. **However, your funds will no longer be available if you terminate employment and are forfeited**.

Your WEX Health Portal and Mobile App

Marshall+Sterling, in partnership with WEX Health, provides you an online system and mobile app that gives you access to your account information along with any other plans you're enrolled in through Marshall+Sterling.
This is convenient, easy-to-access, customized and secure. Plus, it's available to you 24/7!



With this access you can:

- Check your up-to-the-minute account balances
- Store receipts and documents
- View your investment accounts
- Request distributions to pay yourself back for out-of-pocket expenses
- Sign up for or update your direct deposit information
- And much more!

The portal also has links to calculators, tools and other resources to help you plan and make sure you have all the information you need.

Once you are enrolled, your online account will be set-up by Marshall+Sterling's Flex team (this can take up to a week after the start of the Plan Year).

Your login credentials will be supplied to you. To login, go to **https://msflex.lh1ondemand.com**.

Make sure you download the Mobile App!
Go to the app store on your smartphone or tablet and search for ***MSEB Flex*.** Use the same username and password you use to login online. Upon your initial login, you will create a 4-digit code that you will use to get into the app each time you log in.

With the mobile app you can get on-the-go access to much of the same functionality built into your online portal. The app also has useful tools like a built-in eligibility expense scanner and the option to take and upload photos of your receipts for electronic recordkeeping.

Your Flex Debit Card

Your Flex Debit Card provides easy access to all accounts you are enrolled in through Marshall+Sterling. If you have an HSA, FSA, LPFSA, DCAP, Transit Plan or HRA, you will access all funds using the same Flex Debit Card. This card is equipped with "Smartcard" technology and draws from the appropriate account based on each expense.

Your card arrives already activated. You can continue to use your card until its marked expiration date. Marshall+Sterling Employee Benefits will automatically replace your card with a new one when it expires. Your card is equipped with mobile payment functionality- you can add it to your mobile wallet to pay for eligible expenses right from your smartphone at participating retailers. You can also replace your card or order extra cards on your Wex Health Portal.

Dental

The Aetna insurance plan allows you the freedom to see the dentist of your choice. You can utilize a large network of participating dentists who accept the Aetna contracted rate as payment in full after deductible and coinsurance. Dentists who participate in the Aetna network accept Aetna as payment in full after deductible and coinsurance. Non-Aetna dentists may not accept the Fair Health Allowed amount as payment in full and may balance bill without limit.

Plan Features	Aetna High PPO	
	In-Network	Out-of-Network
Deductible / Maximum Accumulation Period	Calendar Year (1/1 – 12/31)	
Dependent Age Limit	Up to Age 26	
Network	Aetna Passive PPO	N/A
Reimbursement Level	N/A	80th Percentile of Fair Health Allowed Amount
Waiting Period (for late entrants)	None	
Plan Deductible (Individual / Family)	$50 / $150	
Deductible Waived For	Preventive Care	
Preventive Care (Cleanings, Oral Exams, etc.)	100% Covered	100% Covered
Basic Procedures (Extractions, fillings, etc.)	90% Covered	90% Covered
Major Procedures (Crowns, dentures, etc.)	60% Covered	60% Covered
Child Orthodontia (up to age 19)	50% Covered	50% Covered
Plan Year Maximum Benefit	$2,000	
Orthodontia Lifetime	$1,000	

- 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.

Dental

The Freedom of Aetna insurance plans allow you the freedom to see the dentist of your choice. With the PPO plan you can utilize a large network of participating dentists who accept the Aetna contracted rate as payment in full after deductible and coinsurance. With the DMO plan you can utilize a network of participating dentists who provide services at a fixed cost. Dentists who participate in the Aetna network accept Aetna as payment in full after deductible and coinsurance. Non-Aetna dentists may not accept the Fair Health allowed amount as payment in full and may balance bill without limit. You can contact Aetna at any time during the plan year to switch between the Freedom of Choice DMO and PPO plan at no additional cost.

Plan Features	Freedom of Choice PPO		Freedom of Choice DMO
	In-Network	Out-of-Network	In-Network Only
Deductible / Maximum Accumulation Period	Calendar Year (1/1 – 12/31)		Calendar Year (1/1-12/31)
Dependent Age Limit	Up to Age 26		Up to Age 26
Network	Aetna Passive PPO	N/A	DHMO
Reimbursement Level	N/A	80th Percentile of Fair Health Allowed Amount	N/A
Waiting Period (for late entrants)	None		N/A
Plan Deductible (Individual / Family)	$50 / $150		N/A
Deductible Waived For	Preventive Care		N/A
Preventive Care (Cleanings, Oral Exams, etc.)	100% Covered	100% Covered	Based on fee schedule
Basic Procedures (Extractions, fillings, etc.)	80% Covered	80% Covered	Based on fee schedule
Major Procedures (Crowns, dentures, etc.)	50% Covered	50% Covered	Based on fee schedule
Child Orthodontia (up to age 19)	50% Covered	50% Covered	Based on fee schedule
Plan Year Maximum Benefit	$1,250		N/A
Orthodontia Lifetime	$1,000		N/A

- 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.

Vision

The EyeMed vision plan allows you the freedom of seeing the provider of your choice. If you choose an in-network provider, you will have lower out-of-pocket expenses, and the provider will submit the claim on your behalf. If you choose an out-of-network provider, the plan will reimburse you according to the out-of-network reimbursement schedule outlined in the below benefits summary. You must submit claims for reimbursement for services rendered by a non-network provider directly to EyeMed at the fax number or address listed on the claim form. After you have exhausted your funded benefit, you are also eligible to access significant discounts on materials through participating network providers.

Plan Features	EyeMed Vision	
	In-Network	Non-Network Reimbursement
General Plan Information		
Dependent Age Limit	Up to Age 26	
Network	EyeMed	N/A
Frequency of Service		
Exam	Once every 12 months	
Frames	Once every 12 months	
Lenses /Contact Lenses	Once every 12 months	
Vision Exam		
Eye Exam	$0 Copay	Up to $40
Frames		
	$150 Allowance, then 20% off balance	Up to $105
Basic Lenses		
Single Vision	$0 Copay	Up to $30
Lined Bifocal		Up to $50
Lined Trifocal		Up to $70
Lenticular		Up to $70
Progressive – Standard		Up to $84
Contact Lenses (in lieu of frames & lenses)		
Conventional	$150 Allowance, then 15% off balance	Up to $120
Planned Replacement / Disposable	$150 Allowance, then 100% off balance	
Medically Necessary	Covered in Full	Up to $300
Evaluation and fitting - Standard	Up to $40, contact lens fit and two follow-up visits	Not Covered
Laser Correction Surgery – Usual Charge, Lasik or PRK from U.S. Laser Network	15% off retail price 5% off promo price	Not Covered

- 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.

Basic Life / AD&D

General Plan Information	
Employee Contribution	None – 100% employer funded
Term Life	
Benefit	2x annual compensation
Maximum Benefit	$750,000
Accelerated Death Benefit	$50,000
Accidental Death & Dismemberment AD&D)	
Benefit	Same as your Term Life Benefit
Seatbelt Benefit	An additional 10% benefit but not more than $10,000
Additional Features	
Conversion	Included, some restrictions may apply
Age Reduction Schedule	
At Age 65	65%
At Age 70	50%

- Guarantee Issue on voluntary life & AD&D amounts 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.
- All unmarried dependent children in family unit are covered to from 14 days to age 26.
- Eligible children under 14 days of age receive a $1,000 benefit

Group Short-Term Disability

General Plan Information	
Employee Eligibility	All active, Full-time Employees classified as Administrators, regularly working a minimum of 30 hours per week, excluding Employees classified as Union Employees.
Employee Contribution	None – 100% employer funded
Short-Term Disability	
Weekly benefit	50% of pre-tax weekly earnings
Maximum Benefit	$750
Waiting Periods	You must be disabled at least 7 calendar days
Maximum Payment Period	26 weeks

Group Long-Term Disability

General Plan Information	
Employee Eligibility	All active, Full-time Employees classified as Faculty & Admin, regularly working a minimum of 30 hours per week, excluding Employees classified as Union Employees.
Employee Contribution	None – 100% employer funded
Long-Term Disability	
Monthly Benefit	60% of pre-tax monthly earnings
Maximum Benefit	$5,000
Survivor Benefit	If you die while receiving benefits, we will pay a survivor benefit to your lawful spouse, eligible children, or estate. The plan will pay a single lump sum equal to 3 months of benefits.
Pre-Existing Condition	3 months/ 12 months
Waiting Period	You must be disabled at least 180 calendar days
Maximum Payment Period	Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit or until you no longer qualify for benefits, whichever occurs first. Should you remain Disabled, your benefits continue according to the following schedule, depending on your age at the time you become Disabled.

urbansitter Kinside

Your Complete Care benefit at a glance

Solutions for every caregiving need

Complete Care pairs UrbanSitter's child care, and senior care, with Kinside's marketplace of daycares and preschools to bring you the very best coverage for all your needs.

What's included?

- ✓ Free UrbanSitter membership
  Child or senior care services in your home.
- ✓ Free Kinside access
  Daycares, preschools, camps, and after-school programs in a center or the provider's home.
- ✓ $4500 Annual Care Credit
  Pay caregivers with these employer-sponsored credits. After your Care Credit is depleted, you can pay caregivers out of pocket.
- ✓ Out of Network Reimbursement
  Submit the out of network form and receipt within 60 calendar days to qualify for reimbursement. Reimbursement is limited up to $100 a day.

How do I get started?

1. Enroll at urbansitter.com/barnardcollege
2. Enter your work email address, then check your email to verify your account.

Available services

In-home child care

For full-time, part-time, occasional and back-up care needs at your house

Daycares, Preschools & Camps

Real-time openings, preferred tuition rates and concierge support, along with after-school programs and camps

Senior care

For non-medical senior companion care

BARNARD

Child Care Solutions

Sitters, backup care, daycares, and preschools, all in one place

With Complete Care, you have access to a nationwide network of background-checked in-home child care providers (sitters, nannies, tutors) and licensed child care programs (daycares, preschools, camps, after-school programs).

It's easy to view care provider recommendations, read reviews, browse detailed profiles, post jobs, and book interviews, tours or jobs with a click.

Services available

Backup care

Full-time & part-time care

Daycares & preschools

Camps & After-school

Tip: Need last-minute care? Post a job to hear back quickly from caregivers.

Complete Care

Enroll in your benefit now!

Senior Care Companions

Access senior care when you need it most

For non-medical needs such as companion care, errands, cooking, light housekeeping and driving to appointments, utilize Complete Care's senior care benefit to schedule experienced and accessible caregivers for your elderly loved ones.

Complete Care helps you quickly find background checked caregivers to comfort and care for your family members day or night.

Services available

Errands & meal prep

Companionship & conversation

Routine assistance

Escorting to appointments

Tip: Post a job to find the best fit for your family. It's quick and easy to do.

Complete Care

Enroll in your benefit now!

urbansitter

Out of Network (OON) Reimbursement Program

Maximize savings on out of network care

Now, you can hire caregivers outside of the UrbanSitter network and effortlessly get reimbursed from your organization.

What's included?

- Use your $4500 Annual care credit towards out of network. Reimbursement is limited up to $100 a day.

How it works

1. Enroll at www.urbansitter.com/barnardcollege with your work email address.
2. Hire your preferred out of network provider.
3. Pay your provider directly, then fill out the reimbursement form and submit all applicable receipts within 60 calendar days from date of care.
4. Once approved, setup a Stripe Connect account and get reimbursed up to the Care Credit amount offered by your organization.

Submit a reimbursement:

Go to Form

https://www.urbansitter.com/claim

*Please note that any reimbursements for care used in December of 2025 must be received by January 31, 2026.

Approved services

Child care
For daycare, camps, preschools and more

Preschools
For tuition and fees

Daycares
For tuition and fees

Camps
For summer camps and holiday coverage costs

Elder care
For senior facilities or nursing homes

Need more help? Contact our reimbursements team at reimbursement@urbansitter.com.

WeightWatchers for Business

Join WeightWatchers®

Reachable goals with simple, science-backed changes

$9 Special pricing

on select plans*

A plan tailored to you

Get your customized nutritional plan based on your unique lifestyle.

Eat healthier, without the guesswork

Prioritize nutrient-dense foods which require no tracking or measuring.

Find your support network

Connect with expert WW coaches, access Virtual Workshops, and celebrate with members like you.

WW.com/wellness • Your Special Code: 16600962

Already a WeightWatchers member?

Call customer service at 866-204-2885 to sync your account.

***Pricing** reflects the cost of an eligible WW membership plan through your organization. If your membership includes a monthly payment, it is required in advance. You'll be automatically charged each month, if applicable, in accordance with company pricing until you cancel. Pricing may adjust to the standard monthly rate if your relationship with your organization changes or terminates, or the agreement between your organization and WW terminates.

Employee Assistance Program (EAP)

Life has its challenges We're here to help

In challenging times, it can be helpful to talk to someone for support and resources. Your employer in partnership with Health Advocate, offers you and your family members access to an Employee Assistance Program (EAP) Professional who will listen and provide emotional support and coping tips for personal, family and work issues, at no cost to you.

How It Works

Your first call starts the brief intake process.

An EAP Professional will:

- Confirm your **contact information**
- **Review the confidentiality** guidelines and your EAP+Work/Life benefits
- **Assess for safety concerns**, such as your risk of harm to yourself or others, domestic violence, abuse, drug or alcohol issues
- **Gather information** about your reason for requesting counseling
- Determine **what type of counseling** may work best for you (individual, family or couples)*
- Review what **counseling options** are available
- Help **connect you to the right EAP Professional** for your needs to begin counseling sessions
- If needed, **put you in touch with Work/Life services** for help with financial or legal issues, childcare, eldercare and more

*If you may need a higher level of care than outpatient counseling, we will help you explore options.

We can help with:

- Stress, anxiety, depression
- Family, relationship, and parenting issues
- Financial and job pressures
- Grief, loss and anger
- Substance abuse

...**Plus** we can find local resources for childcare, eldercare and more

Remember, you, your spouse, dependents, parents and parents-in-law are all eligible for the Health Advocate service.

In a crisis, help is available 24/7.

Turn to us at any time!

877.240.6863

answers@HealthAdvocate.com

HealthAdvocate.com/barnardcollege

Call • Email • Message • Live Chat

HealthAdvocate℠

Pet insurance

from Nationwide®

Fetch the best health coverage for your pet through your voluntary benefits package. With two budget-friendly plans, there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

Nationwide offers two plans for you to choose from: My Pet Protection® and My Pet Protection® with Wellness500.[1]

Both plans are guaranteed issuance,[2] have a $250 annual deductible and include medical coverage with the choice of 50% or 70% reimbursement levels.[3]

	My Pet Protection®	My Pet Protection® with Wellness500
Accidents	✓	✓
Injuries	✓	✓
Illnesses	✓	✓
Hereditary and congenital conditions	✓	✓
Diagnostics and imaging	✓	✓
Procedures and surgeries	✓	✓
Wellness exams		✓
Vaccinations		✓
Flea prevention		✓
Spay or neuter		✓
And more	✓	✓

Did you know? Nationwide is the industry-first provider of coverage for birds and exotic pets.

How to use your pet insurance plan

1. Visit any vet, anywhere.
2. Submit claim.
3. Get reimbursed for eligible expenses.

http://www.petinsurance.com/barnard | 877-738-7874

[1] Existing members can enroll in My Pet Protection® with Wellness500 during their respective renewal period only. Products and discounts not available to all persons in all states. [2] Guaranteed issuance means any new pets enrolling into a My Pet Protection Plan are eligible for enrollment regardless of health status. Guaranteed issuance does not mean guaranteed coverage since certain exclusions could apply. [3] These are examples of general coverage; please review plan document for specific coverages. Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions and annual limits.

Nationwide®

Nationwide®

My Pet Protection®

PLANS SUMMARY

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible—without worrying about the cost.

Nationwide offers two plans for you to choose from: My Pet Protection® and My Pet Protection® with Wellness500.[1]

My Pet Protection is a medical plan that offers an annual benefit of $7,500 for eligible veterinary bills related to accidents, injuries and illnesses, including emergency clinics and specialists.

My Pet Protection with Wellness500 offers the same protection as our medical plan, but includes coverage for preventive care. With this plan, up to $500 of the annual $7,500 benefit can be used for wellness, including checkups, flea and heartworm preventives, vaccinations, spay and neuter and more.

Both plans are guaranteed issuance,[2] have a $250 annual deductible and include medical coverage with the choice of 50% or 70% reimbursement levels.[3]

	My Pet Protection®	My Pet Protection® with Wellness500
Accidents	✓	✓
Injuries	✓	✓
Illnesses	✓	✓
Hereditary and congenital conditions	✓	✓
Diagnostics and imaging	✓	✓
Procedures and surgeries	✓	✓
Wellness exams		✓
Vaccinations		✓
Flea prevention		✓
Spay or neuter		✓
And more	✓	✓

http://www.petinsurance.com/barnard | 877-738-7874

Nationwide®

Calm Business

Free Calm Subscription

The world's #1 app for sleep, meditation and relaxation

Millions of people are experiencing lower stress, less anxiety, improved focus and more restful sleep with Calm. Whether you have 30 seconds or 30 minutes, Calm content is made to suit your schedule and needs.

KIDS SLEEP MUSIC MEDITATIONS FOR WORK WISDOM MOVEMENT

To activate your subscription, scan the QR code or visit:

https://www.calm.com/b2b/barnard-college/subscribe

This must be done on a web or mobile browser (not in the app itself).

Once on the page:

- Sign in to your existing Calm account or create an account
- Enter your work email address in the box provided to activate the subscription on your Calm account
- Download the Calm app and log in to your account to access the premium content
- Once you've signed up, you can add up to 5 dependents (age 16 years or older) via the "Manage Subscription" page inside your Calm account at www.calm.com

Need help? Reach out to the Calm Support Team with any questions.

Calm Business

Free Calm Subscription

The world's #1 app for sleep, meditation and relaxation

Millions of people are experiencing lower stress, less anxiety, improved focus and more restful sleep with Calm. Whether you have 30 seconds or 30 minutes, Calm content is made to suit your schedule and needs.

KIDS SLEEP MUSIC MEDITATIONS FOR WORK WISDOM MOVEMENT

Follow the below instructions to redeem your Calm Premium subscription:

1. Download and open the Calm app
2. Create an account with a personal email address and go to Profile > Settings > Link Employer Subscription
3. Click on *Redeem via Email*
4. Enter your credentials to activate your free subscription. If at any point you're asked to enter your organization name, please enter [barnard-college].

If you already have an existing Calm account, go to your Settings > Link Employer Subscription and follow steps 3 and 4.

Once you've signed up, you can add up to 5 dependents (age 16 years or older) via the "Manage Subscription" page inside your Calm account at www.calm.com.

Need help? Reach out to the Calm Support Team with any questions.

Allstate IDENTITY PROTECTION

product features: Pro+

Comprehensive monitoring and alerts

Allstate Identity Protection's monitoring system analyzes and detects high-risk activity and sends alerts at the earliest sign of fraud. That's how we help members minimize risk, damage, and stress with prevention and rapid restoration.

Dark web monitoring

We go beyond simply scanning for your information online. We utilize bots and human intelligence operatives together to scour closed hacker forums for members' compromised credentials as well as personal information. We alert members whenever compromised data is found, including:

- Social Security numbers
- Email address
- Usernames and passwords
- Credit and debit card numbers
- Government and medical ID numbers
- IP addresses
- Gamer credentials

Financial transaction monitoring

Members can set alerts to trigger from sources including bank accounts, credit and debit cards, account thresholds, 401(k)s, and other investment accounts to help take control of their finances.

High-risk transaction monitoring

Even non-credit-based activity can indicate fraud, so we send alerts for transactions like wire transfers and electronic document signatures matching member information.

Social media account takeover monitoring

Members can add social media accounts for themselves and family members to be notified of suspicious activity that may indicate hacking or an account takeover.

Credit monitoring and alerts

Members can set alerts for transactions like new credit inquiries, accounts placed in collections, newly opened accounts, and bankruptcy filings.

Credit assistance

Should a member's credit monitoring trigger an alert, our in-house team of experts will help freeze files with all major credit bureaus.

Identity Health Status

Our unique tool gives members a snapshot of their identity health and risk level. We provide monthly status updates using an enhanced algorithm with deep analytics to spot fraud trends and alert members before damage occurs.

Fraud restoration tracker

The Allstate Identity Protection identity restoration tracker makes it easy for members to see their case status.

It's your digital identity. Own it.

Allstate Security Pro®
We help keep members one step ahead of bad actors by providing real-time, personalized content about heightened security risks that may affect them. Our alerts leverage internal data to identify emerging threats, how members may be affected, and what steps they can take to better protect themselves.

$1 million identity expense reimbursement†
Members who fall victim to identity fraud will be reimbursed up to $1M for stolen funds as well as many out-of-pocket costs related to resolving their case, including:

- Expenses incurred resolving:
    - Home title fraud
    - Professional fraud
- Stolen funds from:
    - SBA loans
    - Unemployment benefits
    - Stolen tax return refunds

Allstate Digital Footprint®
Only available from Allstate Identity Protection, the Allstate Digital Footprint shows members where their personal information lives online so they can better protect it. Members can track where their personal information is stored, spot possible vulnerabilities, and take action before they're compromised.

Lost wallet protection
Members can store critical information in the secure Allstate Identity Protection portal to retrieve in the event of losing credit cards, personal credentials, or documents. We help members access this information and replace it, if needed.

Stolen wallet emergency cash†
In the event that a member's wallet is stolen, we'll reimburse up to $500 for cash lost.

Solicitation reduction
We make it easy for members to opt in or out of the National Do Not Call Registry, credit solicitations, and junk mail reduction.

Sex offender notifications
We monitor registries and can notify members if an offender is registered nearby in their area.

Robocall blocker‡
Our Robocall blocker can help intercept scam and telemarketing calls and texts to require them to identify themselves before you even pick up.

Mobile app
The Allstate Identity Protection app makes accessing the member services portal easy anywhere. Available on iOS and Android.

Ad blocker‡
We provide a resource center for members to quickly and easily resolve their unemployment fraud claims to save time and stress. Our dedicated specialists are available to help victims through the process of resolving their case.

Unemployment fraud center with dedicated support
We provide a resource center for members to quickly and easily resolve their unemployment fraud claims to save time and stress. Our dedicated specialists are available 24/7 to help victims through the process of resolving their case.

Whole family protection
We have the broadest definition of family in our industry, and we cover family members in members' household as well as anyone financially dependent. If they're "under your roof" or "under your wallet," they're covered.

Family digital safety tools with Bark for AIP△
Our suite of family digital safety tools help parents set healthy limits around how and when kids use their devices, filter undesirable content, and see where kids' devices are. Tools include:

- Web filtering
- Screen time management
- Location tracking

Elder Fraud Center
Safeguard senior family members with our helpful resource hub built specifically for seniors, caretakers, and family members to easily understand and protect against scams and threats. Our Identity Specialists are trained to provide customized care for older family members to identify and resolve scams as well as create a proactive protection plan together.

Best-in-class customer care
Should fraud or identity theft occur, our in-house experts are available to help members fully restore compromised identities — even if the theft or fraud occurred prior to enrollment.

US-based customer support
Our support center is US-based and located in our corporate headquarters, where our customer care team is always available to help answer questions and resolve identity theft or fraud.

Full-service identity restoration
Our restoration specialist team is highly trained and certified to handle every type of identity fraud case. We fully manage restoration cases, leaving members to live their lives and save them time, money, and stress.

† Identity theft insurance covering expense and stolen funds reimbursement is underwritten by American Bankers Insurance Company of Florida, an Assurant company. The description herein is a summary and intended for information purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

‡ Some features require additional activation. For family plans, activation of features such as robocall blocker (up to 10 phone numbers), ad blocker, cybersecurity (up to 10 devices) and family digital safety features can be done only through the primary subscriber's account. Privacy management features cover up to five email addresses.

△ Only available with a family plan.

Products and features are subject to change. Certain features require additional activation and may have additional terms.

Allstate Identity Protection is offered and serviced by InfoArmor, Inc., a subsidiary of The Allstate Corporation.

Kickstart tomorrow's dreams

Enroll in the retirement plan today

Your employer's plan offers an easy, direct way to save for your future goals. You can enroll online in just minutes. And the sooner you start, the more time your money has to work for you.

All you need is:

- Your Social Security number
- Your beneficiary's Social Security number, birth date and address, if possible
- Your selected investment allocations. Need information about your investment options? Please go to www.tiaa.org/barnard to view the menu.

Online tools and resources:

- Want help creating a budget or calculating your needs for retirement? Visit TIAA.org/tools.
- Learn more about saving and managing your finances, go to TIAA.org/webinars to join a live or on demand webinar.
- Create a personalized savings and investment plan visit TIAA.org/retirementadvisor.
- Are you closer to retirement? Visit TIAA.org/retirementincome to see how your retirement plan options can provide income that is guaranteed for life.[1]

Simple steps to set your path

Visit www.tiaa.org/barnard

First-time to TIAA?
Register and then log in

Already registered? Log in with your ID and password

Follow the prompts to choose your investments and set your contribution amounts

Add your beneficiaries

We're here if you need help

A TIAA financial consultant can help you choose investment options for your goals*, at no additional cost.

Schedule a session at TIAA.org/schedulenow or call TIAA at 800-732-8353, weekdays, 8 a.m. to 10 p.m. (ET).

TIAA

BARNARD

403B Eligibility and Contributions-Administrative Staff and Faculty

Effective January 1, 2025:

Full time faculty and administrative staff employees are eligible for employer contributions on base pay earnings based on the following schedule:

(a) an officer of instruction at the rank of professor or term professor, who are eligible for contributions on the date of hire, or

(b) an administrator who is hired as a full-time Employee and whose position is classified as a Grade 11 or above or Grade "Executive", who are eligible for contributions on their date of hire, or

(c) an officer of instruction at the rank of Assistant Professor, Associate Professor, Assistant Professor of Professional Practice, Associate Professor of Professional Practice, Professor of Professional Practice, Visiting Assistant Professor, Visiting Associate Professor, Visiting Professor, Term Assistant Professor or Term Associate Professor, who are eligible for contributions on the first of the month coincident with or following one year of employment, or

(d) an administrator who is hired as a full-time Employee and whose position is classified as Grade 5 through Grade 10, who are eligible for contributions on the first of the month coincident with or following one year of employment, or

(e) a Faculty member or an administrator, who is hired as a full-time Employee and whose positions are classified as a Grade 4 or below, or not outlined on the previous bullets, are eligible for contributions on January 1 or July 1 following their two year anniversary date.

3962425-0426 (10/24)

Tuition Benefits - Administrative Employees

Dependent Children Tuition Assistance Program

Barnard College offers Dependent Children Tuition Assistance for eligible dependents of current full time administrative employees. Dependent Tuition is available for the Fall and Spring semesters for accredited educational institutions.

● Dependent children of full-time administrators attending either Barnard College or Columbia University may receive full undergraduate tuition for a maximum of eight semesters within six years. If your dependent child is attending **Barnard or Columbia University**, please complete the **Application for Dependent Tuition Reimbursement Program** **AND** **The Tuition Exemption Form**

● Dependent children of full-time employees attending institutions other than Barnard or Columbia may receive a benefit payment of 25% of Barnard's own tuition (excluding room, board, and other fees), up to 100% of the other institution's tuition. For the 2024-2025 academic year, this equals a maximum benefit per semester of $8,450.25. For dependent children attending undergraduate colleges or universities **other than Columbia University**, including Barnard College, please complete the **Application for Dependent Tuition Reimbursement Program** and upload an itemized invoice into the application. An itemized invoice must include the following: student name, student identification number, institution name, institution address, and an itemized list of charges. A sample invoice can be found **here**.

Dependent Tuition Eligibility Rules & Procedures for all:

- You must submit an application each fall and spring semester to continue to receive tuition payments for your dependent.
- All required documents should be submitted at least 30 days prior to tuition payment due date.
- Proof of satisfactory completion and final grades for the semester will be required to be submitted. If successful proof of completion for the semester is not received, the employee may not apply for any future dependent tuition applications, and the employee will have to pay back the college the amount of the semester within 30 days.
- Failure to provide all required documents will result in a delay of tuition payment.
- Employees who resign within 1 year from the date of payment must repay the college for the last semester that was paid on behalf of the dependent(s).

Please note that employees hired after January 1, 2025, will have a two year waiting eligibility period to be considered for this program. Dependents will be eligible for tuition assistance the first academic term following the satisfactory completion of the employee's two (2) year waiting period.

Tuition Benefits - Administrative Employees

Employee Tuition Assistance Program

Barnard College is committed to the continued growth and development of its employees. To help achieve that goal, the Employee Tuition Assistance Program offers the opportunity for all qualified employees to receive financial assistance with college and university courses.

For the 2024-2025 academic year, full-time employees have a benefit allowance equivalent to the cost of 6 Barnard credits per each calendar year. This currently equates to a benefit allowance of $13,524 (based on a cost of $2,254 per credit).

- Benefit allowances are based on the calendar year and reset annually on January 1st.
- Benefits can only be used toward tuition expenses, not any other associated fees. In the first year of eligibility, benefits are on a reimbursement-only basis. After the first year, employees can apply for a direct payment from Barnard to their institution.

Employee Tuition Eligibility Rules:

- Tuition reimbursement is applicable for courses towards a degree, or individual credit-bearing courses from an accredited educational institution, or courses related to professional development.
    - Applicable for courses from an accredited educational or vocational institution (Not just Barnard and Columbia!)
    - Courses or programs from recognized professional organizations for professional development
    - Courses do not have to be related to your job or role in order to be eligible
    - Duplicate degrees are not eligible (i.e., a second Associate's, Bachelor's, or Master's degree for employees who already hold that degree), even if the new degree is in an unrelated field
- An employee must be in good standing at the college. This means there can be no previous disciplinary action, including, but not limited to, performance improvement plans, in the employee file for the previous 12 months from the start of the semester. If an employee received disciplinary action or was placed on a performance improvement plan, they are eligible for tuition reimbursement the semester following 12 months from the date of issuance of the latest discipline/PIP. Exceptions can be made if the terms of the disciplinary action require participation in course work to enhance performance.

- Tuition reimbursement will not be granted to employees taking courses on a leave of absence or period of unpaid leave.
- Proof of passing grades are required at the completion of the semester/course in order to maintain eligibility and/or receive reimbursement. If successful proof of completion for the semester is not received, the employee may not apply for any future employee tuition applications, and the employee will have to pay back the college the amount of the semester within 30 days.
    - If an employee fails to complete the semester, or withdraws from school, course, or the program, the employee will be required to repay the full payment amount less applicable taxes back to the college within 30 days.
- Employees who resign within 1 year from the date of tuition reimbursement payment must repay the college for the last semester that was paid on behalf of the employee.
- Exemptions may be made to repayment requirements when the coursework is taken at the direction of the College.

What you need to apply:

- Your completed **Tuition Remission Application form**, signed by yourself and your manager
- A billing statement that has all of the following details on it:
    - Your name
    - Your student ID
    - The institution's name
    - The institution's address
    - An itemized list of charges (including tuition)
- A description or syllabus for each course for which you're seeking benefits
- If you need to be reimbursed: proof of your payment (for example, a receipt or bank statement charge)
- For Columbia courses only: your completed **Columbia Tuition Exemption Form**

Employees hired after January 1, 2025, will have a two year waiting eligibility period to be considered for any tuition programs. They will be eligible for tuition assistance and/or dependent tuition benefits the first academic term following the satisfactory completion of their two (2) year waiting period.

Employee Contributions

Your contributions for your insurance will be paid with pre-tax dollars. This means you usually pay no income or social security taxes on these benefits, lowering your taxable income.

The employee contribution depends on the coverage selected and number of dependents you insure. See table below for your semi-monthly insurance contribution rates effective **January 1, 2025.**

Plan A	<$50K	$50K-$74,999	$75k-$99,9999	$100k-$124,999	$125k-$149,999	$150k
Employee Only	$44.81	$52.29	$67.21	$82.15	$97.11	$112.45
Employee + Spouse	$209.15	$265.51	$313.63	$376.60	$453.65	$487.56
Employee + Child(ren)	$188.24	$238.95	$282.28	$338.94	$408.28	$438.80
Family	$303.13	$384.80	$454.55	$545.81	$657.47	$706.62
Partner Surcharge	$12.50	$15.00	$17.50	$22.50	$27.50	$30.00

Plan B	<$50K	$50K-$74,999	$75k-$99,9999	$100k-$124,999	$125k-$149,999	$150k
Employee Only	$115.50	$122.96	$137.87	$152.76	$167.70	$183.00
Employee + Spouse	$369.87	$428.95	$479.37	$545.38	$626.12	$661.66
Employee + Child(ren)	$333.61	$386.76	$432.17	$491.55	$564.23	$596.21
Family	$525.24	$610.85	$683.95	$779.59	$896.62	$948.13
Partner Surcharge	$20.00	$25.00	$27.50	$30.00	$35.00	$40.00

Plan C	<$50K	$50K-$74,999	$75k-$99,9999	$100k-$124,999	$125k-$149,999	$150k
Employee Only	$9.05	$10.85	$13.57	$16.28	$18.10	$23.05
Employee + Spouse	$18.09	$39.74	$82.03	$109.42	$150.92	$186.17
Employee + Child(ren)	$16.29	$35.76	$73.83	$98.48	$135.83	$167.55
Family	$27.19	$59.72	$123.29	$164.45	$226.84	$279.81
Partner Surcharge	$2.00	$4.00	$7.50	$10.00	$14.00	$17.00

Spousal and Domestic Partner Surcharge

In order to maintain the level of medical benefits we provide, if you wish to cover your spouse or domestic partner who is eligible for coverage through his/her own employer, you will be required to pay a surcharge. The surcharge will apply in addition to your regular medical contribution.

Our objective is not to force your spouse/domestic partner onto a plan that does not offer comprehensive benefits. If their employer's medical plan does not offer essential health benefits, as defined under the Patient Protection and Affordable Care Act (PPACA), we will continue to cover your spouse/domestic partner under our medical plan, and you will not be required to pay the surcharge. However, if we find that your spouse/domestic partner has comprehensive medical coverage available through his/her employer and you attest otherwise as part of your enrollment process, you will be subject to disciplinary action.

Employee Contributions

Your contributions for your insurance will be paid with pre-tax dollars. This means you usually pay no income or social security taxes on these benefits, lowering your taxable income.

The employee contribution depends on the coverage selected and number of dependents you insure. See table below for your semi-monthly insurance contribution rates effective **January 1, 2025.**

Dental	Single	Employee +1	Family
Aetna High PPO	$19.43	$37.89	$61.25
Aetna Freedom of Choice PPO / DMO	$12.67	$24.72	$39.62

Vision	Single	Employee +1	Family
EyeMed	$4.98	$9.46	$13.89

The cost shown below for the Allstate Identity Protection plan is the monthly premium. This benefit is not paid through employee payroll deductions. Participants in the Allstate Identity Protection plan pay Allstate directly upon establishment of their account. If you are interested in enrolling into this benefit, please visit www.myaip.com/barnardcollege to sign up and setup payment.

ID Protection	Single	Family
Allstate	$9.95	**$17.95**

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:

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

Cigna Medical	www.mycigna.com	(800) 244-6224
EyeMed Vision	www.eyemed.com	(866) 939-3633
Aetna Dental	www.aetnanavigator.com	(833) 382-2206
New York Life Basic Life and AD&D, Short-Term and Long-Term Disability	www.newyorklife.com	Contact the benefits and wellness team in the Office of Human Resources to file a claim
Health Advocate Employee Assistance Program (EAP)	www.healthadvocate.com/barnardcollege answers@healthadvocate.com	(877) 240-6863
Marshall+Sterling Flex Benefits FSA, DCA, HSA, Parking & Transit Spending Accounts	MSEB Flex | Marshall & Sterling Insurance	(518) 373-0069, option 4
Urban Sitter Back-Up Care	Coming Soon	
Allstate Identity Protection Pro+	www.myaip.com/barnardcollege	(800) 789-2720
Health Advocate EAP	www.healthadvocate.com/barnardcollege	(877) 240-6863
Nationwide Pet Insurance	www.petinsurance.com/barnard	(877) 738-7874

Marshall+Sterling Team barnard@marshallsterling.com

Contact our Team: (866) 573-4768

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 Barnard College.

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 for coverage starting as early as January 1.

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 Barnard College 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 Barnard College Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your Barnard College that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your Barnard College'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 Barnard College 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 Barnard College that would cover you (and not any other members of your family) is more than 9.02% of your household income for the year, or if the coverage your Barnard College 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 Barnard College, then you may lose the Barnard College contribution (if any) to the Barnard College-offered coverage. Also, this Barnard College contribution – as well as your employee contribution to Barnard College-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 Barnard College-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 Barnard College, please check your summary plan description or contact:

Dylan Flynn
Associate Director, Benefits & Employee Wellbeing (Human Resources)
3009 Broadway
New York, NY 10027
Phone Number: (212)-854-2551
benefits@barnard.edu

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.

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[1] An Barnard College-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 Barnard College 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	OAP Plan A	OAP Plan B	OAP Plan C
Deductible	$750 / $1,500	$600 / $1,200	$1,650 / $3,300
PCP Office Visit	$50 Copay, then Covered in Full	$50 Copay, then Covered in Full	20% Coinsurance after Deductible
Specialist Office Visit	$50 Copay, then Covered in Full	$50 Copay, then Covered in Full	20% Coinsurance after Deductible
Inpatient Hospital Admission	Covered in Full after Deductible	Covered in Full after Deductible	20% Coinsurance after Deductible
Emergency Room	$100 Copay, then Covered in Full	$100 Copay, then Covered in Full	20% Coinsurance 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 Barnard College 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 Barnard College 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.

Dylan Flynn
Associate Director, Benefits & Employee Wellbeing (Human Resources)
3009 Broadway
New York, NY 10027
Phone Number: (212)-854-2551
benefits@barnard.edu

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
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
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

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 Barnard College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact Marshall+Sterling at (866) 573-4768.

Marshall & Sterling Employee Benefits, Inc.
PO Box 2167
ATTN: Marshall & Sterling Employee Benefits
Omaha, NE 68103

10/31/2024

Sample Notice & Family
30 Corporate Dr
Clifton Park, NY 12065

Dear Sample Notice & Family:

GENERAL NOTICE OF YOUR RIGHTS
GROUP HEALTH CONTINUATION COVERAGE RIGHTS UNDER COBRA

THIS LETTER IS FOR YOUR INFORMATION ONLY. PLEASE RETAIN FOR FUTURE REFERENCE.
THERE HAS NOT BEEN A CHANGE IN YOUR EMPLOYMENT STATUS WITH YOUR COMPANY.

Introduction

You're getting this notice because you recently gained coverage under Barnard College group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. This notice does not fully describe COBRA or other rights under the Barnard College group health plan ("Group Health Plan"). For additional information you should review the Group Health Plan's "Summary Plan Description" or contact the Barnard College Plan Administrator at (646) 745-8352. Also, you may visit the Department of Labor website (www.dol.gov) for more information on COBRA.

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.

What is COBRA Continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee of Barnard College covered by the Group Health Plan, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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 covered by the Group Health Plan, you have the right to choose COBRA for yourself if you lose group health coverage under the Group Health Plan for any of the following reasons:

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

In the case of a dependent child of an employee covered by the Group Health Plan, he or she has the right to choose COBRA if the Group Health Plan is lost for any of the following reasons:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends with Barnard College for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare benefits (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 bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Barnard College and that bankruptcy results in the loss of coverage of any retired employee under the Group Health Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Under COBRA, the employee or a family member has the responsibility to inform the Barnard College Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Group Health Plan within 60 days of the date of the event. Barnard College has the responsibility to notify the administrator of the employee's death, termination, and reduction in hours of employment or Medicare entitlement. When the administrator is notified that one of these events has happened, the administrator will in turn notify you that you have the right to choose COBRA. Under COBRA, you have at least 60 days from the later of the date you would lose coverage because of one of the qualifying events described above or the date of notification of your rights under COBRA, whichever is later, to inform the Barnard College Plan Administrator that you want to continue coverage under COBRA.

If you elect COBRA, Barnard College is required to give you and your covered dependents, if any, coverage that is identical to the coverage provided under the plan to similarly situated employees or family members. Under COBRA, you may have to pay all or part of the premium for your continuation coverage. If you do not choose COBRA on a timely basis, your group health insurance coverage will end.

How is COBRA continuation coverage provided?

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 coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

1. The month after your employment ends; or
2. The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Health FSA Information

COBRA coverage under the Barnard College Health FSA will be offered only to Qualified Beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for the Barnard College Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Barnard College Health FSA coverage in force at the time of the qualifying event. The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and the COBRA coverage for the FSA plan will terminate at the end of the plan year. Unless otherwise elected, all qualified beneficiaries who were covered under the Barnard College Health FSA will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only with a separate Health FSA annual limit and a separate premium.

For Non-COBRA eligible Plans - Life Insurance Conversion/Portability Privilege

If you are only enrolled in a Group Life/Voluntary Life policy upon qualifying event, you will not receive a COBRA election notice, though you would have the option to continue your life insurance benefits based on the conversion or portability provision of your group/voluntary life insurance policy. There is a strict 31-day application period from your qualifying event date for conversion/portability privilege. If you are interested in continuing your coverage at that time, please contact your Life Insurance Carrier directly or reach out to HR.

Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Barnard College during the covered employee's period of employment with Barnard College is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

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.

Plan Contact Information

To ensure that all covered individuals receive information properly and timely, it is important that you notify Human Resources Department of any change in dependent status or any address change of any family member as soon as possible. Certain changes must be submitted in writing. Failure on your part to notify us of any changes may result in delayed notification or loss of continuation of coverage options.

If you have any questions about COBRA, please contact COBRA Team at (518) 373-0069 Option 5 or by email at cobra@marshallsterling.com with any questions during business hours.

Sincerely,

Marshall & Sterling Employee Benefits, Inc.

Barnard College
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT WAIVER OF ENROLLMENT NOTIFICATION REVISED 11/97

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents, if any, waive coverage due to coverage under another plan, and desire to participate in the plan offered at a later date, coverage may be subject to treatment as a late enrollee. If you decline enrollment for yourself or your dependents (including your spouse), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after such marriage, birth of a child or placement of a child for adoption.

PRE-EXISTING CONDITION EXCLUSION

A pre-existing condition is an injury or sickness which was diagnosed or treated or for which prescription medications or drugs were prescribed or taken within the six months ending on the person's date of hire. A pre-existing condition does not include pregnancy or apply to newborn children or newly adopted children. To shorten or eliminate the period of time during which the pre-existing condition applies, you have the right to provide evidence of continuous creditable coverage. Any or all of the plans that provide prior coverage must give you a Certificate of Creditable Coverage. If necessary, the insurance carrier of this employer will assist in obtaining this certificate from the prior coverage. You will be notified of any pre-existing condition exclusion period, if one applies, upon receipt of a Certificate of Creditable Coverage. Limited or no coverage is provided for eligible expenses which result from a pre-existing condition until the earlier of the date you have had continuous creditable coverage for a period of six consecutive months and have not received treatment for the pre-existing condition or the date you have had continuous creditable coverage for 12 months.

CERTIFICATE OF CREDITABLE COVERAGE

If you have a Certificate of Creditable Coverage you should attach it to your enrollment form and submit it to your group administrator for processing. If you receive the certificate after submitting your enrollment form, please forward it to your group administrator at your first opportunity.

If you have any questions about COBRA, please contact MSEB COBRA Team at (518) 373-0069 Option 5 or by email at cobra@marshallsterling.com with any questions during business hours.

Sincerely,

Marshall & Sterling Employee Benefits, Inc.

Notes

MARSHALL
+STERLING

Contact our team for all your insurance needs!

www.marshallsterling.com

- Employee Benefits
- Personal Home, Renter's & Auto
- Disability Insurance
- Long-Term Care
- Business Insurance
- Life Insurance
- Wealth Management