SWARTHMORE

2026
Swarthmore College Benefits Guidebook

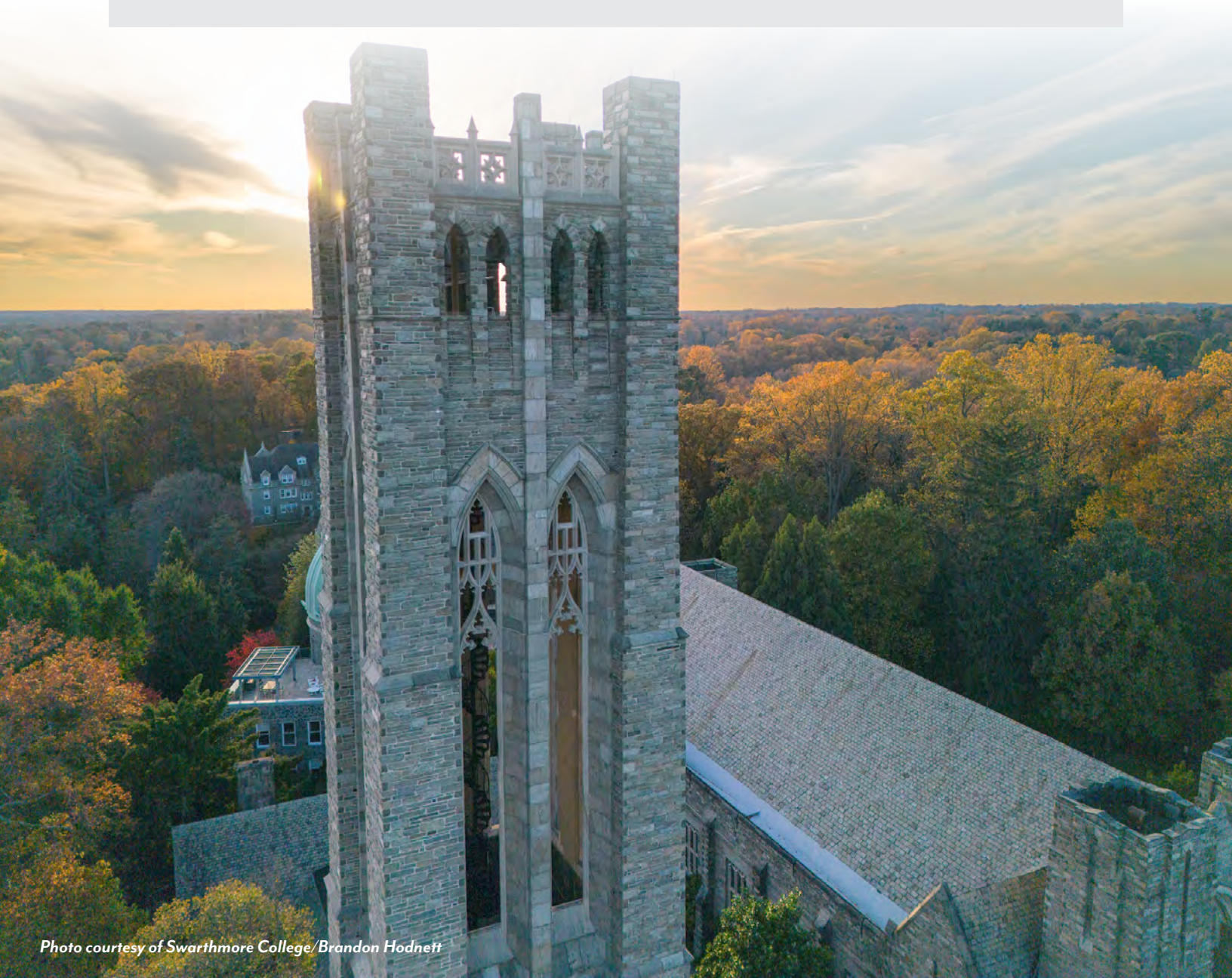

Photo courtesy of Swarthmore College/Brandon Hodnett

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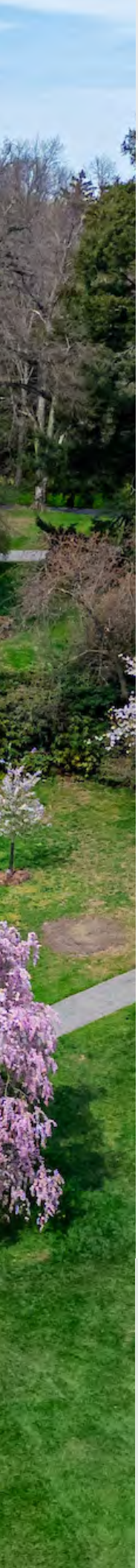
Photo courtesy of Swarthmore College/Brandon Hodnett



Welcome —

Swarthmore College is dedicated to supporting the health and well-being of our community through offering a high-quality, competitive suite of benefits that meets the varied needs of our faculty, staff members and their families at a fair and equitable cost.

Our employee benefits include an array of options, from medical, dental, and vision plans to disability and life insurance. We also offer several pre-tax savings accounts — including a Health Savings Account (HSA), Health Care and Limited Purpose Flexible Spending Accounts, Dependent Care Flexible Spending Account (FSAs), and Transportation/Parking Flexible Spending Accounts (Commuter FSAs) — to help you manage expenses for your health, childcare, and commuter needs. To further support our community members in the practice of being well we offer a variety of health and well-being resources and host events throughout the year, emphasizing the importance of preventative care.

This guidebook details our benefit offerings for 2026. You are encouraged to review it carefully as you consider what coverage options are right for you and your family and make your benefit elections for the coming year.

Please be aware that in order to participate in the Health Savings Account (HSA) or Flexible Spending Accounts (FSA) in 2026 that you are required to proactively enroll in these programs.

Our Human Resources team is available to assist you and answer any questions you may have. Please contact us by email at **benefits@swarthmore.edu** or by calling 610-328-8397.

About this Benefits Guidebook

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

Medicare Part D Creditable Coverage Disclosure Notice

If you and/or your dependent(s) have Medicare or will become eligible for Medicare in 2026, a federal law gives you more choices about your prescription drug coverage. Please refer to **page 35** for more details and share this information with your dependent(s).

Plan Rules, Dates & Eligibility —

Plan Year

The Plan Year for Swarthmore College's benefit programs begins on January 1, 2026 and ends on December 31, 2026.

Eligibility

You are considered benefit eligible if you have a regular position of 0.5 full-time equivalent (FTE), or multiple positions equal to 0.5 FTE, or greater. Benefits you elect and coverage provided by the College is effective the first day of the month following or coinciding with your first day of employment with the College, or the date you move into a benefits eligible position.

Dependent Coverage

Employees who are eligible to participate in Swarthmore College's benefit programs may also enroll their dependents. For the purposes of our benefit plans, your eligible dependents are defined as follows:

- **Your spouse:** wife/husband or domestic partner
  - For your domestic partner to be eligible for coverage, you and your partner must meet specific criteria to qualify and must complete an **Affidavit of Domestic Partnership** before the benefits effective date. It is your responsibility to update this relationship via a Life Event change in Benefitfocus. *Please note that employee premium contributions for domestic partners must be deducted from your pay on a post-tax basis.*
- **Your/your domestic partner's children: eligible children are covered to age 26 (coverage continues to the end of the calendar year following their 26th birthday)**
  - **For medical:** dependent children are eligible to age 26 regardless of student status, marital status, residency, or financial dependency
  - **For dental, vision, voluntary life and voluntary AD&D insurance:** unmarried dependent children are eligible to age 26
  - Your/your domestic partner's children age 26 and over who are mentally or physically disabled and dependent upon you for support and maintenance *(proof of condition and dependence must be submitted prior to age 26).*

Plan Rules, Dates & Eligibility —

Benefitfocus

Benefitfocus serves as the enrollment site for Swarthmore College employees' health and welfare benefits. The system simplifies the process for enrolling in and managing benefits during Open Enrollment and throughout the year. Benefitfocus is your resource to make qualified mid-year changes, as allowed by plan rules, and it acts as the document repository for such changes.

Through Benefitfocus, you can learn about your benefit options and easily enroll in medical, dental, vision and life insurance plans. You can also manage your Health Savings Account (HSA) and Flexible Spending Accounts (FSA) and more all through a single tool. When considering your medical plan choices, Benefitfocus can compare your out-of-pocket costs and payroll contributions under various plan options, to help you select the plan that is right for you.

Log into your mySwarthmore account to access the Benefitfocus portal. You can also access the portal from a mobile device by scanning the QR code to the right, or downloading the Benefitfocus mobile app (called Benefitplace) from **Google Play** or the **Apple App Store**; use the company code **Swarthmore**.

Medical Benefits —

Medical Plan Options

Swarthmore College will continue to offer employees a choice of four medical plans for 2026. The Enhanced HDHP, Basic HDHP, HMO and PPO plans will continue for 2026, and will again be administered by Independence Blue Cross (Independence).

The High Deductible Health Plans (HDHP): the Basic HDHP continues to have no payroll cost (for FT employees) and the Enhanced HDHP has a low payroll cost, as compared to the HMO and PPO plans. The HDHP's have an annual deductible that applies to all services (except preventative care) which must be met before the plan will pay benefits. These HDHPs may be paired with a Health Savings Account (HSA), which includes a contribution from the College for employees with a .75 FTE or greater. An HSA allows you to set aside funds on a pre-tax basis to pay for qualified medical care (including deductibles and copays). Refer to page 12 of this guidebook for information on Health Savings Accounts.

The **Basic HDHP** is available to employees with no payroll cost for 2026. This plan features:

- an "embedded" deductible, meaning if one family member meets the individual deductible, their deductible is satisfied for the year even if the family doesn't collectively satisfy the family deductible
- coinsurance which applies once the deductible is met; the plan will pay in-network 90% and you will pay 10% of the plan's allowed amount.

The **Enhanced HDHP** deductible works differently. Consistent with past years, this plan includes an aggregate deductible. For employees who have dependent(s) enrolled, the full family deductible must be satisfied before the plan pays benefits for non-preventive services. The individual deductible applies only to employees who do not have any dependents enrolled. When the deductible is met the plan will cover 100% of the in-network allowance, however, prescriptions will still have a copay once the deductible is met.

Enhanced HDHP and Basic HDHP deductibles and out-of-pocket maximums are combined for in-network and out-of-network expenses. Enrolling in the Health Savings Account will help to offset these out-of-pocket expenses.

Photo courtesy of Swarthmore College/Laurence Kesterson

Medical Benefits —

HDHP Preventive Prescription Drugs: both HDHPs include an enhancement to waive the deductible for a specific list of prescription drugs used for treatment of these chronic conditions: asthma, COPD, diabetes, high blood pressure, high cholesterol, mental/emotional disorders, osteoporosis, as well as pre-natal vitamins. If you are enrolled in an HDHP, login to **https://www.ibx.com/login** to access the drug formulary navigator tool to check if the deductible applies to your medications, or refer to the Basic HDHP & Enhanced HDHP Preventive Prescription Drug list from Independence, found in the Online Resources available with this Benefits Guidebook (refer to page 34).

The Keystone HMO Plan: this Health Maintenance Organization plan requires you to select a Primary Care Physician (PCP) who coordinates your care and authorizes visits to specialists or other providers for in-network services. Generally, you will pay a copay when you visit your PCP or a specialist, and when you receive a service from any other in-network provider. For certain services (x-ray, lab, podiatry, and physical/occupational therapy) your PCP is contractually required to refer you to a designated network location. Please note: referrals can be issued electronically and can be written for up to 90 days. You may change your PCP at any time, which may also change your designated network locations for the ancillary services as noted above. PCP changes must be done by calling the telephone number on the back of your medical card, or through your **Independence member portal**.

The PPO Plan: allows you and your dependents to visit the physician, specialist or hospital of your choosing without designating a PCP or obtaining referrals. Copays apply for in-network services. This plan option has a deductible and coinsurance for out-of-network services and has a higher employee payroll contribution than the other plan options.

Balance billing will apply when you use non-participating providers. Out-of-network expenses are paid at the stated percentage (after the deductible) of the lesser of the provider's charge or Medicare's allowable amount.

Medical Benefits —

In-Network Providers

Search for participating providers for all plans on the Independence website. While the PPO, Enhanced HDHP and Basic HDHP members use the Personal Choice PPO network and have access to the National BlueCard PPO network, HMO members use the Keystone HMO network. Login to **https://www.ibx.com/login** to search for participating doctors, hospitals, pharmacies, therapists, etc.

Infertility Treatment

While the benefits differ under each of our four medical plan options, each plan generally covers the same services in some way. Treatment of infertility is different in that certain services are not a covered benefit under each of our plans. Covered services for each plan include:

- **HMO:** diagnosis of infertility, counseling and artificial insemination
- **PPO:** diagnosis of infertility and counseling
- **Enhanced HDHP & Basic HDHP:** diagnosis of infertility, counseling, artificial insemination and assisted fertilization, up to a $30,000 lifetime maximum.

Livongo Diabetes Management

Livongo is designed to help individuals manage their diabetes, by understanding their blood sugar and developing healthy lifestyles to improve their glycemic control. Swarthmore members with diabetes should expect to be contacted by Livongo; members will be identified via claims submitted with a diabetes diagnosis.

Eligible members will receive a Livongo Connected Blood Glucose Meter and unlimited glucose test strips, at no cost to the member. The Blood Glucose Meter connects to the Livongo cloud for real-time data analytics and monitoring.

Prescription Drugs

Coverage for prescription drugs is included with each medical plan; benefits for in-network and out-of-network services are outlined on the following pages. Search for participating pharmacies in your area from your **https://www.ibx.com/login** account. The Independence network includes more than 68,000 retail pharmacies nationwide, including CVS, Walmart and Target.

Reminder: Each of Swarthmore's plans allows you to purchase a 90-day fill of maintenance medications at any in-network retail pharmacy. To take advantage of this convenient option, you'll need to provide the pharmacy with a script from your physician for a 90-day supply. Your cost to purchase a 90-day supply at an in-network retail pharmacy will be 3 times the copay charged for a 30-day supply (Enhanced HDHP and Basic HDHP members must satisfy their deductible before copays apply, except for those medications on the HDHP preventive prescription drug list).

Home Delivery Pharmacy

If you take a maintenance medication for a chronic condition, you may be eligible to use the Home Delivery pharmacy services to purchase a fill of up to 90 days for your prescription drug. Home delivery of medications provides the convenience of fewer trips to the pharmacy, and also saves money – you'll pay the equivalent of 2 monthly retail copays for a 3-month supply of your medication (Enhanced HDHP and Basic HDHP members must satisfy their deductible before copays apply, except for those medications on the HDHP preventive prescription drug list). Independence is the only Home Delivery pharmacy that is in-network for Swarthmore's plans.

To utilize the Independence Home Delivery Pharmacy for the first time:

- Contact your physician to request a prescription for a 90-day supply of your maintenance medication
- Complete the Independence **New Home Delivery Prescription Form**, and mail it to Independence with your physician's prescription

There's no cost for shipping unless overnight delivery is requested. To track delivery and request refills, login to **https://www.ibx.com/login**.

Specialty Drug Programs – New for 2026

Specialty drugs are used to treat complex or rare chronic conditions such as cancer, rheumatoid arthritis, psoriasis, and hepatitis C. Specialty drugs typically have special handling or administration requirements. These drugs are also the costliest type of medications on the market today. To help mitigate the high cost of these medications, two programs are being implemented with Independence Blue Cross. Through these programs, the cost of specialty drugs can be significantly reduced for both the member and Swarthmore College.

Independence Blue Cross Copay Assistance Program: If your doctor prescribes a specialty drug and the manufacturer of this drug offers a coupon or other copay assistance program, the Independence team will reach out to you to help you access the manufacturer's program. With this help, the manufacturer copay assistance program will cover most, if not all, of your out-of-pocket expenses for your specialty medication.

HelpScript: This program is specific to medical specialty drugs which are typically administered in a hospital or clinical setting. Members who participate in the HelpScript program have $0 cost share on over 200 specialty drugs.

It is important to understand that the above services are only applicable to members who are prescribed the specialty drugs covered under these programs. Additionally, this service is applicable only to employees and dependents enrolled in either the Keystone HMO or PPO plans. (Members of either the Basic or Enhanced HDHP plans are not eligible to participate.) **Only those members who are eligible to participate will receive outreach from Independence Blue Cross or HelpScript with instructions on how to participate.**

Medical Plan Features —

Telehealth

Teladoc is Independence's virtual care network providing telehealth services to all four medical plans. Telehealth services are virtual visits conducted via secure video or mobile app with a board-certified physician from the Teladoc network. Telehealth allows you and your eligible family members to address your medical concerns from the convenience of your home or office. Teladoc providers are available 24/7 to address simple medical issues (skin rash, cold/flu, pink eye, nausea, etc.); prescriptions can be written as needed.

Teladoc Health includes access to Behavioral Health and Dermatology services from Teladoc. Refer to the Medical Plan Highlights in the following pages for details on your cost for these services.

You must register and activate your account with Teladoc (visit **teladochealth.com**, or call 1-800-835-2632), so you are ready to go when the need arises for your first Telehealth visit.

For employees in the Enhanced HDHP or Basic HDHP, the 2026 cost of Teladoc services is as follows:

- General Medicine: $60
- Dermatology: $85
- Behavioral Health: $90 to $220
- Enhanced HDHP and Basic HDHP participants will pay the full cost of service until their deductible has been satisfied for the year.

Teladoc Online Primary Care – New for 2026

Starting January 1, 2026. members enrolled in the Basic HDHP, Enhanced HDHP or PPO plans can access primary care online with board-certified physicians through Teladoc Primary 360. This service can be used for:

- Annual checkups and wellness visits by phone or video
- Dedicated time with your online physician to go through your medical history and needs
- A personalized care plan to help you meet your health goals
- Referrals, prescriptions and lab orders as needed

Before you can access this care, register for Teladoc and answer questions about your health. Basic HDHP, Enhanced HDHP and PPO members can access Teladoc via the options below:

- Call 1-800-835-2362
- Visit teladochealth.com
- Download the Teladoc mobile app

NOTE: The Teladoc Online Primary Care service is not available to members of the Keystone HMO plan.

Medical Plan Features —

Preventive Care

No matter which Swarthmore College medical plan you choose, one thing is consistent with each plan option: preventive care is covered at 100%. What services are considered preventive care?

- Annual physical exam – keeping up with your annual preventive exams is an important way to stay healthy
- Seasonal Vaccines – Swarthmore's medical plans cover annual seasonal flu shots and COVID-19 immunizations at 100% if you visit an in-network provider
- Colorectal cancer screening for members age 45 and older:
  - Fecal occult blood testing – annually
  - Colonoscopy – every 10 years
- Well woman services
  - Pelvic and breast examination - annually
  - Mammogram – annually starting at age 40
  - PAP test – annually starting at age 21

This list is not all-inclusive; well child exams, routine immunizations, etc. also fall under the Preventive Care benefit.

Well-Being

Swarthmore College cares about you and your health. The College provides various opportunities to participate in well-being programs throughout the year; keep a lookout for your chance to engage in well-being activities!

Services and programs available to you include:

- **Nutrition counseling for Weight Management** - each of Swarthmore's medical plan options covers 6 visits per year, payable at 100% if services are provided by an Independence participating provider
- **Independence Healthy Lifestyles Reimbursements** – earn up to $150 back on fitness center fees, an approved weight management program, and/or for tobacco cessation assistance
- **AllOne Health's Employee Assistance Program –** access a wide range of programs including mental health support, work-life services, and life coaching (refer to page 27 for more details).

Medical Plan Highlights —

Benefit	Basic High Deductible Health Plan		Enhanced High Deductible Health Plan	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Deductible Individual / Family	$3,400 / $6,800		$2,500 / $4,500	
Out-Of-Pocket Maximum Individual / Family	$5,600 / $11,200		$5,600 / $11,200	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit Primary Care / Specialist	90% after deductible	80% after deductible	100% after deductible	80% after deductible
Teladoc Virtual Care	90% after deductible	Not Covered	100% after deductible	Not Covered
Teladoc Virtual Behavioral Health & Dermatology	90% after deductible	Not Covered	100% after deductible	Not Covered
Preventive Care	100% no deductible	80% no deductible	100% no deductible	80% no deductible
Emergency Room	90% after deductible	90% after deductible	100% after deductible	100% after deductible
Urgent Care	90% after deductible	80% after deductible	100% after deductible	80% after deductible
Diagnostic X-Ray	90% after deductible	80% after deductible	100% after deductible	80% after deductible
Laboratory	90% after deductible	80% after deductible	100% after deductible	80% after deductible
Rehabilitation Therapy[1]	90% after deductible Limit 60 visits/year[1]	80% after deductible Limit 60 visits/year[1]	100% after deductible Limit 60 visits/year[1]	80% after deductible Limit 60 visits/year[1]
Inpatient Hospitalization	90% after deductible	80% after deductible 70 inpatient days max	100% after deductible	80% after deductible 70 inpatient days max
Outpatient Surgical Facility Charges	90% after deductible	80% after deductible	100% after deductible	80% after deductible
Inpatient Mental Health Care or Substance Abuse Treatment	90% after deductible	80% after deductible 70 inpatient days max	100% after deductible	80% after deductible 70 inpatient days max
Outpatient Mental Health Care or Substance Abuse Treatment *(Facility & Clinic)*	90% after deductible	80% after deductible	100% after deductible	80% after deductible
Prescription Retail *(30 Day)* Generic Brand Non-Formulary	(after deductible) $10 copay $25 copay $45 copay	50% after deductible	(after deductible) $10 copay $25 copay $45 copay	50% after deductible
Prescription Mail Order *(90 Day)* Generic Brand Non-Formulary	(after deductible) $20 copay $50 copay $90 copay	Not Covered	(after deductible) $20 copay $50 copay $90 copay	Not Covered

If you use out-of-network providers, Independence will pay the lesser of the Medicare Allowable Payment or the provider's charge for services rendered. The provider has the right to balance bill you the difference.

[1] Limits for Physical, Occupational and Speech Therapy are combined for in and out-of-network services. Enhanced HDHP and Basic HDHP limits are combined for Physical and Occupational Therapy.

[2] Refer to page 4 for a description of how the Enhanced HDHP and Basic HDHP plans' deductibles apply differently for those with family coverage.

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

Medical Plan Highlights —

Benefit	Keystone HMO Plan	Personal Choice PPO Plan	
	In-Network Only	In-Network	Out-Of-Network*
Deductible Individual / Family	None	$0 / $0	$500 / $1,000
Out-Of-Pocket Maximum Individual / Family	$1,000 / $2,000	$1,500 / $3,000	$3,000 / $6,000
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Office Visit Primary Care / Specialist	$15 copay / $25 copay	$25 copay / $40 copay	70% after deductible
Teladoc Virtual Care	$5 copay	$5 copay	Not Covered
Teladoc Virtual Behavioral Health & Dermatology	$15 copay	$15 copay	Not Covered
Preventive Care	100% covered	100% covered	70% no deductible
Emergency Room	$150 copay *(waived if admitted)*	$150 copay *(waived if admitted)*	$150 copay *(waived if admitted)*
Urgent Care	$15 copay	$15 copay	70% after deductible
Diagnostic X-Ray	100% covered	$40 copay	70% after deductible
Laboratory	100% covered	100% covered	70% after deductible
Rehabilitation Therapy[1]	100% covered Limit 60 consecutive days/ condition/year[1]	Visits 1 – 30: $25 copay Visits 31+: $40 copay Limit 60 visits/year[1]	70% after deductible Limit 60 visits/year[1]
Inpatient Hospitalization	$100 copay/day $500 maximum/admission	$150 copay/day $750 maximum/admission	70% after deductible 70 inpatient days maximum
Outpatient Surgical Facility Charges	$50 copay	$150 copay	70% after deductible
Inpatient Mental Health Care or Substance Abuse Treatment	$100 copay/day $500 maximum/admission	$150 copay/day $750 maximum/admission	70% after deductible 70 inpatient days max
Outpatient Mental Health Care or Substance Abuse Treatment *(Facility & Clinic)*	$25 copay	$40 copay	70% after deductible
Prescription Retail *(30 Day)* Generic Brand Non-Formulary	 $15 copay $35 copay $50 copay	 $15 copay $35 copay $50 copay	Covered 30% at a non-participating pharmacy
Prescription Mail Order *(90 Day)* Generic Brand Non-Formulary	 $30 copay $70 copay $100 copay	 $30 copay $70 copay $100 copay	Not Covered

If you use out-of-network providers, Independence will pay the lesser of the Medicare Allowable Payment or the provider's charge for services rendered. The provider has the right to balance bill you the difference.

[1] Limits for Physical, Occupational and Speech Therapy are combined for in and out-of-network services. HMO and PPO limits are combined for Physical, Occupational and Speech Therapy.

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

Health Savings Account (HSA) —

If you enroll in the Enhanced High Deductible Health Plan or Basic High Deductible Health Plan (HDHP), you may be eligible to open an Health Savings Account (HSA). An HSA allows you to save pre-tax money through payroll deductions and to use those funds to pay for qualified medical expenses for you and your family (tax dependents). Qualified medical expenses include deductibles, copays, and coinsurance, as well as out-of-pocket expenses for dental and vision care. HSA funds can also be used to pay for retiree health care expenses, and COBRA premiums if you are no longer employed. You are not required to make your own HSA contributions, but you must enroll in the HSA, in Benefitfocus, to receive the College's HSA contribution, for employees with a .75 FTE or greater.

To be eligible for an HSA, you must be enrolled in an IRS-qualified HDHP, and you cannot have any other non-HDHP health coverage. This includes Medicare (parts A, B, C and D), Medicaid, coverage through your spouse's or domestic partner's employer, or a Health Care Flexible Spending Account. If your eligibility status changes and you don't meet these criteria, you can still use the funds you've accumulated in your HSA, but you and your employer cannot contribute to your HSA.

Important Details Regarding HSAs

- An HSA is a bank account that is owned and controlled by you.
- When you enroll in an HDHP with Independence, you may also elect to enroll in an HSA via Benefitfocus and an account will be set-up for you with WealthCare Saver. **You must activate and set up your WealthCare account and debit card to be able to receive HSA contributions.**
- HSA contributions are made through pre-tax payroll deductions; you may also deposit directly (outside of payroll deductions). Total HSA contributions (through payroll and outside payroll) cannot exceed the annual IRS contribution limit. Employee contribution amounts can be changed on a monthly basis in Benefitfocus throughout the benefit plan year.
- You will never forfeit money you have deposited. Unused funds remain in your account and roll over year after year.
- Once your HSA balance exceeds $500, amounts over $500 may be invested though investment options offered by WealthCare. You must retain a minimum of $500 in uninvested HSA funds.
- If you ever leave Swarthmore College, or disenroll from a Swarthmore HDHP, you may keep your account.
- Your HSA can be accessed online at **https://www.ibx.com/login**; where you can access your account balance, transaction history and access online bill pay services to pay providers directly from your Health Savings Account.
- HSA Account Holders will receive an HSA debit card which can be used to pay for eligible expenses, including:
  - Eligible health care expenses not otherwise paid for by insurance
  - Expenses applied to your plan deductible, copays, and coinsurance
  - Over the counter medications
  - Dental and vision expenses not reimbursed by insurance.
- HSA funds can be used to pay for eligible expenses for you and your tax dependents. Your domestic partner may not use your HSA funds, but if they are enrolled in your HDHP plan may be able to establish their own HSA through a bank of their choosing.
- **Important:** WealthCare Saver will not request receipts to substantiate your HSA purchases. It is the HSA account holder's responsibility to use HSA funds for eligible expenses, and to retain receipts for all HSA expenditures with your tax records.
- **You must enroll in the HSA each year; your election will not carry forward to the next plan year.**

Health Savings Account (HSA) —

2026 HSA Contribution Limits

The maximum amount that can be contributed to your HSA in 2026 is:

- $4,400 for employee only HDHP coverage
- $8,750 for all other HDHP coverage tiers (special rules apply if you cover a non-tax dependent)
- For HSA account holders age 55 or older, you may also make an annual catch-up contribution of up to $1,000.

These maximum amounts include any HSA contribution the College makes on your behalf.

Both the **Enhanced HDHP** and **Basic HDHP** provide participants who are 0.75 FTE or higher with the same **HSA** contribution from the College:

- $1,000 for Employee Only coverage
- $2,000 if you enroll one or more dependents

Half of this contribution is made in January, and the balance is deposited in July. The College contribution amount is prorated and the pay dates will differ if your benefit eligibility date is after January 1st.

There is no HSA contribution from the College for those who are less than 0.75 FTE.

Important Note: Even if you do not wish to contribute to an HSA, you may still be eligible to receive the HSA contribution that the College makes on your behalf, but you must enroll in the HSA in Benefitfocus to receive the College contribution.

Are You Eligible for Medicare?

- If you are enrolled in any part of Medicare (parts A, B, C or D), you are not eligible to contribute to an HSA.
- If you enroll in Medicare during the year, you may not contribute the full annual amounts as noted above; your contribution limit is prorated based on the number of months during the year for which you were HSA eligible.
  - **Example:** Your Medicare Part A coverage is effective July 1. This means you are eligible to contribute to an HSA for 50% of the year. Your contribution limit for the year is 50% of the applicable annual limit noted above (including 50% of the catch-up contribution).
- If you enroll in Medicare after age 65 (i.e., your Medicare effective date is after you become Medicare-eligible at age 65), Medicare will be effective retro-actively to the later of the first of the month in which you reached age 65, or 6 months.
  - **Example:** You reach age 65 on January 15, and enroll in Medicare on July 1. Your Medicare coverage will be effective January 1. This means that as of January 1 you are no longer eligible to make contributions to your HSA.
- If you enroll in Medicare, contact Swarthmore's Benefits Team at **benefits@swarthmore.edu** (or call 610-328-8397) as you must enroll in a medical plan option suitable for Medicare participants.

Please note – You may not be required to enroll in Medicare at age 65 if you are still actively working for Swarthmore College. To learn more, please visit the Medicare.gov website via the link below.

Medicare.gov – Working Past 65

Dental Benefits —

Dental Plan Options

Swarthmore College offers employees a choice of two Dental Plans through Delta Dental: The Basic Plan and the Enhanced Plan. The Basic Plan provides coverage for preventive care, as well as basic services and endodontics, but does not provide any coverage for major services or orthodontia. The Enhanced Plan provides coverage for preventive care, basic care, major restorative care. The Enhanced Plan also includes orthodontia coverage for employees, spouses, and domestic partners, as well as dependent children up to age 26.

Both plans grant you the freedom to obtain services from an in-network, participating Delta Dental provider, or an out-of-network provider. The level of benefits is the same for in and out-of-network services; however, utilizing a participating (in-network) dentist may result in savings for you because participating dentists have agreed to accept the insurance carrier's fees as full payment for covered services. There is no balance billing for covered services provided by a participating dentist, so you will usually pay the least when you visit an in-network PPO dentist.

The Diagnostic & Preventive (D&P) Maximum Waiver benefit applies to both plans, meaning most diagnostic and preventive services will not affect your annual plan maximum. Claims paid for services such as routine exams, cleanings and x-rays will not accumulate towards your yearly benefit limit, allowing you to get the most from your dental plan.

Looking for a Dentist?

Visit: **www.deltadentalins.com**. On the homepage, complete the information under "**Find a Dentist**." Select either the Delta Dental PPO or Delta Dental Premier Network. Both networks are available to Swarthmore members, but Delta Dental PPO dentists provide you with the greatest discounts.

Be sure to download the Delta Dental mobile app from the **App Store** or **Google Play**.

Dental Benefits —

Benefit	Basic Dental		Enhanced Dental	
	In-Network*	Out-of-Network*	In-Network*	Out-of-Network*
Calendar Year Maximum	$1,000 per person per year		$2,000 per person per year	
Diagnostic & Preventive: Exams, cleaning, x-rays, sealants	100% Most Diagnostic & Preventive services do not count towards the Calendar Year Maximum		100% Most Diagnostic & Preventive services do not count towards the Calendar Year Maximum	
Basic Services: Fillings, denture repair, stainless steel crowns, posterior composites	100%		100%	
Endodontics: Root canals	100%	100%	100%	100%
Periodontics: Gum treatments	Not covered	Not covered	50%	50%
Oral Surgery	Not covered	Not covered	100%	100%
Major Services: Crowns, inlays, onlays, cast restoration	Not covered	Not covered	50%	50%
Prosthodontics: Bridges and dentures, implants	Not covered	Not covered	50%	50%
Orthodontics Benefits: Adults, dependent children up to age 26	Not covered	Not covered	50%	50%
Orthodontia Maximum	Not covered	Not covered	$2,000 Lifetime	

Reimbursement is based upon PPO contracted fees for PPO dentists; Premier contracted fees for Premier dentists; and Premier contracted fees for non-Delta Dental dentists.
Note: This chart is a summary of benefit options offered under the plan. For more information, please refer to the plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

Photo courtesy of Swarthmore College/Brandon Hodnett

Vision Benefits —

Photo courtesy of Swarthmore College/Brandon Hodnett

Vision Plan Options

Swarthmore College offers vision coverage through Independence, administered by Davis Vision. Employees have a choice of two vision plans: the Basic plan and the Enhanced plan (formerly named the Buy-Up plan). Each plan provides substantial savings on your eye-care purchases. Services are available through thousands of provider locations participating in the Davis Vision network. Go to **www.davisvision.com** or call **1-800-999-5431** to find a nearby provider.

Be sure to download the Davis Vision mobile app from the **App Store** or **Google Play**.

Benefit	Basic		Enhanced	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Examination	100% covered	$35 reimbursement	100% covered	$35 reimbursement
Frames	100% covered for Fashion & Designer Collection, $20 copay for Premier Collection, $60 allowance for Visionworks & Non-Collection frames	$75 reimbursement for covered frames and lenses	100% covered for Fashion, Designer & Premier Collection, $100 allowance for Visionworks & Non-Collection frames	$175 reimbursement for covered frames and lenses
Eyeglass Lenses: Standard Lenses, single vision, bifocal, trifocal, lenticular	100% covered	$75 reimbursement for covered frames and lenses	100% covered	$175 reimbursement for covered frames and lenses
Eyeglass Lens Options: Glass grey #3 prescription, tinting	100% covered	Not Covered	100% covered	Not Covered
Contact Lens, Including Evaluation and Fitting[1]	$75 allowance	$75 reimbursement	$175 allowance	$175 reimbursement
Exam Frequency	Once every 24 months		Once every 12 months	
Hardware Frequency	Once every 24 months		Once every 12 months	

[1]Allowances for Contact Lenses are in-lieu of allowances for eyeglass frames and lenses.
Note: This chart is a summary of benefit options offered under the plan. For more information, please refer to the plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern.

Employee Payroll Contributions —
(Full-Time)

Medical Plans (Full-Time Employees*)

For the 2026 plan year, for eligible employees who are 0.75 FTE or higher and are enrolled in the Basic HDHP or the Enhanced HDHP, the College will contribute to your HSA: $1,000 if you enroll with Employee Only coverage or $2,000 if you cover one or more dependents, paid in 2 equal semi-annual deposits. This is in addition to the College's costs for the HDHPs shown below; amounts are prorated if your benefit eligibility is after January 1st. There is no employee or employer contribution to a Health Savings Account for those enrolled in the HMO or PPO.

Coverage Tier	Basic High Deductible Health Plan			Enhanced High Deductible Health Plan		
	Monthly College Cost	Employee Payroll Cost		Monthly College Cost	Employee Payroll Cost	
		Monthly	Semi-Monthly		Monthly	Semi-Monthly
Employee Only	$881.66	$0.00	$0.00	$942.73	$13.96	$6.98
Employee & Child	$1,340.13	$0.00	$0.00	$1,424.78	$27.92	$13.96
Employee & Children	$1,932.58	$0.00	$0.00	$2,027.90	$69.80	$34.90
Employee & Spouse/ Partner	$2,017.23	$0.00	$0.00	$2,085.14	$104.70	$52.35
Family	$2,601.24	$0.00	$0.00	$2,686.03	$139.60	$69.80

Coverage Tier	Keystone HMO Plan			Personal Choice PPO Plan		
	Monthly College Cost	Employee Payroll Cost		Monthly College Cost	Employee Payroll Cost	
		Monthly	Semi-Monthly		Monthly	Semi-Monthly
Employee Only	$899.02	$41.88	$20.94	$738.75	$263.43	$131.72
Employee & Child	$1,344.34	$67.01	$33.51	$691.63	$811.63	$405.82
Employee & Children	$1,870.64	$199.35	$99.68	$1,272.11	$932.67	$466.34
Employee & Spouse/ Partner	$1,822.34	$341.74	$170.87	$1,286.89	$1,018.10	$509.05
Family	$2,149.64	$663.66	$331.83	$1,928.55	$1,067.94	$533.97

Employees who are paid bi-weekly will have the medical deduction withheld on a semi-monthly basis over 24 pays.

Employee Payroll Contributions —
(Part-Time)

Medical Plans (Part-Time Employees*)

For the 2026 plan year, the following payroll costs apply for eligible employees who are 0.50 to 0.74 FTE.

Coverage Tier	Basic High Deductible Health Plan			Enhanced High Deductible Health Plan		
	Monthly College Cost	Employee Payroll Cost		Monthly College Cost	Employee Payroll Cost	
		Monthly	Semi-Monthly		Monthly	Semi-Monthly
Employee Only	$824.39	$57.27	$28.64	$877.00	$79.69	$39.85
Employee & Child	$1,169.65	$170.48	$85.24	$1,241.08	$211.62	$105.81
Employee & Children	$1,749.96	$182.62	$91.31	$1,860.72	$236.98	$118.49
Employee & Spouse/ Partner	$1,784.48	$232.75	$116.38	$1,896.54	$293.29	$146.65
Family	$2,353,39	$247.85	$123.93	$2,503.93	$321.70	$160.85

Coverage Tier	Keystone HMO Plan			Personal Choice PPO Plan		
	Monthly College Cost	Employee Payroll Cost		Monthly College Cost	Employee Payroll Cost	
		Monthly	Semi-Monthly		Monthly	Semi-Monthly
Employee Only	$899.02	$41.88	$20.94	$503.37	$498.81	$249.41
Employee & Child	$999.98	$411.37	$205.69	$293.77	$1,209.49	$604.75
Employee & Children	$1,486.99	$583.00	$291.50	$824.80	$1,379.98	$689.99
Employee & Spouse/ Partner	$1,469.06	$695.02	$347.51	$787.55	$1,517.44	$758.72
Family	$1,694.02	$1,119.28	$559.64	$1,430.22	$1,566.27	$783.14

Employees who are paid bi-weekly will have the medical deduction withheld on a semi-monthly basis over 24 pays.

Photo courtesy of Swarthmore College/Laurence Kesterson

Employee Payroll Contributions —
(Dental & Vision)

Dental Plan (Full-Time and Part-Time Employees*)

The College provides Basic Dental at no cost to you.

Coverage Tier	Enhanced Dental Plan		
	Monthly College Cost	Employee Payroll Cost	
		Monthly	Semi-Monthly
Employee Only	$22.28	$17.62	$8.81
Employee & Child	$59.82	$46.57	$23.29
Employee & Children	$59.82	$46.57	$23.29
Employee & Spouse/Partner	$59.82	$46.57	$23.29
Family	$59.82	$46.57	$23.29

Vision Plan (Full-Time and Part-Time Employees*)

The College provides Basic Vision at no cost to you.

Coverage Tier	Enhanced Vision Plan		
	Monthly College Cost	Employee Payroll Cost	
		Monthly	Semi-Monthly
Employee Only	$4.35	$1.79	$0.90
Employee & Child	$11.29	$4.58	$2.29
Employee & Children	$11.29	$4.58	$2.29
Employee & Spouse/Partner	$11.29	$4.58	$2.29
Family	$11.29	$4.58	$2.29

Employees who are paid bi-weekly will have the dental and vision deductions withheld on a semi-monthly basis over 24 pays

Photo courtesy of Swarthmore College/Laurence Kesterson

Life and Disability —

Basic Life and AD&D Insurance

Swarthmore College provides benefit eligible employees who are 0.5 FTE or greater with Basic Life and AD&D Insurance of 1.5 times their annual earnings to a maximum of $200,000. Symetra insures these coverages for the College. Both coverages are 100% paid for by the College.

Supplemental Life & AD&D Insurance

Employees may elect to purchase supplemental life and/or supplemental AD&D insurance. Coverage is available up to the lesser of 5 times your annual earnings or $750,000 ($10,000 minimum). The cost of supplemental life coverage is dependent upon your age at the time you enroll and the amount of coverage you elect. Supplemental life premiums are based on 5-year age brackets (refer to page 22). Your payroll contribution for supplemental life will increase during the plan year (at date of birth) should your new age put you in a new rate bracket.

You must complete and submit Symetra's Evidence of Insurability (EOI) Questionnaire when:

- Electing supplemental life insurance in excess of the lesser of 3 times Annual Earnings or $200,000;
- Requesting an increase of coverage by more than one multiple of Annual Earnings; or
- Electing coverage for the first time more than 31 days after you are first eligible (only permitted during open enrollment or within 31 days of a Qualifying Life Event).

Amounts of coverage requested after an individual's initial eligibility will not be effective until evidence of insurability is submitted and approved.

Enrollment rules for the Annual Enrollment period are as follows:

- Eligible employees who are currently enrolled may increase coverage by one increment of earnings, up to the lesser of 3 times Annual Earnings or $200,000, without submission of an EOI Questionnaire.
- Eligible employees who are not currently enrolled who are past their initial enrollment period must submit an EOI Questionnaire for approval for any amount of coverage.
- Employees or dependents previously denied are not eligible for the annual enrollment opportunity.

Supplemental life coverage subject to EOI will be effective when approved by Symetra. The maximum employee supplemental life benefit for employees is the lesser of 5 times salary or $750,000.

For EOI requirements that apply outside of Annual Enrollment, please refer to the **Symetra Life and AD&D Insurance certificate** for details.

Spouse Life Insurance Coverage

Employees may also purchase life insurance for their spouse or domestic partner in $5,000 increments up to the lesser of $100,000 or the amount of the employee's supplemental life insurance. As with employee supplemental life insurance, coverage for your spouse is dependent upon your spouse's age at the time they are enrolled, and the amount of coverage elected. Supplemental life premiums for your spouse's coverage are based on 5-year age brackets (refer to page 22). Your payroll contribution for spouse supplemental life will increase during the plan year (at date of birth) should your spouse's new age put them in a new rate bracket.

Symetra's EOI Questionnaire must be completed when spouse or domestic partner life insurance coverage is elected:

- In excess of $25,000; or
- For the first time more than 31 days after initially becoming eligible (only permitted during Open Enrollment or within 31 days of a Qualifying Life Event).

Employees must purchase supplemental life insurance for themselves in order to enroll their spouse or domestic partner. During the Annual Enrollment period, coverage for an employee's spouse or domestic partner who is currently enrolled may be increased by one $5,000 increment, not to exceed a total coverage amount of $25,000, without having to submit an EOI Questionnaire.

Dependent Child(ren) Life Insurance Coverage

You may purchase insurance for your/your domestic partner's dependent children in increments of $5,000 to a maximum of $20,000, but not more than the amount of the employee's life insurance. Unmarried children are eligible up to age 26. Employees must purchase supplemental life insurance for themselves to purchase coverage for their child(ren). The cost of this coverage is the same if you cover one or more children. Unlike coverage for you or your spouse or domestic partner, the cost of this coverage is a flat rate per each $1,000 of coverage (it is not rated based on age).

Supplemental Accidental Death & Dismemberment (AD&D) Coverage

You may purchase Supplemental AD&D coverage for yourself for an amount up to the lesser of 5 times your annual salary or $750,000. You may also elect Family Supplemental AD&D coverage, where the benefit amount for your dependents is a percentage of the benefit you elect for yourself:

- Spouse only: 50% of employee supplemental AD&D coverage, up to a maximum of $375,000
- Child(ren) only: 15% of employee supplemental AD&D coverage, up to a maximum of $50,000
- Spouse and child(ren):
  - Spouse benefit: 40% of employee supplemental AD&D coverage, up to a maximum of $300,000
  - Child(ren) benefit: 10% of employee supplemental AD&D coverage, up to a maximum of $50,000

Employees must purchase Supplemental AD&D insurance for themselves in order to enroll their spouse, domestic partner or children.

Beneficiaries must be added in Benefitfocus for each enrolled benefit for Basic Life/AD&D, Voluntary Employee Life, and Voluntary AD&D. Benefitfocus is the only system of record for your beneficiaries for these benefits.

Life and AD&D Premium Rates —

Voluntary Life Coverage for You*

	Monthly Rates per $1,000 of Coverage
Under Age 30	$0.060
Age 30 to 34	$0.080
Age 35 to 39	$0.092
Age 40 to 44	$0.110
Age 45 to 49	$0.173
Age 50 to 54	$0.265
Age 55 to 59	$0.495
Age 60 to 64	$0.702
Age 65 to 69	$1.334
Age 70 and over	$2.070

Voluntary Life Coverage for Your Spouse or Domestic Partner*

	Monthly Rates per $1,000 of Coverage
Under Age 30	$0.060
Age 30 to 34	$0.081
Age 35 to 39	$0.092
Age 40 to 44	$0.110
Age 45 to 49	$0.161
Age 50 to 54	$0.299
Age 55 to 59	$0.483
Age 60 to 64	$0.840
Age 65 to 69	$1.461
Age 70 and over	$2.300

Voluntary Life Coverage for Your Dependent Children*

	Monthly Rate per $1,000 of Coverage
Up to age 26	$0.10

Voluntary AD&D Coverage for You and Your Family*

	Monthly Rates per $1,000 of Coverage
Employee Only	$0.013
Employee and Family	$0.022

Employees who are paid bi-weekly will only have life and accidental death & dismemberment benefits and/or imputed income amounts withheld from the first paycheck of the month. These are not withheld for the 2nd and 3rd pay dates in a month.

Life and Disability —

Staff Short Term Disability/Salary Continuation Plan

Swarthmore College provides benefit eligible employees of 0.5 or greater with Short Term Disability (STD) coverage, effective the 1st of the month following or coinciding with your date of hire or the date you move into a benefits-eligible position. If you are disabled and unable to work, you may be eligible for continuation of income under the Salary Continuation Plan (SCP). Benefit eligible employees are eligible for the SCP on the 61st day of employment. Salary Continuation benefits begin on the 3rd week of disability due to a non-work related illness or injury and are payable for up to 26 weeks (including the initial 14 days of disability). Accrued sick and/or vacation days are paid during the first 2 weeks of disability leave. If all accrued sick and/or vacation days have been exhausted, the first 2 weeks will be unpaid. The benefit you receive varies based upon the length of your disability absence and your length of service with Swarthmore College.

Weeks of Disability	Benefit
Weeks 1 - 2	Accrued sick and/or vacation days
Weeks 3 - 13	61 days to 48 months of service: 75% of base pay 48 months (or more) of service: 100% of base pay
Weeks 14- 26	60% of base pay

Long Term Disability

Long Term Disability (LTD) insurance is purchased by the College for all benefit eligible employees of 0.75 FTE or greater. LTD insurance provides a continuation of income if you are disabled and unable to return to work after six months. The LTD benefit is 60% of your base salary, payable up to your maximum monthly benefit; the duration of these benefits is based upon your ongoing disability status and your age at the time your disability began.

LTD premiums are based upon your salary and your maximum available LTD benefit. For employees who are enrolled for payment of LTD premiums on an after-tax basis, the College will add the value of the premium to your paycheck (subject to taxes), then deduct the cost of coverage, thus, allowing you to pay the tax on the value of the premium **and receive a tax-free LTD benefit**. Employees who do not pay the tax on the value of the LTD premium (pre-tax option), any LTD benefits paid to you will be subject to applicable income taxes.

For more details, refer to the **Taxation Explanation Document** found on the Human Resources homepage.

- **Pre-tax Option:**

  This option is only available to employees who were enrolled prior to November 2014. In the event that LTD benefits are payable, the payments you receive will be subject to applicable income taxes.

- **Post-tax Option:**

  You pay taxes on the premiums the College pays on your behalf. As a result, if you receive LTD benefits the income you receive will not be federally taxable. The post-tax option is a permanent election and applies to all employees hired after November 2014.

Disability Claim Process

When you will be out of work due to illness or injury, please contact **benefits@swarthmore.edu** and/or the Provost office (**provost@swarthmore.edu**) for information on the claim process.

Symetra Employee Assistance Program (EAP)

As an employee of Swarthmore College, you and your family members have access to Disability Guidance, Symetra's Employee Assistance Program (EAP). These services are provided to you at no cost. Included in Disability Guidance are 5 counseling sessions per year (plus an additional 5 sessions with a covered disability claim). To learn more, review the EAP program flyer posted in the online resources section of this guidebook (page 34). Two new services available with Disability Guidance are highlighted below:

Well-being coaching – New for 2026:

One-on-one phone or video coaching is available to help you identify and work toward your personal goals, with a focus on overall well-being, balance and success. Using evidence-based strategies, certified coaches will guide you to initiate positive and sustainable behavior changes aligned with your core values.

Computerized cognitive behavioral therapy (CCBT) – New for 2026:

This EAP program gives you access to an app-based platform with digital self-care tools that directly address behavioral health issues in a user-friendly way. Guided programs can help users overcome common behavioral health challenges like anxiety, depression, stress, trauma, insomnia and more.

To access the Disability Guidance EAP:

- Call: 1-888-327-9573
- Online: **guidanceresources.com**
- Web ID: SYMETRA

Flexible Spending Accounts —

Health care, limited purpose, dependent care, and commuter spending accounts all require enrollment each year. Your election will not roll over to the new plan year.

Health Care FSA

A Health Care Flexible Spending Account (HCFSA), administered by Inspira Financial, provides you with the ability to save money on a pre-tax basis to pay for any IRS-allowed medical, prescription drug, dental or vision expenses that are not otherwise covered by insurance. Examples of these types of expenses include:

- Deductibles, copayments and coinsurance,
- Expenses for medical services or supplies not paid for by your insurance plan,
- Dental, vision and hearing care expenses not otherwise paid by insurance,
- Over the counter medications, including feminine menstrual care products (no prescription required).

Your annual contribution of up to the maximum permitted by the IRS ($3,400) is divided by your number of pay periods and that amount will be deducted each pay period on a pre-tax basis, reducing your taxable income. The amount you elect may not be changed or revoked during the plan year unless you experience a qualifying life event. You may not transfer funds between a Health Care FSA and a Dependent Care FSA.

Carryovers: Unused balances of up to the maximum permitted by the IRS (20% of the annual election maximum, or $680) will carry over to the next plan year. Unused balances that exceed the carryover limit will be forfeited (use it or lose it).

Limited Purpose FSA

If you enroll in the Enhanced HDHP or Basic HDHP medical plan and have a Health Savings Account (HSA), IRS eligibility rules for HSAs do not allow you to have a Health Care FSA.

If you enroll in either HDHP and would like an FSA, a Limited Purpose (LPFSA) is the solution. This type of FSA is available for reimbursement of dental and vision expenses only. In every other way this works just like the Health Care FSA, but eligible expenses are limited to eligible dental and vision expenses that are not paid or covered by insurance. The Limited Purpose FSA will not reimburse any medical or pharmacy expenses.

If you want to want to maximize your HSA savings and watch your HSA balance grow, a Limited Purpose FSA may be a valuable benefit to you. The IRS limit for Limited Purpose FSA contributions is $3,400 annually.

Carryovers: Unused balances of up to the maximum permitted by the IRS (20% of the annual election maximum, or $680) will carry over to the next plan year. Unused balances that exceed the carryover limit will be forfeited (use it or lose it).

Dependent Care FSA

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

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

Flexible Spending Accounts —

Dependent Care FSA continued:

For the 2026 Plan Year, the maximum amount that you may contribute to a Dependent Care FSA is $7,500. The IRS has set the maximum allowable contribution per calendar year for a Dependent Care Flexible Spending Account as follows:

- $7,500 for a married couple filing jointly
- $7,500 for a single parent
- $3,750 for a married person filing separately

Carryovers are not permitted for Dependent Care Savings Accounts; unused funds not claimed prior to the end of the run-out period (through March 31, 2027) will be forfeited (use it or lose it). Please note that Inspira Financial does not issue a debit card for use with the Dependent Care FSA, you must submit receipts for reimbursement via the Inspira Financial portal or mobile app.

Commuter Benefits

The Commuter Benefit plan allows you to set aside money on a pre-tax basis to pay for parking or mass transit expenses as necessary for your commute to and from work. Funds remaining in your Transit and/or Parking accounts roll over from year to year for active employees. You may change your enrollment or election amount for the parking and/or transit benefit monthly during the plan year in Benefitfocus; this election is not limited to the open enrollment period. Should you leave Swarthmore, any unused Transit or Parking funds will be forfeited.

You may contribute up to the maximum permitted by the IRS ($340 per month) into a Parking and/or Transit account. If you are electing to contribute the maximum monthly contribution for your Transit FSA, you will need to reduce that amount by the monthly amount you are contributing towards your **Faculty and Staff SEPTA Key Advantage UPass Pilot Program**. Transit FSA funds cannot be used to pay for the College's SEPTA Key Advantage UPass.

Debit Card

FSA participants will receive an FSA debit card which can be used for:

- Qualified health care expenses
- Over the counter medications
- Eligible transit and parking expenses
- Limited Purpose FSA dental and vision expenses

Re-Enrollment

If you participated in an FSA account last year and want to participate again for the upcoming plan year, you must re-enroll and specify your annual election in Benefitfocus. Your election from the last plan year WILL NOT carry over to the new plan year.

Each plan year, Swarthmore allows you to elect up to the maximum permitted by the IRS ($3,400 in 2026).

Eligible Expenses

FSA accounts may only reimburse for eligible expenses that are incurred during the plan year (coverage period). An expense is considered incurred when the service is provided and not when payment is rendered by the participant for that service. An expense incurred before or after the plan year (coverage period) is not reimbursable.

Claims Submission

You will have until March 31, 2027 to submit claims for reimbursement for expenses incurred between January 1, 2026 and December 31, 2026. Except for permissible FSA carryover amounts, unused balances will be forfeited if not claimed before March 31, 2027 (use it or lose it).

Mobile App

Be sure to download the Inspira Financial mobile app from the **App Store** or **Google Play**

FSA Claim Substantiation

All claims must be substantiated through the Inspira mobile app or online member portal, by providing a detailed receipt for each FSA claim, even if you are using your FSA debit card at the time of service.

Additional Benefits —

AllOne Health Employee Assistance Plan (EAP)

Just when you think you have life figured out, along comes a challenge. Whether those challenges are big or small, the AllOne Health Employee Assistance Program (formerly known as Carebridge EAP) is available to help you and your family find a solution and restore your peace of mind. Take advantage of the following services that are available to you and your family[1]:

- Basic clinical and work/life support by phone or web
- Up to seven free face-to-face and/or virtual sessions per issue, per 12-months for each family member with licensed behavioral clinicians
- 24/7 phone consultation with an AllOne Health licensed clinician
- Monthly phone seminars on relevant topics
- Unlimited access to online research and other key resources related to emotional well-being, health, relationships, legal, financial and personal/professional growth
- Life events research and qualified referrals (i.e., childcare and eldercare providers)
- The EAP services are available at no cost to you, and are completely confidential.

[1]The EAP is available to all Swarthmore College employees. Eligible family members include any related individual residing in the employee's household, and any children up to age 26 living outside of the household.

24/7 Assistance

You can access AllOne Health's Employee Assistance Program by calling toll-free any time, any day.

For Personal Assistance:

Call AllOne Health at 1.800.451.1834

Visit the AllOne Health website at **www.AllOneHealth.com** for helpful information. When registering, enter Swarthmore College's access code: **YXDEY**

Health Advocate

Health Advocate understands the intricacies of the health care and insurance worlds. They also know how to make health care work for you and your family. It is easy to get help. All you need to do is make one phone call and Health Advocate will take care of the rest. Your Health Advocate benefit can be accessed 24/7. Normal business hours are Monday - Friday, between 8 am and 8 pm Eastern Time. Staff is available for assistance after hours and during weekends; however, you may need to leave a message to reach a representative outside of normal business hours. Swarthmore provides this benefit at no cost to you, and there is no cost to you to use Health Advocate's services.

Health Advocate's services are free and completely confidential.

- Contact Health Advocate by calling 1-866-695-8622.
- Email Health Advocate at **answers@HealthAdvocate.com**.
- Visit Health Advocate's Website via the following link: **www.healthadvocate.com/swarthmore.**

Additional Benefits —

Here's How It Works

As soon as you contact Health Advocate, you will be assigned a Personal Advocate who will work with you to resolve a health care problem. Each Personal Advocate is a trained professional who can assist with coordination of care, claim and related paperwork problems, fee negotiations, prescription drug issues and much more. In some circumstance, your Personal Advocate will be a Registered Nurse (as needed for health care situations).

How Health Advocate Can Help

Health Advocate complements basic health care coverage and can assist you in maximizing the benefits available through the Swarthmore College health plans. Many of the services available through Health Advocate are summarized below. **In addition, Health Advocate can help you better understand and compare your benefit plan options – they are available as a resource to assist with your annual enrollment decisions!**

Who is Covered?

Health Advocate is available to benefit-eligible employees, their spouse or domestic partner, dependent children up to age 26, parents and parents-in-law.

Your Personal Health Advocate Will:

- Take the time to listen to your concerns and carefully assess your issue or problem
- Find the right answers for your situation and make the necessary follow-up arrangements
- Protect your privacy and keep your information strictly confidential
- Act quickly and efficiently
- Always be on your side

Health Advocate

Administrative Services	Service Support
• Untangle and resolve insurance claims • Navigate within an insurance company • Identify and correct billing errors • Assist with heath care issues • Explore and arrange elder care	• Obtain information to allow for informed health care decisions • Help members complete necessary paperwork • Identify and coordinate/arrange wellness services • Coordinate a member's special service and/or transportation needs
Clinical Services	**Health Coaching**
• Find the right specialists and hospitals • Research treatment options & complex conditions • Secure second opinion appointments • Schedule appointments with hard-to-reach specialists • Identify renowned "best-in-class" medical facilities	• Help prepare patients for health care appointments • Assist members in better understanding their conditions • Educate members on how to become active participants in their health care • Explain the advantages of in-network care

Additional Benefits —

MetLife Pre-Paid Legal Service

If you opt to enroll in the legal services program, you will have access to an extensive network of attorneys through MetLife Legal Plans for various types of legal matters. Services include, but are not limited to, estate planning, financial and real estate matters, defense of civil litigation, family law, and traffic offenses. MetLife provides you with telephone and office consultations for an unlimited number of matters with the attorney of your choice. This plan will also cover matters for you and your dependents[1] at no additional cost. For non-covered matters that are not otherwise excluded, the MetLife Legal Plan provides 4 extra hours of attorney time and services each plan year.

The fee for this service is $19.50 per month, or $9.75 if you are paid biweekly.

Contact MetLife by going to **www.legalplans.com** or call 1-800-821-6400 for more information. To access plan details online, enter access code 6090009.

[1]Eligible dependents include your spouse, domestic partner, and dependent children up to age 26.

HTA Insurance Services

Are you or a loved one nearing retirement? Is your Medicare eligibility date (typically age 65) right around the corner? If you have questions about Medicare and the many plans available in the Medicare market, HTA Insurance Services is available to answer your questions. HTA's services are available at no cost to Swarthmore employees, retirees and family members.

HTA will help you to understand Medicare, and for those that do not qualify for retiree health care benefits from Swarthmore College, HTA can do your insurance shopping for you. They work with over 40 insurance companies, with various Medicare products including Medicare Supplement, Medicare Advantage, Prescription Drug, Dental and Vision coverage. Once you select a plan, let HTA assist you with the enrollment process! HTA remains available for unlimited telephone support for any questions you have or to help with any issues that may arise. Visit **HTA's website** for more information or call them at 610-430-6650.

Photo courtesy of Swarthmore College/Brandon Hodnett

Additional Benefits —

Pets Best Pet Insurance

All Swarthmore employees have the opportunity to purchase insurance from Pets Best. Why pet insurance? Just like their human owners, pets can have unexpected medical expenses. Insuring your pet provides peace of mind when dealing with veterinary bills.

Pets Best pet insurance is a direct pay carrier. This means that you can enroll on their website and pay the monthly premium directly to Pets Best. Pets Best will provide a premium discount to Swarthmore employees, and that discount increases if more than one pet is enrolled - up to a 10% discount if 2 or more pets are enrolled[1]. Pets Best offers coverage for dogs and cats age 7 weeks and older. Contact Pets Best directly to enroll your pets!

With Pets Best, you choose the type and amount of coverage you want:

- **Accident Only -** $250 deductible, then 90% reimbursement up to $10,000 per year
- **Accident & Illness –** customize your coverage level
  - Annual benefit limits from $5,000 to Unlimited
  - Annual Deductible from $50 to $1,000
  - Reimbursement percentage from 70% to 90%
- **Routine Care –** no deductible applies; plan pays a set amount per service based on the routine care option you choose

Visit **www.petsbest.com/SWPETS** or call 1-888-984-8700 to get a quote or to enroll.

Reference discount code **SWPETS**.

[1]Discounts do not apply to the cost for Routine Care coverage.

Additional Benefits —

Bright Horizons

Swarthmore College employees have access to emergency back-up childcare services, both In-Home and In-Center, for when unanticipated child care needs arise, through Bright Horizons.

This valuable resource is available to help you manage work, family and personal responsibilities. Bright Horizons can provide:

- **Support for Working Parents**
  - Help fill care gaps with back-up care in centers and at home; or jump ahead on the waitlist for full-time child-care. If you need a babysitter, use your free city Sittercity membership. You can also use Jovie, a high-touch Nanny Placement Service, and Right at School to find before and after school care.
- **Academic Support & Enrichment**
  - Get your child the help they may need with tutoring, test prep and educational enrichments.
- **Elder Care Support**
  - Book elder care when you need back-up care that is available in your home or theirs.
- **Household Support**
  - Through your free Sittercity membership, find pet care and house cleaning services.

How to get started:

- Log in to your mySwarthmore account and click the link for **Employee**, then click the link for **Bright Horizons**, next click on **Join Today** to begin your registration.
- The Bright Horizons contact center is open 24/7, 365 days a year, so someone will always be available. Bright Horizons can be reached at 1-877-BH-CARES (242-2737).
- Learn more at **https://clients.brighthorizons.com/swarthmorecollege**
- There are no payroll deductions for this program, you pay them directly when services are rendered.
- A minimum of 4-hours notice is required for most services.

Retirement Plan —

Swarthmore College employees may be eligible to participate in the **Swarthmore College Regular Retirement Plan (403(b) Plan)** for Mandatory/Basic contributions after completing a one year waiting period and satisfaction of the 1,000 hours of service requirement. This waiting period may be waived by providing a completed **Early Entry Form** and submitting it to **benefits@swarthmore.edu** for review and approval.

Mandatory/Basic contributions include:

1. Employee contribution of 5.5% of your eligible base salary over $20,000 (prorated on a per pay basis)
2. College contribution of 10% of your eligible base salary

Employees may make voluntary supplemental contributions upon date of hire. These elective supplemental contributions cannot exceed the legally allowed IRS maximum per calendar year. Supplemental contributions can be withheld from the payroll on either a pre-tax basis or as a Roth post-tax 403(b) basis, or a combination of both as designated on the **Salary Deferral Agreement** (SDA) to be submitted to the benefits department.

The current 2026 IRS maximum limits for voluntary/supplemental contributions are as follows (these are separate from the Mandatory contributions):

- **Employees under 50 years old:** Will be able to contribute an annual IRS maximum of $24,500 as voluntary/supplemental contributions.
- **Employees ages 50-59 and 64+:** The catch-up contribution limit will be increased to $8,000, allowing employees to contribute an annual IRS maximum of $32,500 in voluntary/supplemental contributions.
- **Employees ages 60-63:** The super catch-up contribution limit will remain the same at $11,250, allowing employees to contribute an annual IRS maximum of $35,750.
- Voluntary 403(b) contributions can be all pre-tax, Roth 403(b) post-tax, or a combination of both pre-tax and Roth 403(b) post-tax.
- Employees with prior year FICA wages of $150,000 or more are required to make catch-up contributions on a Roth post-tax basis. Please refer to the **Swarthmore College Retirement Plan** web page for more information about the Retirement Plan and Roth.

Qualified Life Events (QLE)

The Internal Revenue Service (IRS) rules state that employees enrolled in pre-tax benefit plans may only make elections or changes to their plans once per year. Because of these rules, your benefit elections (with the exception of Health Savings Account contributions and Transit/Parking elections) will be binding through December 31, 2026; however, you may make changes to your elections if you experience one or more of the following special circumstances, which are known as Qualifying Life Events (QLE):

- Marriage, divorce[1], annulment, or death of your spouse
- Confirmation or dissolution of domestic partnership or civil union
- Birth, adoption, placement for adoption or death of a dependent
- Commencement or termination of your or your spouse's employment, change in work status (e.g., full-time to part-time), strike, lockout or commencement or return from an unpaid leave of absence
- Any event that causes your dependent to satisfy or cease to satisfy the requirement for coverage due to reaching an age limit, a change in student status, or similar circumstances
- Change in your residence, or your dependents' resident (applicable to the Keystone HMO plan only)
- A significant increase or decrease in the cost of a coverage option
- A significant curtailment of a coverage option, or significant improvement or addition of a coverage option
- A change in coverage under another employer's plan (e.g., your spouse's plan) or an open enrollment occurs for the employee, spouse, or dependent
- Enrolling in Medicare or Medicaid; or loss of Medicaid coverage (may impact a dependent)
- As required by a Qualified Medical Child Support Order (QMCSO)
- Loss of coverage under a state Children's Health Insurance Program (CHIP) (only impacts the child who loses coverage)
- Enrollment under a qualified health plan offered by a state health insurance exchange due to you becoming eligible for a Special Enrollment Period (SEP) to obtain coverage under a qualified plan offered by a state insurance exchange (allows mid-year change to medical plan enrollment only)

[1]Legally separated spouses continue to be eligible for the Plan's benefits until the divorce is finalized. However, if a spouse's employer plan does not continue coverage for legally separated spouses and you, or your eligible dependents, lose coverage under that plan, you may request a mid-year benefit election change.

All QLEs must be submitted through Benefitfocus and/or emailed to benefits@swarthmore.edu.

Qualified Life Event Changes To Benefits

Qualifying Life Events allow you to make plan changes outside of the College's Annual Open Enrollment Period. For most allowable changes, you must inform Human Resources within 30 calendar days of the event, and provide supporting documentation; these requests with the supporting documentation must be submitted through Benefitfocus. For changes requested due to entitlement to premium assistance under Medicare or loss of coverage eligibility for Medicaid or CHIP, the request must be submitted to Human Resources within 60 days of the event. Requests for enrollment changes for all other reasons must be submitted within 30 days of the event.

Benefit changes requested due to a "change of mind" or requested more than 30 days after the event cannot be allowed until the next Annual Enrollment Period.

Online Resources —

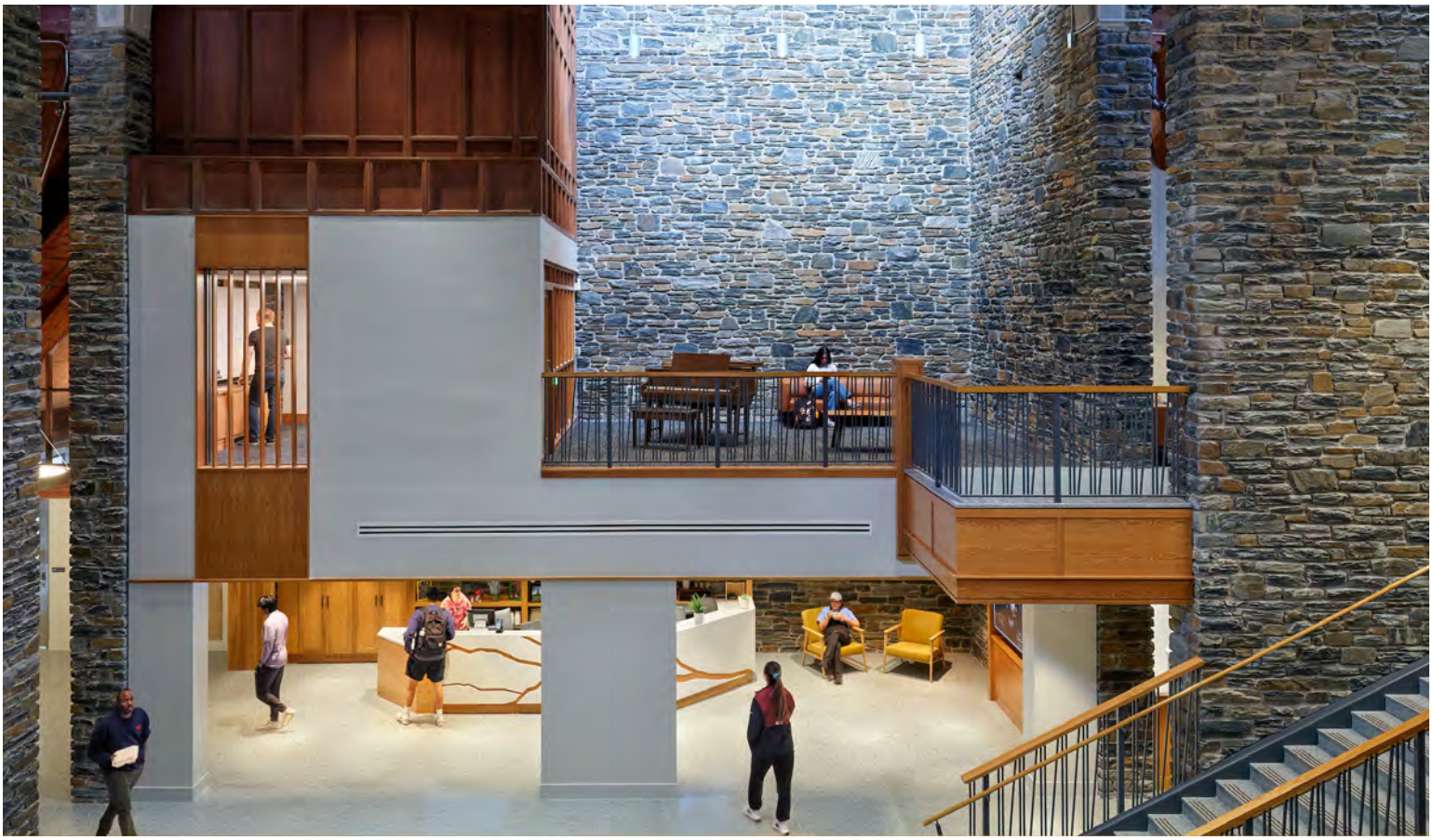


Photo courtesy of Swarthmore College/Laurence Kesterson

Learn about all of the benefits available to you and your family. All of your benefits information is stored in one easy to access location. Find links to carrier documents, forms, etc., including detailed benefits information for all of your company provided benefits.

Access your online resources by scanning the QR code to the right, or by visiting:

https://mybenefits.nfp.com/Swarthmore/2026/Resources

You can also visit the Virtual Benefits Fair to access all the latest information from our benefits partners.

https://mybenefits.nfp.com/Swarthmore/2026/fair

Medicare Part D — Creditable Coverage Disclosure Notice

Important Notice from Swarthmore College About Your Prescription Drug Coverage and Medicare

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

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

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. Swarthmore College has determined that the prescription drug coverage offered by the College's Independence Blue Cross plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Swarthmore College coverage will not be affected. If you elected Medicare Part D, the Swarthmore College plan will coordinate with the Part D coverage, provided you remain actively employed. However, enrollment in any part of Medicare will make you ineligible to put money into a Health Savings Account.

If you do decide to join a Medicare drug plan and drop your current Swarthmore College coverage, be aware that you and your dependents will not be able to get this coverage back until the next annual open enrollment or if/when you experience a qualifying life event.

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 Swarthmore College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 2025

Name of Entity/Sender: Swarthmore College

Contact—Position/Office: Human Resources

Address: 500 College Ave, Swarthmore PA 19081

Phone Number: 610-328-8397

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

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

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid | http://www.in.gov/fssa/dfr
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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

LOUISIANA – Medicaid

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

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 / TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage
Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 / Lincoln: 402-473-7000 / Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: https://www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

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

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

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 July 31, 2025, 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

HIPAA Notice of Availability of Notice of Privacy Practices

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

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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).

Women's Health and Cancer Rights Act Annual Notice

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, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator for more information.

Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment no more than 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact Swarthmore College Human Resources at 610-328-8397, or **benefits@swarthmore.edu**.

Patient Protections Model Disclosure

Swarthmore College generally requires the designation of a primary care provider for Keystone HMO plan participants. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Independence Blue Cross at **www.ibx.com** or 800-275-2583.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Keystone 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 our 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Independence Blue Cross at **www.ibx.com** or 800-275-2583

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, or for more information about your rights, you may file a complaint with the federal government and access more information at **https://www.cms.gov/nosurprises/consumers** or by calling 1-800-985-3059.

YOUR RIGHTS UNDER USERRA
THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website at **http://www.dol.gov/vets**. An interactive online USERRA Advisor can be viewed at **http://www.dol.gov/elaws/userra.htm**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: **http://www.dol.gov/vets/programs/userra/poster.htm**. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice

Office of Special Counsel

1-800-336-4590

Publication Date — April 2017

Notice Regarding Wellness Program

Independence Blue Cross' (Independence) Achieve Well Being Program is a voluntary wellness program available to all employees enrolled in an Independence plan with Swarthmore College. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA.

The information from your HRA will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Swarthmore College may use aggregate information it collects to design a program based on identified health risks in the workplace, Independence's Achieve Well Being Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Swarthmore College's Human Resource Department at 610-328-8397, or **benefits@swarthmore.edu**.

Your Employee Rights Under the Family and Medical Leave Act

What is FMLA leave?

The Family and Medical Leave Act (FMLA) is a federal law that provides eligible employees with **job-protected leave** for qualifying family and medical reasons. The U.S. Department of Labor's Wage and Hour Division (WHD) enforces the FMLA for most employees.

Eligible employees can take **up to 12 workweeks** of FMLA leave in a 12-month period for:

- The birth, adoption or foster placement of a child with you,
- Your serious mental or physical health condition that makes you unable to work,
- To care for your spouse, child or parent with a serious mental or physical health condition, and
- Certain qualifying reasons related to the foreign deployment of your spouse, child or parent who is a military servicemember.

An eligible employee who is the spouse, child, parent or next of kin of a covered servicemember with a serious injury or illness **may take up to 26 workweeks** of FMLA leave in a single 12-month period to care for the servicemember.

You have the right to use FMLA leave in **one block of time**. When it is medically necessary or otherwise permitted, you may take FMLA leave **intermittently in separate blocks of time, or on a reduced schedule** by working less hours each day or week. Read Fact Sheet #28M(c) for more information.

FMLA leave is **not paid leave**, but you may choose, or be required by your employer, to use any employer-provided paid leave if your employer's paid leave policy covers the reason for which you need FMLA leave.

Am I eligible to take FMLA leave?

You are an eligible employee if all of the following apply:

- You work for a covered employer,
- You have worked for your employer at least 12 months,
- You have at least 1,250 hours of service for your employer during the 12 months before your leave, and
- Your employer has at least 50 employees within 75 miles of your work location.

Airline flight crew employees have different "hours of service" requirements.

You work for a **covered employer** if **one** of the following applies:

- You work for a private employer that had at least 50 employees during at least 20 workweeks in the current or previous calendar year,
- You work for an elementary or public or private secondary school, or
- You work for a public agency, such as a local, state or federal government agency. Most federal employees are covered by Title II of the FMLA, administered by the Office of Personnel Management.

How do I request FMLA leave?

Generally, to request FMLA leave you **must:**

- Follow your employer's normal policies for requesting leave,

- Give notice at least 30 days before your need for FMLA leave, or
- If advance notice is not possible, give notice as soon as possible.

You do not have to share a medical diagnosis but must provide enough information to your employer so they can determine whether the leave qualifies for FMLA protection. **You must also inform your employer if FMLA leave was previously taken** or approved for the same reason when requesting additional leave.

Your employer may request certification from a health care provider to verify medical leave and may request certification of a qualifying exigency.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

State employees may be subject to certain limitations in pursuit of direct lawsuits regarding leave for their own serious health conditions. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress.

What does my employer need to do?

If you are eligible for FMLA leave, your employer **must**:

- Allow you to take job-protected time off work for a qualifying reason,
- Continue your group health plan coverage while you are on leave on the same basis as if you had not taken leave, and
- Allow you to return to the same job, or a virtually identical job with the same pay, benefits and other working conditions, including shift and location, at the end of your leave.

Your employer cannot interfere with your FMLA rights or threaten or punish you for exercising your rights under the law. For example, your employer cannot retaliate against you for requesting FMLA leave or cooperating with a WHD investigation.

After becoming aware that your need for leave is for a reason that may qualify under the FMLA, your employer must confirm whether you are eligible or not eligible for FMLA leave. If your employer determines that you are eligible, your employer must notify you in writing:

- About your FMLA rights and responsibilities, and
- How much of your requested leave, if any, will be FMLA-protected leave.

Where can I find more information?

Call **1-866-487-9243** or visit **dol.gov/fmla** to learn more.

If you believe your rights under the FMLA have been violated, you may file a complaint with WHD or file a private lawsuit against your employer in court. **Scan the QR code to learn about our WHD complaint process.**

WH1420 REV 04/23

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

SCAN ME

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96%[1] of your annual household income for 2026, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% of the employee's household income for 2026. [2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] ***Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-25-25.pdf for 2026.***

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage.

Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered by your employment, please check your health plan's summary plan description or contact Swarthmore College Human Resources at 610-328-8397, or **benefits@swarthmore.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.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the **Marketplace application**.

3. Employer name Swarthmore College	**4. Employer Identification Number (EIN)** 23-1352683	
5. Employer address 500 College Avenue	**6. Employer phone number** 610-328-8397	
7. City Swarthmore	**8. State** PA	**9. ZIP code** 19081
10. Who can we contact about employee health coverage at this job? Human Resources Department		
11. Phone number (if different from above)	**12. Email address** **benefits@swarthmore.edu**	

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

As your employer, we offer a health plan to:

☑ Employees who have a regular position of 0.5 full-time equivalent ("FTE") or greater

With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

1. Spouse who is legally married to you and is treated as a spouse under the Internal Revenue Code of 1986, or Domestic Partner
2. Your/your domestic partner's son, daughter, stepchild, legally adopted child or eligible foster child who has not yet attained age 26.

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

Contact Information —

Medical

Independence Blue Cross Personal Choice
Keystone Health Plan East
https://www.ibx.com/login
1.800.275.2583

Dental

Delta Dental
www.deltadentalins.com
1.800.932.0783

Vision

Davis Vision
www.davisvision.com
1.800.999.5431

Life and AD&D

Symetra
www.symetra.com
1.877.377.6773 – Claims Inquiries
1.800.426.7784 – Evidence of Insurability

STD & LTD

Symetra
www.symetra.com
1.877.377.6773

Flexible Spending Accounts

Inspira Financial
www.inspirafinancial.com
1.888.678.8242

Employee Assistance Program

AllOne Health
www.AllOneHealth.com
1.800.451.1834

Voluntary Legal

MetLife
www.legalplans.com
1.800.821.6400

Member Advocacy

Health Advocate
www.healthadvocate.com/swarthmore
Email: **answers@HealthAdvocate.com**
1.866.695.8622

Retirement

TIAA
www.tiaa.org
1.800.842.2252

Medicare Assistance

HTA Insurance Services
https://www.hta-insurance.com/individuals/swarthmore-college
Email: **info@HTA-insurance.com**
1.610.430.6650

Child & Elder Care

Bright Horizons
https://clients.brighthorizons.com/swarthmorecollege
1.877.BH.CARES (1.877.242.2737)

Pet Insurance

Pets Best
www.petsbest.com/SWPETS
1.888.984.8700

Benefits Support Team

Email: **Swartmorebenefits@nfp.com**
1.877.410.2011

Human Resources (Benefits)

benefits@swarthmore.edu
610.328.8397

Photo courtesy of Swarthmore College/Laurence Kesterson