Smith College Health and Welfare Benefits Summary Plan Description

This booklet contains important information about specific health and welfare benefits at Smith College including Healthcare, Dental, and Vision insurance, Life and Accident, Dismemberment and Disability (AD&D) insurance, Long Term Disability insurance, Healthcare Flexible Spending Accounts (FSA), and an Employee Assistance Program.

This booklet focuses primarily on eligibility, enrollment, and rights under each plan. Along with this booklet, a summary for each benefit is available, which explains how the plan works, what is covered and how covered members receive benefits. This booklet and the benefit summaries are intended to satisfy the written plan document requirements of Section 402 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. This booklet is also intended to satisfy the written plan document requirements of Section 125, 105H and 129 of the Internal Revenue Code.

Every attempt has been made to ensure the accuracy of this booklet. However, the legal documents, policies or certificates pertaining to various benefits prevail in the event of any discrepancy.

The benefits summarized here are not conditions of employment. Smith College, in its sole discretion, reserves the right to amend, modify or terminate any plan or provision contained in the booklet or the accompanying plan summaries, including insurance certificates. Neither this document nor any of its terms or provisions constitutes a contractual obligation of Smith College. Smith College has the sole and absolute authority to interpret the terms of these plans, determine benefit eligibility and resolve any and all ambiguities or inconsistencies in the plans.

Eligible persons have certain rights under the Employee Income Security Act of 1974 (ERISA), as amended. A statement of ERISA rights and information about the plans' claims and appeals procedures are included in this booklet.

If you have any questions about health and welfare benefits, contact the plan insurer/claims administrator (listed on pages 36-37) or contact Human Resources at hrbenefits@smith.edu.

Contents

Eligibility **5**
When Coverage Begins 5
Dependent Eligibility 5
Enrollment **8**
Rehires and Benefit Eligibility Status Changes 8
If You Waive Health, Dental and/or Vision Coverage 9
Changing Coverage **9**
Annual Open Enrollment 9
Status Changes/Qualifying Life Events 9
When Coverage Ends **10**
Certification of Healthcare Coverage 10
Retroactive Termination Rules 11
Healthcare Plan **11**
Paying for Coverage 12
Participating Providers 12
Patient Protection Disclosure 13
Newborns and Mothers Health Protection Act 13
Women's Health and Cancer Rights Act 13
Medicaid and the Children's Health Insurance Program (CHIP) 14
Dental Care Plan **14**
Paying for Coverage 14
Vision Care Plan **14**
Paying for Coverage 14
Life and Accident Plans **15**
Basic Life Insurance 15
Accidental Death & Dismemberment (AD&D) Insurance 15
Travel Accident Insurance 15
Supplemental Life Insurance 16

Dependent Life Insurance 16
Beneficiary Designation 16
Accelerated Benefit 17
Long Term Disability Insurance 17
Pre-existing Condition Limitations 17
Healthcare Flexible Spending Accounts 17
FSA Enrollment 18
Payment of Claims 18
Grace Period 19
Employee Assistance Program 20
Confidential, Professional Assistance 20
Accessing EAP Services 20
When EAP Coverage Ends 20
Qualified Medical Child Support Order 21
Coverage During Leave of Absence 21
Continuing Coverage Under COBRA 23
Eligibility for COBRA 24
How Long COBRA Coverage Lasts 25
When COBRA Coverage Ends 26
Type of Coverage 26
How to Continue Coverage 26
COBRA Participant Cost 27
Changing COBRA Coverage 27
Newborn and Adopted Children 28
If a Covered Employee Becomes Entitled to Medicare 28
Questions About COBRA Coverage 28
Claims and Appeal Process 28
Healthcare Plan, Dental Care Plan, Vision Care Plan and Healthcare Flexible Spending Account 29
Life Insurance, Travel Accident Insurance, Long Term Disability 30

Your Rights Under ERISA **33**
Receive Information About Your Plan and Benefits 33
Continue Group Health Plan Coverage 33
Prudent Actions by Plan Fiduciaries 33
Enforce Your Rights 34
Assistance with Your Questions 34
Plan Administrator **34**
Funding Policy **35**
Plan Termination **35**
Plan Information **35**
If You Have Questions **37**
Appendix: Federal CHIP Notice **38**

Eligibility

The benefits described in this booklet are available to regular Smith College employees who are scheduled to work at least 17.5 hours per week. Most benefits are also available to fixed-term employees, as outlined in the Employee Handbook.

Temporary employees and/or employees scheduled to work less than 17.5 hours per week are eligible for Travel Accident Insurance but are not eligible for any other benefits described in this booklet. Agency employees (those employed by temporary agencies and/or not by Smith College) are not eligible for any Smith College benefits.

Special rules also apply to employees whose hours are reduced to less than 17.5 hours per week due to a furlough. Such furloughed employees (and their spouses, domestic partners and dependents) will be allowed to continue their coverage with respect to the benefits in which the employees were enrolled on the date the furlough commences.

Special rules apply to employees participating in a Staff Early Retirement or Faculty Phased Retirement program offered by the College to qualifying employees who meet specified continuous years of service, job classification, and age restrictions. Qualified employees who voluntarily opt into an early retirement program (and their dependents) will be allowed to continue the specific benefits identified in the program under the terms and conditions outlined in the election documents for the program.

When Coverage Begins

Coverage for Healthcare, Dental, Vision, Basic Life, Supplemental Life (up to guaranteed issue amounts), AD&D, Healthcare Flexible Spending Account (FSA), Travel Accident, and Long Term Disability insurance begins on the date of hire for newly hired benefit eligible employees. For employees with a change in eligibility status (such as moving from a non benefit eligible to a benefit eligible position) the effective date of coverage is the eligibility status change date. For mid-year status changes due to a qualifying life event (QLE), the enrollment date will be the date of the qualified status change (such as marriage date, date of birth or adoption if adding a child, or the date that previous coverage was lost). Please note that for Long Term Disability, coverage may be subject to pre-existing condition limitations (see page 17).

Dependent Eligibility

The following dependents may be eligible for coverage under the Healthcare, Dental Care, Vision Care, Dependent Life Insurance, Flexible Spending Account and Employee Assistance Programs.

> **Spouse**: A spouse is a person to whom the employee is married. The laws of the Commonwealth of Massachusetts must recognize the marriage.

Ex-Spouse: For Healthcare, Dental Care and/or Vision Care only, an ex-spouse is a person to whom the employee was married. The laws of the Commonwealth of Massachusetts must have recognized the marriage. Ex-spouses are ineligible for other coverage including Dependent Life Insurance. Unless the Ex-Spouse is a tax-qualified dependent, the College's contribution to benefit premiums will be imputed to the Employee as taxable income and employee contributions toward premiums for the Ex-Spouse cannot be taken on a pre-tax basis.

Domestic Partner: For Healthcare, Dental Care, and/or Vision Care only, a Domestic Partner is a person with whom the covered employee jointly resides and with whom the covered employee is in an exclusive mutual committed relationship similar to that of marriage, which is expected to continue indefinitely. Both the employee and the Domestic Partner must sign an affidavit verifying these conditions, as well as confirming that they are both at least 18 years old, mentally and legally competent to consent, not legally married to one another or to any other person, and not related, by adoption or blood, to any degree that would bar legal marriage in their state of residence. The domestic partnership must have been in place for at least twelve continuous months prior to the effective date of the affidavit. Domestic partner status shall cease on the date such individual ceases to reside with the covered employee. Domestic partners are ineligible for other coverage including Dependent Life Insurance. Unless the Domestic Partner is a tax-qualified dependent, the College's contribution to benefit premiums will be imputed to the Employee as taxable income and employee contributions toward premiums for the Domestic Partner and Children of Domestic Partner cannot be taken on a pre-tax basis.

Eligible employees may enroll up to one Spouse or Ex-Spouse or Domestic Partner at any time.

Children: The term *children* includes an employee's natural or legally adopted children, foster children, children who are placed in the employee's home for adoption and stepchildren who are primarily supported by the employee, including children of the employee's legal spouse. It also includes children that a benefit eligible employee is required to cover under the terms of a Qualified Medical Child Support Order (see page 21). Generally, children may be covered up to age 26. A child who is older than age 26 but who is unmarried and physically or mentally disabled and primarily dependent on the Employee for financial support may be eligible to remain an eligible dependent provided that the Employee has submitted acceptable documentation of such incapacity within 30 days of the date that the child reached age 26 and that the disability was diagnosed prior to their 26th birthday. For more information about maintaining a disabled dependent on the plan, contact the carrier.

Children of Domestic Partner: The term *children of domestic partner* includes the domestic partner's natural or legally adopted children who are unmarried, under the age of 26, and primarily dependent on the eligible employee for their support (i.e. resides with the Employee and Domestic Partner, qualifies as a tax dependent of either the Employee or the Domestic Partner, or is required to be covered by the Domestic Partner or the Employee under the terms of a Qualified Medical Support Order (see page 21)). The term *children of domestic partner* also includes a domestic partner's natural or legally adopted child who is older than age 26 but who is unmarried and physically or mentally disabled and primarily dependent on the Employee for financial support as described above, provided that the Employee has submitted acceptable documentation of such incapacity within 30 days of the date that the child reached age 26 and that the disability was diagnosed prior to their 26th birthday. Children of domestic partners are ineligible for other coverage including Dependent Life Insurance. Unless the Child of Domestic Partner is a tax-qualified dependent, the College's contribution to benefit premiums will be imputed to the Employee as taxable income and employee contributions toward premiums for the Domestic Partner and Children of Domestic Partner cannot be taken on a pre-tax basis.

Exclusions: An employee's parents, siblings, ex-spouses (unless required under state law), ex-domestic partners, roommates, friends, and other relatives are not considered eligible dependents unless otherwise stated. When an ex-spouse becomes ineligible for coverage, they may be eligible to continue under COBRA (see page 23-28).

Notification of Dependent Status Changes: Employees must notify Human Resources within 30 days in the event of divorce, termination of a domestic partnership, or in the event that a dependent child ceases to meet the eligibility requirements for benefit coverage.

Documentation of Dependents: The College maintains the right to request documentation at any time to ensure that dependents meet eligibility criteria. Any attempt to secure or maintain coverage for a non-eligible person may lead to disciplinary action, up to and including termination of employment.

Enrollment

Some benefits require an eligible employee to actively enroll. For other benefits, coverage is automatic.

Enrollment Required:

- Health Insurance
- Dental Insurance
- Vision Insurance
- Healthcare Flexible Spending Account
- Supplemental Life Insurance
- Dependent and Spouse Life Insurance

Coverage is Automatic for Eligible Employees (enrollment not required):

- Basic Life Insurance
- Accidental Death and Dismemberment (AD&D) Insurance
- Long Term Disability Insurance
- Travel Accident Insurance
- Employee Assistance Program (EAP)

Newly hired benefit eligible employees who have completed required critical onboarding tasks such as completion of the I-9 will receive a new hire benefit enrollment task via Workday. New hires must complete their initial enrollment within 30 days of their date of hire. Otherwise, coverage will not be available until the next annual open enrollment period or upon certain qualified status changes. If a new hire wishes to enroll in Supplemental Life or Spouse/Dependent Life Insurance more than 30 days after they are first eligible, or in amounts that exceed the guaranteed issue amount for new hires, medical documentation and approval by the carrier (Evidence of Insurability, "EOI") will be required

Benefit eligible employees need to designate a Life/AD&D beneficiary in Workday. This beneficiary designation will apply to any elected Basic Life, AD&D, Supplemental and Travel Accident Insurance policies. An employee may change their beneficiary at any time in Workday.

Rehired Employees or Changes in Benefit Eligible Status

If an employee is rehired within 30 days of a previous termination date, they will not be permitted to make new pre-tax benefit elections without a corresponding change in status (see pages 9-10). Also, if an employee's position becomes non-benefit eligible for a period of 30 days or less, their benefits will be reinstated with no option to make new pre- tax elections when the position becomes benefit eligible again. Employees may not change their pre-tax elections outside of their initial eligibility event or during annual Open Enrollment unless there is a qualified status change/qualifying life event (also called a QLE). Refer to pages 9-10.

If You Waive Healthcare Coverage, Dental Coverage and/or Vision Coverage

If an employee waives enrollment for themselves or any eligible dependent(s) because of other healthcare, dental, and/or vision insurance coverage, involuntary loss of that coverage is considered a qualifying life event (QLE). This allows a 30 day special enrollment period for the employee to elect to enroll on the corresponding Smith plan. Any such enrollment must be completed via Workday within 30 days of the date that the other coverage ended and documentation of involuntary loss of coverage must be provided. Note that termination of other coverage for non-payment of premiums does not qualify for a special enrollment period. In addition, if an eligible employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, they will have a 30 day special enrollment period to make corresponding benefit changes. The change must be completed in Workday within 30 days after the marriage, birth, adoption, or placement for adoption.

Changing Coverage

Annual Open Enrollment

The annual open enrollment period is held each November/December for a January 1 effective date. During annual open enrollment, benefit eligible employees may change their Healthcare coverage, Dental Care coverage, Vision Care coverage, Supplemental Life and their Flexible Spending Account contributions as well as add or drop qualifying dependents.

Unless otherwise communicated, Healthcare, Dental, Vision, and Supplemental Life elections **will** carry over from year to year unless the employee makes changes during Open Enrollment. Flexible Spending Account elections will not carry over from year to year and a new election is required for each year.

Qualified Status Changes/Qualifying Life Events (QLEs)

Under certain circumstances, known as qualified status changes or qualifying life events (QLEs), employees have 30 days from the date of the qualifying event to make corresponding changes to their Healthcare, Dental, Vision and/or Flexible Spending Account election(s). Certain QLEs may have a longer Special Enrollment Period by statute. The employee must make any such election changes in Workday within 30 days of the qualified status change. Otherwise, enrollment changes cannot be made until the next annual enrollment period or unless the employee experiences another qualified status change/QLE.

The election change must be *on account of and consistent with* the type of qualified status change. For example, if the QLE is marriage, the employee may add their spouse to their Smith College coverage or drop Smith coverage to join their spouse's plan. Following is a list of qualified status changes/QLEs:

- Change in marital status, including marriage, divorce, legal separation or annulment
- Change in number of qualified dependents, including birth, adoption, placement for adoption, death of a dependent or an employee assuming primary support of a grandchild (a child of the employee's own unmarried dependent child who is under age 26)
- Change in the eligibility of a covered dependent, such as turning age 26

- Employee moving into or out of the HMO coverage area (qualifies for a corresponding healthcare plan change)
- Issuance of a family relations judgment, decree or order, such as a Qualified Medical Child Support Order (a longer special enrollment period may apply)
- Change in employee eligibility or that of an eligible spouse, domestic partner or covered dependent child(ren) for Medicare or Medicaid (a longer special enrollment period may apply)
- Gain or involuntary loss of other insurance coverage, such as losing coverage through a spouse's employer (note that losing other coverage for nonpayment of premiums is specifically excluded from being a qualifying life event)

Please note that retroactive coverage cannot be provided on a pre-tax basis except in the case of birth of a child, adoption or placement for adoption. Therefore, if an enrollment change occurs and there are retroactive deduction adjustments, the retroactive deductions must be taken on an after-tax basis.

When Coverage Ends

Healthcare, Dental, Vision, Life, AD&D, Travel Accident, and Long-Term Disability insurance for covered employees and their dependents ends on the last day of employment. Eligibility for the Employee Assistance Program also ends on the employment termination date. Coverage may end sooner if an employee ceases to be in an eligible position (for example, if hours reduce to less than half-time), if an employee fails to make their required premium contributions, or if the plan is discontinued for the employee's class of employee. Health and welfare plan coverage will not end if hours are reduced (even to zero) as the result of a furlough.

Employees and eligible dependents whose Healthcare, Dental Care, Vision Care, and EAP coverage ends may be eligible to continue coverage under COBRA (see page 23-28).

When Dependent Coverage Ends

A dependent child's coverage generally ends on the date that they no longer meet the plan's definition of an eligible dependent.

Specific to the Healthcare, Dental, and Vision plans, a Dependent Child or Child of Domestic Partner's coverage ends on the last day of the month in which they turn age 26.

Domestic Partners and the Children of Domestic Partners who are not the employee's natural or legally adopted children are not entitled to COBRA coverage.

Certification of Healthcare Coverage

Upon request, Smith College will provide a "coverage certification," to employees and/or their dependents who have lost coverage. This is a written record of the coverage received under the healthcare plan and under COBRA, if applicable. Employees and their covered dependents can receive a coverage certification when coverage terminates, again when COBRA coverage terminates (if COBRA is elected), and upon a request made within 24 months following termination of coverage or termination of COBRA. Coverage certification(s) may be needed to prove prior coverage when enrolling in a new healthcare plan or purchasing healthcare insurance.

Retroactive Termination of Coverage and Recissions

The Plan will not rescind or retroactively cancel coverage for any covered Employee, Dependent, or beneficiary once that individual has been enrolled, except in cases of one of the permitted reasons listed below or in the event of fraud or an intentional misrepresentation of a material fact as prohibited by the terms of the Plan. A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect. A retroactive cancellation is strictly prohibited if the delay in processing the termination is due to an administrative oversight or mistake by the Employer, Plan Sponsor, or Third-Party Administrator (TPA), unless fraud or intentional misrepresentation is present.

Permitted Retroactive Adjustments

Retroactive termination of coverage is strictly limited to the following federal exceptions:

- Non-Payment of Premiums: Failure to timely pay required participant contributions or COBRA premiums.
- Routine Administrative Processing: Short-term, routine recordkeeping delays in processing a dynamic event (such as a termination of employment or loss of eligibility status), provided the adjustment is executed within standard administrative timelines and no employee contributions are accepted for the post-termination period.
- Participant-Initiated Cancellations: Retroactive terminations requested by an employee or participant that are explicitly permitted by the Plan (e.g., a late notice of a qualifying life event like divorce, where coverage is cancelled back to the date of the event).

Required Advance Notice

In the rare event that the Plan intends to rescind coverage retroactively due to fraud or intentional misrepresentation of a material fact, the Plan Administrator will provide at least 30 days' advance written notice to each affected individual before coverage is retroactively cancelled. The participant retains the right to appeal the rescission decision through the Plan's standard internal claims and appeals procedures during this 30-day window.

Healthcare Plan

Smith College offers a choice of four medical plans, each of which includes a carve out pharmacy benefit administered via OptumRx:

- Blue Cross Blue Shield of Massachusetts Preferred Provider Organization (PPO) Plan (Blue Care Elect Preferred)
- Blue Cross Blue Shield of Massachusetts Health Maintenance Organization (HMO) Plan (Network

Blue New England)

- Blue Cross Blue Shield of Massachusetts Value Health Maintenance Organization (Value HMO) Plan (Network Blue NE $500 Deductible)
- Blue Cross Blue Shield of Massachusetts High Deductible Health Plan with Health Savings Account (HDHP) Plan (Blue Care Elect Saver)
- OptumRx (Pharmacy Program) (cannot be elected separately, is bundled with each medical plan option)

This booklet describes Smith College's eligibility and enrollment provisions, certain rights enrollees have under the healthcare plan and other important information. Along with this booklet, enrollees may request a plan summary from Human Resources or from Blue Cross Blue Shield of Massachusetts and OptumRx that describes what is (and isn't) covered and how the plan works.

Paying for Coverage

Enrolled employees and Smith College share the cost of the Healthcare Plan. The college-paid contribution is prorated at 75% of the full-time benefit level for employees whose full time equivalent basis is more than half-time (0.5 FTE) but less than full-time (1.0 FTE). Employee contributions are made via payroll deduction on a pre-tax basis (except for retroactive coverage for status changes other than birth of child, adoption and placement for adoption or if an employee is not receiving any pay during a furlough or other leave). Making contributions on a pre-tax basis reduces an employee's taxable income, which may slightly reduce their future Social Security retirement benefit.

Participating Providers

Enrollees in the PPO or HDHP receive a higher level of covered benefits when using Blue Cross Blue Shield of Massachusetts participating ("in network") providers. Enrollees in the HMO or Value HMO are covered *only* when services are provided or authorized by their in network primary care physician (PCP), with the exception of emergency or urgent care. Blue Cross Blue Shield of Massachusetts' participating providers include doctors, hospitals, laboratories and other healthcare professionals and facilities.

Blue Cross Blue Shield of Massachusetts determines and maintains the list of in-network providers. You may access this via Blue Cross Blue Shield of Massachusetts website, member app, or by calling Member Services using the number on the insurance card.

Employees may only switch between healthcare plan options during the annual enrollment period (see page 9), or if the primary subscriber moves into or out of the service area, unless there is a corresponding qualifying life event.

Patient Protection Disclosure

Smith College's HMO and HMO Value plans typically require the designation of an in-network primary care provider (PCP). The HDHP and PPO plans encourage, but do not require, enrollees to establish a relationship with PCP. Enrollees have the right to designate any primary care provider who participates in the respective Blue Cross Blue Shield network and who is available to accept the enrollee as a patient. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Member Services using the number on the insurance card. Children may have a pediatrician designated as their primary care provider.

Enrollees do not need prior authorization from the health insurance carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in the respective Blue Cross Blue Shield network who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact Member Services.

Newborns and Mothers Health Protection Act

Group health plans and health insurance companies 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

Smith College's healthcare plans cover expenses for reconstructive surgery following a mastectomy. In addition to covering the medical and surgical benefits related to a mastectomy, all medical plans cover:

- 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, and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services are subject to any plan deductibles, coinsurance and copayments that are applicable to other medical and surgical services covered under the plan.

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 also 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. Refer to the appendix at the end of this Summary Plan Description Document to view the full federal CHIP notice.

Dental Care Plan

Smith College offers a choice of two dental plans:

- Delta Dental High Plan (Delta Dental PPO Plus Premier)
- Delta Dental Value Plan (Delta Dental Plus Premier Value Plan)

This booklet describes Smith College's eligibility and enrollment provisions, certain rights enrollees have under the dental care plan and other important information. Along with this booklet, a plan summary is available by contacting Human Resources or Delta Dental or logging in to their member portal.

Paying for Coverage

Enrolled employees and Smith College share the cost of the Dental Plan. The college-paid contribution is prorated at 75% of the full-time benefit level for employees whose full-time equivalent basis is more than half-time (0.5 FTE) but less than full-time (1.0 FTE). Employee contributions are made via payroll deduction on a pre-tax basis (except for retroactive coverage for status changes other than birth of child, adoption and placement for adoption or if an employee is not receiving any pay during a furlough or other leave). Making contributions on a pre-tax basis reduces an employee's taxable income, which may slightly reduce their future Social Security retirement benefit.

Vision Care Plan

This booklet describes Smith College's eligibility and enrollment provisions, certain rights enrollees have under the vision care plan and other important information. Along with this booklet, a summary from EyeMed that describes what is covered and how to receive plan benefits is available by contacting Human Resources or EyeMed or logging in to their member portal.

Paying for Coverage

Enrolled employees pay the cost of the Vision Plan. Employee contributions are made via payroll deduction on a pre-tax basis (except for retroactive coverage for status changes other than birth of child, adoption and placement for adoption or if an employee is not receiving any pay during a furlough or other leave). Making contributions

on a pre-tax basis reduces an employee's taxable income, which may slightly reduce their future Social Security retirement benefit.

Life and Accident Plans

This section provides a brief summary of Smith College's life and accident plans. For more information, see the Certificate of Insurance issued by The Hartford. For the travel accident plan, see the Travel Accident Insurance & Travel Services Program Summary of Coverage. These documents may be requested from Human Resources or from the insurance carrier.

The College pays the cost of Basic Life Insurance, Accidental Death & Dismemberment and Travel Accident Insurance, which are automatically elected for eligible employees. Enrolled employees pay the cost of Supplemental and Dependent Life Insurance if those coverages are elected.

Basic Life Insurance

Basic Life Insurance coverage provides a benefit equal to a covered employee's basic annual earnings, rounded to the next highest $1,000. At age 65 and beyond, the Basic Life Insurance benefit is subject to the age-reduction formula specified in the Certificate of Insurance. The maximum allowed Basic Life Insurance benefit is $500,000.

Basic annual earnings includes the standard wages expected to be earned at the College in a fiscal year. "Basic annual earnings" do not include overtime, stipends, etc. Basic Life Insurance coverage is adjusted automatically to conform to any changes in an employee's salary or age.

Employees are taxed on any employer-provided group term life insurance in excess of $50,000 according to section 79 of the Internal Revenue Code.

Accidental Death & Dismemberment (AD&D) Insurance

AD&D Insurance coverage provides a benefit in the event that a covered employee dies or suffers certain injuries as a result of a qualifying accident. AD&D benefits are payable in addition to Basic and Supplemental Life Insurance. If a covered employee dies as the result of a qualifying accident, the AD&D benefit will be an amount equal to their Basic Life Insurance and is payable to the beneficiary/ies of their Basic Life policy. If a covered employee suffers certain injuries as a result of an accident, they may be eligible to receive a percentage of the AD&D death benefit.

Travel Accident Insurance

Life and disability insurance coverage is provided for a covered employee who is required to travel on College business outside the corporate limits of their municipality of residence or to which they are regularly assigned for employment duties. Coverage begins at the start of an anticipated trip whether it is from the workplace, the employee's home, or other locations. Coverage terminates when the employee returns to their home, the College,

or their other regular work location if not at the Smith campus, whichever occurs first.

Coverage from $50,000 to $300,000 is provided for accidental death, dismemberment and permanent total disability. Coverage does not apply to situations such as commuting, intentionally self-inflicted injuries, or during war or while a covered employee is serving on active military duty. Any death benefit provided by this coverage is payable to the beneficiary/ies the employee designated under the College's Basic Life Insurance plan.

Supplemental Life Insurance

Eligible employees may elect Supplemental Life Insurance equal to an additional one, two, three, four or five times their basic annual earnings (up to a maximum benefit limit of $700,000), rounded to the next highest $1,000. If enrolling within 30 days of hire, proof of good health (evidence of insurability) is not required for the lesser of up to an additional three times basic earnings or $475,000. If enrollment is requested more than 60 days after hire or if the employee elects four or five times their basic annual earnings or an amount greater than $475,000, they must submit proof of good health (Evidence of Insurability) and obtain acceptance of the requested change from the insurance company.

Employees pay the cost of Supplemental Life Insurance through payroll deduction on an after- tax basis. Supplemental life insurance premiums vary based on age.

Dependent Life Insurance

Employees enrolled in Supplemental Life insurance may also elect Dependent Life Insurance coverage for their legal spouse and/or eligible dependent children (see page 5-6).

Employees may purchase from $10,000 to $150,000 in life insurance for their legal spouse and $5,000 or $10,000 for each dependent child. If electing over $40,000 in coverage for a legal spouse, they must submit proof of their good health acceptable to the insurance company and be accepted by the insurance company for coverage. Covered employees pay the full cost of Dependent Life Insurance through payroll deduction on an after- tax basis.

Beneficiary Designation

It is important that all covered employees name a beneficiary or beneficiaries in Workday and that they keep this information up-to-date. Employees may change their beneficiary/ies at any time in Workday.

If an employee does not designate a beneficiary in Workday or if no beneficiary is surviving at the time of a covered enrollee’s death, life insurance and/or AD&D benefits would be payable as described in the Certificate of Insurance. This certificate provides that The Hartford may pay benefits to the first of the following survivors in the following order: the enrollee’s spouse, the covered enrollee’s children or the covered enrollee’s parents. The Hartford will make this determination depending on the circumstances surrounding the claim. For this reason, it's important to indicate a beneficiary or beneficiaries in Workday. This is especially true if a covered employee wants their domestic partner or another party who is not their legal spouse, child(ren) or parent to receive their life

insurance benefits in the event of death.

Accelerated Benefit

Accelerated benefits may be payable if a covered enrollee becomes terminally ill and has a medical prognosis of 12 months or less to live. This option allows a covered employee to receive a portion of their own or a covered dependent's life insurance while the covered enrollee is living.

Please contact Human Resources or see the Certificate of Insurance if additional information is needed about the College's life and accident insurance plans.

Long Term Disability Insurance

Long Term Disability (LTD) insurance is an important part of the income protection offered by the College. LTD insurance provides a covered employee with salary continuation in the event that illness or injury prevents them from working for an extended period of time. Both job-related and non-job-related disabilities are covered. Income benefits are payable after six months of partial or total disability as certified by the College's LTD insurance carrier.

This booklet describes Smith College's eligibility and enrollment rules, certain rights covered employees have under the LTD plan and other important information. Additional information on coverage amounts, how the plan works, recurrent disability, partial disability, mental illness limitation, maximum benefit period, waiver of premium, survivor benefits, general exclusions, conversion rights, etc., is provided in the Group Long Term Disability Benefits Certificate of Insurance that the carrier will provide upon request. Please refer to this booklet and to the Employee Handbook to determine how other benefits are affected while receiving LTD benefits.

Eligible employees will be enrolled at a 60% coverage level on their date of hire. 60% coverage is paid for by the College. The value of the LTD premium is considered imputed income for tax purposes (a taxable fringe benefit) so that any benefit received while on LTD will be tax-free to the covered employee.

Pre-existing Condition Limitations

Although there is no waiting period to enroll, employees should be aware that, in the event of disability, conditions for which they received treatment within three months prior to the effective date of insurance will not be covered until they have been insured under the plan for 12 consecutive months.

Healthcare Flexible Spending Account (FSA):

The Healthcare Flexible Spending Account (FSA) offers the opportunity to save tax dollars on eligible out-of-pocket medical/dental/vision/pharmacy and certain over the counter healthcare products.

Eligible employees can make contributions to the FSA on a before-tax basis and then use the funds in the FSA to pay for qualifying expenses tax-free. Participation in Flexible Spending Accounts reduces taxable income on the W-2 for any years in which an employee participates and may therefore slightly reduce their basis for Social

Security retirement benefits.

Because of the tax advantages that flexible spending accounts offer, they are subject to certain IRS restrictions, and unspent balances are forfeited after the end of the calendar year.

This booklet briefly describes eligibility and enrollment provisions, certain rights that participants have and other important information.

Enrolled employees may use this account to pay for out of pocket (not covered by an insurance plan or paid by any public benefit program such as Medicare) medical, dental, vision, pharmacy and other health-related expenses for themselves or their eligible dependents (see page 5-7 for information on dependent eligibility) during a calendar year. Some examples of qualifying expenses include copays, deductibles, coinsurance payments, medical, dental, vision, and pharmacy services and supplies, and certain over-the-counter drugs, supplies, and medical equipment. Some expenses are not eligible for reimbursement, such as expenses reimbursable by other plans, premiums for health insurance or Medicare, or medically unnecessary cosmetic treatments or procedures.

Eligible employees may set aside voluntary contributions up to the IRS established annual maximum on a tax-free basis. Enrolled employees may submit expenses for themselves and for their tax eligible dependents. If coverage under the Flexible Spending Account ends, a covered employee may be eligible to continue participation under COBRA. For more information on COBRA, see page 23-28.

Enrolling in a Flexible Spending Account (FSA)

Eligible employees may enroll during the College's annual open enrollment period or within 30 days of their date of hire. Enrollment is completed via Workday. FSA elections do **not** carry over from year-to-year. Employees must re-enroll in Workday during the Open Enrollment Period every year that they want to participate.

When enrolling, eligible employees are reminded to estimate their eligible out of pocket expenses conservatively, as unused funds remaining in the account at year-end must be forfeited, according to IRS regulations. This is known as the *"use it or lose it"* rule. Midyear changes are generally not permitted unless made within 30 days of a qualifying life event (QLE).

Payment of Claims

Enrolled employees may pay for eligible purchases and services using an FSA debit card if one is issued by Voya. Alternatively, they may submit claims to Voya for reimbursement of eligible expenses that could not be or were not paid for using their Voya FSA debit card. Online and paper claim forms are available at https://myhealthaccountsolutions.voya.com or by calling 833-232-4673.

FSA reimbursement claims must be accompanied by detailed bills or receipts for expenses incurred during the plan year (see section on Grace Period). Claims may be submitted any time during the plan year, but must be received before the end of the Run-Out Period (March 31 following the end of the plan year). Enrollees will forfeit any unused FSA balance remaining in their account at the end of the plan year if they have not filed a claim for it by the end of the Run-Out Period. For example, claims for the 2026 plan year must be postmarked or submitted by March 31, 2027.

Grace Period

Smith College has established a "grace period" for Healthcare FSAs that follows the end of the Plan Year (January 1 through December 31) during which unused FSA balances may be used to reimburse eligible expenses incurred during the grace period.

The grace period begins on the first day of the next Plan Year and ends two and a half months later. For example, if the Plan Year ends December 31, 2026, the grace period begins January 1, 2027 and ends March 15, 2027.

In order to take advantage of the grace period, you must be:

- A Participant in the applicable spending account(s) on the last day of the Plan Year to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the Health FSA on the last day of the Plan Year to which the grace period relates.

The following additional rules will apply to the grace period:

- Eligible expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the Plan Year to which the grace period relates and then from any amounts that are available to reimburse expenses incurred during the current Plan Year. Claims will be paid in the order in which they are received. This may impact the potential reimbursement of eligible expenses incurred during the Plan Year to which the grace period relates to the extent such expenses have not yet been submitted for reimbursement. Previous claims will not be reprocessed or recharacterized so as to change the order in which they were received.

  For example, assume that $200 remains in your Healthcare FSA account at the end of the 2026 Plan Year and further assume that you have elected to allocate $2,400 to the Health FSA for the 2027 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on January 15, 2027, $200 of your claim will be paid out of the unused amounts remaining in your Healthcare FSA from the 2026 Plan Year and the remaining $300 will be paid out of amounts allocated to your Healthcare FSA for 2027.

- Expenses incurred during a grace period must be submitted before the end of the Run-out Period described in this SPD. This is the same Run-out Period for expenses incurred during the Plan Year to which the grace period relates. Any unused amounts from the end of a Plan Year to which the grace period relates that are not used to reimburse eligible expenses incurred either during the Plan Year to which the grace period relates or during the grace period will be forfeited if not submitted

for reimbursement before the end of the Run-out Period.

- The Healthcare FSA and the Dependent Care FSA are separate accounts allocated for separate purposes and cannot be combined or used to pay for non-qualified expenses. For example, the Healthcare FSA cannot be used to pay for daycare expenses for a dependent child. The Dependent Care FSA cannot be used to pay for a dependent child's medical treatment.

- The Plan Administrator reserves the right to reprocess grace period expenses after the end of the Run-out Period so that amounts previously applied to grace period expenses are applied to prior plan year expenses submitted before the end of the Run-out Period. You will be notified of any such reprocessing if it occurs.

Employee Assistance Program

The College offers a confidential and voluntary counseling and referral service provided free of charge to employees and members of their family household through an Employee Assistance Plan (EAP). The EAP provides brief interventions and counseling to address a range of personal, family, and workplace concerns. In addition, the EAP offers legal and financial consultation and service referrals and referrals to local resources such as childcare and elder care.

Confidential, Professional Assistance

Use of the EAP is confidential. In accordance with professional standards, the EAP will not share information about your use of services with the College or others without your knowledge and written permission, except as required by law.

Accessing EAP Services

The EAP is administered by ComPsych. EAP services may be provided in person or over the telephone. Each eligible person may receive up to twelve (12) free personal counseling sessions per issue, per contract year (November 1 to October 31).

Many problems can be resolved or improved through short-term counseling without need for further services. However, in some instances, the EAP counselor may make follow up referrals to appropriate resources. If a referral beyond the EAP is made, any charges relating to those outside services will be explained to the user. An EAP counselor may be reached toll free at 855-784-2056 24 hours a day, 7 days per week.

When EAP Coverage Ends

EAP coverage ends on the covered employee's termination date or when an eligible employee ceases to be in a benefit eligible role (for example, if they reduce to less than half-time). When EAP coverage ends, covered employees may be eligible to continue coverage under COBRA (see page 23-28).

Qualified Medical Child Support Order

Healthcare benefits may be subject to certain judgments by state courts that extend medical coverage to a child(ren) named in a Qualified Medical Child Support Order (QMCSO). If a determination is made that the court order satisfies all legal requirements, Smith College will comply with the order, and the affected employee will be notified. A copy of the QMCSO procedures is available from Human Resources upon request.

Coverage During Leave of Absence

Eligible employees may generally continue participation in the College's Healthcare plan, Dental Care plan, Vision insurance plan, Life Insurance plans, Long Term Disability plan and EAP plan during an approved leave of absence. The College will continue its contributions at the same level and under the same conditions as if an employee on an approved leave had continued to work. If the leave is unpaid, the employee will be billed for their share of the premiums.

Healthcare Flexible Spending Account participation may continue during your leave of absence**.**

Benefits not subject to ERISA (non-ERISA benefits) such as (but not limited to) Dependent Care Accounts and Tuition Assistance benefits are not normally available during a leave of absence.

This section describes benefit continuation for four specific types of leave: Family and Medical Leave of Absence, Active Military Leave of Absence, Paid Family Medical Leave, and Long-Term Disability. For more information about any type of leave of absence, see the Employee Handbook.

Family and Medical Leave of Absence

In accordance with the Family and Medical Leave of Act of 1993, the College provides eligible employees with up to 12 weeks of Family and Medical Leave of Absence (FMLA) during any 12-month period. This leave may be paid, unpaid or a combination of both. For more information about FMLA, see the Employee Handbook.

Employees on an approved Family and Medical Leave of Absence (FMLA) may be eligible to continue certain benefits, including participation in Medical, Dental, Vision, and EAP coverage, during their FMLA. The College will continue its contribution toward the cost of coverage during an approved FMLA. If the FMLA is paid, the employee’s cost for coverage will continue to be deducted from their pay. If the FMLA leave is unpaid, the employee will be billed for their share of the cost.

Employees on an approved FMLA may also continue participation in the Healthcare Spending Account during their leave (but not non-ERISA benefits such as the Dependent Care Flexible Spending Account). If the FMLA is paid, employee contributions will continue to be deducted from pay. If the FMLA is unpaid, the contributions that

are missed will be withheld from the employee's pay when they return to work.

If a covered employee chooses not to continue their Healthcare Spending Account during an FMLA, claims incurred during the FMLA will not be eligible for reimbursement. The employee may resume participation if they return to work after their FMLA. If they return in the same plan year, they will have two options:

1. Resume coverage at the same annual contribution amount as before and make up the contributions missed during the unpaid FMLA; or
2. Resume coverage at a reduced annual contribution amount and continue the same rate of contributions.

Military Leave of Absence

An employee who is a member of the National Guard or a military reserve unit who gets called to active military duty during a national, state or local emergency will be granted unpaid military leave of absence in accordance with state and federal law, including the Uniformed Services Employment and Reemployment Rights Act (USERRA). For more information on active military leave, see the Employee Handbook.

Employees on active military leave may be eligible to continue certain benefits. (Note: Some benefits have contractual exclusions for some injuries or illnesses that result from military service). The College will continue its premium contribution toward costs for health, dental, life, long-term disability and EAP plans for up to 12 weeks, and the employee will be billed for their share of the premium. After 12 weeks, the employee may continue coverage under the health, dental, life, long term disability and EAP plans, but the College will discontinue its contributions, and the employee must pay the full cost.

If an employee chooses not to continue benefits during an active military leave, coverage will be reinstated when they return to work at Smith College, provided they return to work in an eligible position.

Employees may also continue participation in the Healthcare Spending Account during a military leave (but not in non-ERISA plans like the Dependent Care Flexible Spending Account). Missed contributions will be withheld from the employee's pay when they return to work.

If an employee chooses not to continue their Healthcare Spending Account during their leave, claims incurred during the leave will not be eligible for reimbursement. The employee may resume participation if they return to work after the leave of absence. If the employee returns in the same plan year, they will have two options:

1. Resume coverage at the same annual contribution amount as before and make up the contributions missed during the military leave; or
2. Resume coverage at a reduced annual contribution amount and continue the same rate of contributions.

MA Paid Family Medical Leave

In accordance with the Massachusetts Paid Family and Medical Leave, the College provides eligible employees

with up to a combined 26 weeks of family and medical leave in a benefit year*. For more information about PFML, see the Employee Handbook.

During PFML, an eligible employee will receive a weekly benefit amount, based on a percentage of the employee's earnings, up to the current year maximum as defined by the Massachusetts Department of Family and Medical Leave.

An employee on an approved MA Paid Family and Medical Leave (PFML), may be eligible to continue certain benefits, including participation in the Medical, Dental, Vision, and EAP plans, during their PFML. The College will continue its contribution toward the cost of coverage during PFML. As long as a covered employee is receiving compensation under PFML, their cost for coverage will continue to be deducted from their pay. If the leave is unpaid or the cost of contributions cannot be deducted, the employee will be billed for their share of the cost.

If an employee takes leave for their own serious health condition, the College may require them to provide a fitness-for-duty certification from their healthcare provider, certifying that the employee is able to resume work, prior to returning.

**Benefit year is 52 weeks starting on the Sunday prior to the first day of paid leave.*

Long Term Disability Leave

An employee who is approved for Long Term Disability (LTD) benefits may continue to participate in the College's group health, dental, vision, life insurance and EAP coverage for up to two years from the beginning of their LTD leave. Life insurance will continue at the salary level in effect at the time the LTD leave began. Affected employees remain subject to the specific terms of each insurance contract. The College will continue to pay its share of premiums for these coverages and the employee will be billed for their share and must make timely payments to continue coverage.

After two years of disability, employees on LTD may qualify for Medicare benefits, which are determined independently by Medicare. Employees may also be entitled to continue participation in healthcare, dental care, vision care and EAP coverage under COBRA, and to convert their life insurance to non-group life insurance policies. Employees on LTD are not eligible for flexible spending accounts or Travel Accident Insurance during an LTD leave, but may be eligible to continue their Healthcare Spending Account coverage under COBRA (see page 23-28).

Continuing Coverage Under COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Smith College provides covered employees and their eligible dependents the opportunity to continue participation in Smith College healthcare, dental, and vision care plans and the employee assistance program (EAP) under certain circumstances. These circumstances are called qualifying events (QLEs).

Eligible employees may also, under certain circumstances, be eligible to continue participation in a Healthcare

Flexible Spending Account by making after-tax payments. Healthcare Flexible Spending Account continuation under COBRA is generally available only if an employee has unclaimed money remaining in their FSA account when the qualifying event occurs. If an employee has already claimed all the money they contributed at the time of the QLE, they are ineligible to continue FSA participation under COBRA. Non-ERISA benefits, such as the Dependent Care Flexible Spending Account, are not eligible for continuation under COBRA.

Smith College contracts with Voya to administer COBRA benefits. Voya administers COBRA notifications, billing and enrollment, changes and termination of coverage.

Eligibility for COBRA

Smith Employees Losing Coverage

Employees enrolled in the healthcare plan (including the carved-out pharmacy benefit), dental plan, vision plan, EAP and/or Healthcare Flexible Spending Account become eligible to continue coverage through COBRA when one of the following qualifying events causes a loss of coverage:

- Employment ends for any reason other than gross misconduct, or
- Scheduled work hours are reduced to a level no longer eligible for coverage

Covered Legal Spouse (Eligible) or Domestic Partner (Ineligible)

A covered legal spouse may be eligible to continue coverage through COBRA if their coverage ends because:

- The covered employee loses coverage due to end of Smith employment or reduction of hours
- The covered employee becomes eligible for Medicare
- Legal separation or divorce from the covered employee
- Death of the covered employee

Domestic Partners and Children of Domestic Partners are not entitled to COBRA coverage.

Employees must keep the Plan Administrator/COBRA Administrator informed of any changes in the addresses of eligible family members, and should also keep a copy of any correspondence to or from the Plan or COBRA Administrator.

Employee's Dependent Children

Covered dependent children of the employee may be eligible to continue coverage through COBRA if their coverage ends for any of the reasons listed under "Covered Legal Spouse" above. In addition, if a dependent child no longer meets the plan's definition of an eligible dependent (for example, if they turn age 26) they may be eligible for COBRA continuation coverage.

How Long COBRA Coverage Lasts

Continuation for 18 Months

Employees and eligible covered family members may continue healthcare, dental care, vision care and EAP coverage under COBRA for up to 18 months if coverage ends because of any of the following qualifying events:

- Employment ends for any reason other than gross misconduct, or
- The employee's scheduled work hours are reduced to a level that they are no longer eligible for coverage.

An employee may be eligible to continue Healthcare Flexible Spending Account participation until December 31 of the calendar year in which any of the above qualifying events occurs.

Continuation for 36 Months

A covered spouse and covered dependent children of the employee may continue healthcare, dental care, vision care and EAP coverage for up to a total of 36 months if coverage ends because of any of the following qualifying events:

- Legal separation or divorce from the covered employee
- The covered employee becomes entitled to Medicare
- Death of the covered employee

Covered dependent children of the employee may also continue healthcare, dental care, vision care and EAP coverage for up to a total of 36 months if they lose coverage because they no longer qualify as eligible dependents (for example if they turn age 26).

In the Case of Disability

If the Social Security Administration determines that a covered employee or a covered family member was totally disabled under Title II or Title XVI of the Social Security Act at the time of the qualifying event, or during the first 60 days of the 18-month continuation period, the continuation period will be extended from 18 months to 29 months. This extension is available to all covered family members, even if the disabled family member does not take advantage of the extension. The person requesting the extension must send a copy of the determination notice to Voya before the end of the initial 18-month period and within 60 days of the date of the notice. Covered individuals must also notify Voya within 30 days of a determination that the disabled person is no longer disabled.

Multiple Qualifying Events

If a covered spouse or dependent child experiences more than one qualifying event, they may be eligible for an additional period of continued coverage, not to exceed a total of 36 months from the initial qualifying event.

For example, suppose an employee terminates employment on December 31, 2025, and is eligible to continue

coverage for 18 months (until June 30, 2027). Their covered child ceases to be an eligible dependent (a second qualifying event) on December 31, 2026. The child is then eligible to extend coverage, up to a maximum of 36 months from the date of the original qualifying event. In this example, the child may continue coverage through December 31, 2028, which is 36 months from the original qualifying event date of December 31, 2025.

To be eligible for extended coverage after a second qualifying event, the covered person must notify Voya within 60 days of the date of the second qualifying event.

When COBRA Coverage Ends

COBRA coverage ends if any of the following occurs:

- The COBRA participant fails to make a required payment within 30 days of the date it is due,
- Smith College stops offering healthcare, dental care, vision care, EAP and/or Healthcare Flexible Spending Account coverage to all employees,
- The COBRA participant begins participation in other group healthcare, dental care, vision care, EAP and/or Healthcare Flexible Spending Account coverage after the election of COBRA coverage (If the other plan limits coverage of a preexisting condition, COBRA coverage may be continued in certain circumstances), or
- The COBRA participant becomes entitled to Medicare after the election of COBRA medical coverage

Healthcare Flexible Spending Account participation under COBRA ends on the earlier of: December 31 of the calendar year in which the qualifying event occurs or the date that any of the events listed above occurs.

Type of Coverage

The healthcare, dental care, vision care, EAP and Healthcare Flexible Spending Account plans available to you through COBRA are the same as the plans offered to active employees. Any changes to the plans for active employees will automatically apply to those enrolled under COBRA.

How to Continue Coverage

If the qualifying event is termination of employment or a reduction in work hours, Voya will notify the employee and any covered eligible dependents of their continuation rights. If a covered employee dies, Voya will send the COBRA notification to any covered dependents.

Smith College and Voya will not, however, be aware of all qualifying events - such as divorce or a child no longer qualifying as a dependent. It is the covered employee's responsibility to notify Smith College's Human Resources within 60 days of the qualifying event. A COBRA notice explaining continuation rights will be sent to affected covered family members after Smith College receives notification of a qualifying event.

Covered employees and their eligible covered family members have 60 days from the date of the qualifying event or the date the COBRA notice is sent by Voya, whichever is later, to elect to continue coverage. Eligibility to continue coverage via COBRA is forfeited if not elected within 60 days.

Employee/Dependent Cost for COBRA

Covered subscribers will receive monthly bills for COBRA coverage from Voya. Payment must be made in full no later than 30 days from the due date. Failure to pay on a timely basis will result in cancellation of coverage with no option for reinstatement.

The cost of COBRA coverage is determined as follows:

- **Healthcare, dental care, vision care and EAP coverage.** Covered subscribers are required to pay the full cost of healthcare, dental care, vision care and EAP coverage, which includes Smith College's full cost for providing the elected coverage, plus an additional 2% of that amount to cover the cost of administrative services. If Smith College's cost for providing coverage changes, the COBRA cost will also change.
- **Healthcare Flexible Spending Accounts.** The employee's remaining contributions will be converted to a monthly contribution rate and will be made by the employee electing continuation on an after-tax basis. Enrollees are also required to pay an administrative fee of 2% of their contribution.

Changing COBRA Coverage

Healthcare, Dental Care, Vision Care and EAP Coverage

COBRA enrollees may make changes to their healthcare, dental care, vision care and EAP coverage during the annual open enrollment period (such as switching between plans). However, the annual open enrollment period cannot be used to add COBRA coverage for a benefit that was not elected during the initial 60 day COBRA election period.

COBRA enrollees may also make certain qualified status changes to their COBRA coverage, such as:

- Adding a new spouse or a newborn, a newly adopted child or a child that is placed for adoption to their healthcare, dental care, vision care or EAP coverage,
- Adding an eligible dependent who loses other healthcare, dental care, vision care or EAP coverage,
- Adding a dependent to healthcare, dental care, vision care or EAP coverage if required by a Qualified Medical Child Support Order, and
- Changing healthcare plan option if the subscriber moves into or out of the HMO coverage area.

Enrollees must contact Voya within 60 days of the event that caused the status change in order to change coverage while on COBRA. Coverage will be effective on the date of birth, adoption or placement for adoption for newborn or newly adopted children who are enrolled within 31 days of birth, adoption or placement for adoption. In the case of a domestic relations judgment, decree or order, the child will be covered on the date specified in the judgment, decree or order.

Healthcare Flexible Spending Account

While continuing participation in the Healthcare Flexible Spending Account under COBRA, covered employees may submit eligible expenses for a new spouse or newborn or newly adopted child for reimbursement.

Because Healthcare Flexible Spending Account participation under COBRA ends on December 31 of the calendar year in which the qualifying event occurs, a covered employee may not elect to continue participation in a Healthcare Flexible Spending Account during annual enrollment.

Newborn and Adopted Children

If the covered employee/former employee adopts a child (or a child is placed with them for adoption) the child will be a "qualified beneficiary" with independent election rights and multiple qualifying event rights.

If a covered dependent has a baby, adopts a child or a child is placed with that dependent for adoption during the COBRA continuation period, that child will be eligible for healthcare, dental care, vision care and/or EAP coverage under COBRA. The child of the covered dependent will not, however, be considered a qualified beneficiary with independent election rights and multiple qualifying event rights.

If a Covered Employee Becomes Entitled to Medicare

If an active employee becomes entitled to Medicare and later experiences a qualifying event (for example, termination of employment), they and their dependents may be eligible for continued healthcare coverage when the qualifying event occurs. In this case, coverage may be continued for up to 18 months following the qualifying event. A covered spouse and covered dependents may continue coverage for the longer of: 18 months from the qualifying event or 36 months from the date of the employee's Medicare entitlement.

If an employee becomes entitled to Medicare after electing to continue coverage under COBRA, the continued coverage will end on their Medicare entitlement date. Covered dependents, however, may be eligible for up to 36 months of continued COBRA coverage from the date of the original qualifying event.

Questions About COBRA Coverage

If you have questions about COBRA coverage or payments, contact the COBRA administrator, Voya.

Telephone:	833-232-4673
Address:	Voya Financial
	P.O. Box 23983
	New York, NY 10087-3983

CLAIMS PROCEDURES

Except as provided below, claims for benefits under each plan that is either insured or self-insured will be reviewed in accordance with procedures contained in the policies, contracts, summary plan descriptions, or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator. If a claim under the Plan is denied in whole or in part, the covered person or their beneficiary will receive written notification. The notification will include the reasons for the denial, with reference to the specific

provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If the Claims Administrator fails to respond within 90 days, the claim is treated as denied. (This period may be extended to 180 days under certain circumstances.) Within 60 days after denial, a covered person or their beneficiary may submit a written request for reconsideration of the application to the Claims Administrator.

Any such request should be accompanied by documents or records in support of the appeal. The appealing party may review pertinent documents and submit issues and comments in writing. The Claims Administrator will review the claim and provide a written response to the appeal within 60 days. (This period may be extended to 120 days under certain circumstances.) In this response, the Claims Administrator will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based. The Claims Administrator has the exclusive right to interpret the provisions of the Plan. Decisions of the Claims Administrator are final, conclusive, and binding.

Claims Procedures For Group Health Plans (Healthcare Plan, Dental Care Plan, Vision Care Plan and Healthcare Flexible Spending Accounts):

The following claims procedure shall apply specifically to claims made under any group health plan under this Plan. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for the group health plan, the claims procedure in such other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with applicable Department of Labor regulations. These regulations and claims procedures are subject to change, so please contact the party that processes your healthcare claims (the "Claims Administrator") or the Plan Administrator for a current written explanation of the claim procedures for group health plans.

For information on how to file an initial claim, see the plan's summary or certificate of coverage or contact Human Resources.

You have the right to a full and fair review when you disagree with a decision that is made by the benefit carrier / insurance company to deny a request for coverage or payment for services; or you disagree with how your claim was paid; or you are denied coverage in this plan; or your coverage is canceled or discontinued by benefit carrier / insurance company for reasons other than nonpayment of your cost for coverage in this group plan. You also have the right to a full and fair review when you have a complaint about the care or service you received from a benefit carrier / insurance company or from a provider who participates in your health / dental / vision care network.

When making a determination under the plan, the benefit carrier / insurance company has full discretionary authority to interpret this benefit booklet and to determine whether a health service or supply is a covered service under the plan. All determinations by the benefit carrier / insurance company with respect to benefits under the plan will be conclusive and binding unless it can be shown that the interpretation or determination was arbitrary and capricious.

For help resolving a problem or concern, you should first contact the benefit carrier / insurance company's customer service office. The toll-free phone number to call is shown on your ID card. A customer service representative will work with you to help you understand your coverage or to resolve your problem or concern.

The benefit carrier / insurance company will consider all aspects of the particular case when resolving a problem or concern. This includes looking at: all of the provisions of the plan; the policies and procedures that support the plan; the provider's input; and your understanding of coverage by the plan. The benefit carrier / insurance company may use an individual consideration approach when it judges it to be appropriate. The benefit carrier / insurance company will follow its standard guidelines when it resolves your problem or concern.

If after speaking with the benefit carrier / insurance company's customer service representative, you still disagree with a decision that is given to you, you may request a formal review through the benefit carrier / insurance company's Appeal and Grievance Program.

Claims Procedures for Life Insurance, Travel Accident Insurance

Claim Review Procedures

For information about filing your initial claim, see the plan's summary or certificate of coverage or contact Human Resources for a copy.

After you file a claim for benefits, the claims administrator will notify you of the claim determination within 90 days of the receipt of your claim. This period may be extended by 90 days if an extension is necessary to process your claim due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and when the plan expects to decide your claim, will be furnished to you within the initial 90- day period.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice of your denial. The notice will include:

- The specific reason(s) for the denial
- References to the specific plan provisions on which the benefit determination was based
- A description of any additional information that would be useful in reconsidering your claim and an explanation of why that information is necessary
- A statement regarding your rights to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A description of the plan's appeals procedures and applicable time limits
- A statement of your right to bring a civil action under ERISA following an adverse benefit determination on review

Claim Appeal Procedures

You or your authorized representative may appeal a denied claim in writing to the claims administrator within 60 days of the receipt of the written notice of denial. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if they were not submitted with your original claim.

A full review of the information in the claim file and any new information that you submit to support your appeal will be conducted. The claims administrator will make a determination on your claim appeal within 60 days of the receipt of your appeal request. This period may be extended for an additional 60 days if the claims administrator determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the claims administrator expects to render a decision will be furnished to you within the initial 60-day period.

If your claim appeal is denied in whole or in part, you will receive a written notification of the denial. The notice will include:

- The specific reason(s) for the denial
- References to the specific plan provisions on which the benefit determination was based
- A statement regarding your rights to obtain, upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A statement of your right to request access to and copies of all documents, records and other information relevant to your denied claim, free of charge
- A statement of your right to bring a civil action under ERISA (see page 34) following an adverse benefit determination on review

LONG TERM DISABILITY

CLAIMS PROCEDURE FOR BENEFITS BASED ON DETERMINATION OF DISABILITY

The following claims procedure shall apply specifically to claims made under the Plan for benefits based on a determination of disability. To the extent that this procedure is inconsistent with the claims procedure contained in the policies, contracts, summary plan descriptions or other written materials for such plans, the claims procedure in the other policies, contracts, summary plan descriptions, or other written materials shall supersede this procedure as long as such other claims procedure complies with Department of Labor regulations.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification. This claim denial will include the reasons for the denial, reference to the Plan provision supporting the denial, and a description of the Plan's appeals procedures. The discussion of the claim denial will also include:

- if applicable, an explanation for disagreeing with or not following the views of healthcare professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration;
- the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist); and a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request).

You will receive a benefit denial notice within a reasonable period of time, but no later than 45 days after the Claims Administrator's receipt of the claim. The Claims Administrator may extend this period for up to 30 additional days provided the Claims Administrator determines that the extension is necessary due to matters beyond the Claims Administrator's control and the claimant is notified of the extension before the end of the initial 45-day period and is also notified of the date by which the Claims Administrator expects to render a decision. The 30-day extension can be extended by an additional 30 days if the Claims Administrator determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

You have 180 days to appeal an adverse benefit determination. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits. You will be notified of the Claims Administrator's decision upon review within a reasonable period of time, but no later than 45 days after the Claims Administrator receives your appeal request.

The 45-day period may be extended for an additional 45-day period if the Claims Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

For information about filing Long Term Disability (LTD) claims, see The Hartford's Certificate of Insurance or contact Human Resources.

Rights Under ERISA

As a participant in the Smith College health and welfare plans described in this booklet, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), except in the case of benefits plans that are not subject to ERISA (including but not limited to, Health Savings Accounts). ERISA provides that all plan participants in ERISA subject plans shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, your spouse, or your eligible dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one,

including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit subject to ERISA or otherwise exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Plan Administrator

Smith College, as the Plan Administrator, shall be responsible for the overall administration of the benefit plan. Smith College shall be the "named fiduciary" within the meaning of ERISA. Smith College may adopt rules and procedures, as it deems desirable for the conduct of its affairs and the administration of the benefit plans, provided that any such rules and procedures shall be consistent with the provisions of such plans and ERISA.

The Plan Administrator shall have the duty and authority to interpret and construe the terms of the benefit plan,

including, but not limited to, all questions of eligibility, the status and rights of benefit plan participants, and, unless delegated to the claim's administrator, the manner, time, and amount of payment of any benefits under the Plan.

The Plan Administrator shall discharge its duties with respect to the benefit plan (i) solely in the interest of the benefit plan participants (ii) for the exclusive purpose of providing benefits to the benefit plan participants and of defraying reasonable expenses of administering the benefit plans and (iii) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

Funding Policy

Smith College may establish a funding policy and method consistent with the objectives of the benefit plans and applicable law.

Plan Termination

Smith College expects to continue the health and welfare plans. However, Smith College, in its sole discretion, reserves the right to amend, modify or terminate any plan or provision contained in the booklet or the accompanying plan summaries, including insurance certificates. Claims arising before the date of termination would be reviewed and honored if the Plan Administrator determines such claims are valid.

Plan Information

This section contains important information about the administration of your health and welfare benefits.

Plan Sponsor

Smith College

10 Elm Street

Northampton, MA 01063

Plan Administrator

Trustees of Smith College

Office of Human Resources

42 West Street, Northampton, MA 01063

Legal Process

You may serve legal process on the Plan Administrator.

Plan Name

Smith College Health and Welfare Benefit Plans

Plan Year

The plan year for all benefits described in this booklet is January 1 to December 31 unless otherwise

specifically stated.

Employer Identification Number

Smith College's employer identification number is 04-1843040.

Plan Administration and Funding

Contributions necessary to fund the plans are provided by Smith College and the employees. Smith College shall contribute the difference between the amount employees contribute and the amount required to pay benefits under the plan.

Plan	Type of Plan	Plan Insurer/Claims Administrator	Type of Administration	Funding	Plan Number
Healthcare Plan	Welfare Health	Blue Cross Blue Shield of Massachusetts 101 Huntington Ave, Ste. 1300, Boston, MA 02199-7611	Self-funded; claims paid by third-party administrator	College and employees pay premiums	510
Pharmacy Plan	Welfare Health	OptumRx 2300 Main St Irvine, CA 92614	Self-funded; claims paid by third-party administrator	College and employees pay premiums	510
Dental Care Plan	Welfare Health	Delta Dental 465 Medford St. Boston, MA 02129	Self-funded; claims paid by third-party administrator	College and employees pay premiums	510
Vision Care Plan	Welfare Health	EyeMed 3130 Broadway Kansas City, MO 64111	Insured	Employees pay premiums	510
Long Term Disability Insurance	Welfare Disability	The Hartford 690 Asylum Ave. Hartford, CT 06155	Insured; claims paid by third-party administrator	College pays premiums for basic coverage; If offered, employees pay premiums for supplemental coverage	510
Life Insurance Basic AD&D Supplemental Dependent	Welfare Life Insurance	The Hartford 690 Asylum Ave. Hartford, CT 06155	Insured; claims paid by third-party administrator	College pays premiums for Basic Life and AD&D Insurance; employees pay premiums for Supplemental and Dependent Life Insurance	510
Travel Accident Insurance	Welfare Accident	The Hartford 690 Asylum Ave. Hartford, CT 06155	Insured; claims paid by third-party administrator	College pays premiums	510

Healthcare Flexible Spending Account	Welfare Flexible Spending Accounts	Voya Benefits Company, LLC PO Box 1168 Minneapolis, MN 55440	Third-party administrator pays claims	Employees make contributions; College pays administrative fees	510
Employee Assistance Program	Welfare Employee Assistance Program	ComPsych 855-784-2056 Guidanceresources.com	Insured	College pays premiums	510

If You Have Questions

If you have questions about your health and welfare benefits, please contact the plan directly. You may also contact Human Resources at hr@smith.edu.

Plan	**Plan Insurer Claims Administrator**	**Web/E-mail**	**Telephone**
Healthcare Plan	Blue Cross Blue Shield of Massachusetts	https://www.bluecrossma.org	800-782-3675
Pharmacy Plan	OptumRx	www.optumrx.com	888-374-8127
Dental Care Plan	Delta Dental	https://deltadentalma.com	800-872-0500
Vision Care Plan	EyeMed	www.eyemed.com	866-939-3633
Long Term Disability Insurance	The Hartford	https://abilityadvantage.thehartford.com	888-301-5615
Life Insurance	The Hartford	https://abilityadvantage.thehartford.com	866-294-7987
Travel Accident Insurance	The Hartford	Email: assist@imglobal.com	800-243-6108
Flexible Spending Accounts	Voya Financial	https://myhealthaccountsolutions.voya.com	833-232-4673
Employee Assistance Program	ComPsych	www.guidanceresources.com	855-784-2056

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, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	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	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: https://dss.mo.gov/mhd/hipp Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ 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	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	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, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)