Your Smith College Health and Welfare Benefits Summary Plan Description

Administrative and Staff Positions

About This Booklet

In this booklet you'll find important information about health and welfare benefits at Smith College. Health and welfare benefits include Health Care, Dental Care, Vision Care, Life and Accident, Disability, Healthcare Spending Accounts, Employee Assistance Program and Tuition 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 you 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.

You 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 page 51-53) or contact Human Resources at hrbenefits@smith.edu.

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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*.

Temporary employees and/or employees scheduled to work less than 17.5 hours per week are eligible for Identity Theft Protection and 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 spouses 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 also 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 in to 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

Plan	**When Coverage Begins** (provided you complete all required enrollment steps in the specified timeframe, see page 7)
Health Care Plan	Date of hire
Dental Care Plan	Date of hire
Vision Care Plan	Date of hire
Life Insurance • Basic • Supplemental • Dependent • AD&D	Date of hire
Travel Accident Insurance	Date of hire
Long Term Disability Insurance	Date of hire Coverage may be subject to pre-existing condition limitations (see page 21)

**A fixed-term employee is one who is hired for a specified period of more than five months and generally up to two years and who is scheduled to work 17.5 or more hours per week. A fixed-term position that is grant-funded may be extended for longer than two years contingent on renewed grant funding.*

Health Care or Dependent Care Flexible Spending Accounts	Date of hire
Health Savings Account	Date of hire provided you enroll in a qualified HDHP and are not enrolled in Medicare
Employee Assistance Program	Date of hire
Tuition Assistance Program	Following years of service stipulated in the Employee Handbook
Mid-year status changes** (i.e. birth/adoption, marriage, loss of coverage)	Date of the qualified status change (i.e. date of birth, date of marriage, date previous coverage ended)

Dependent Eligibility

The following dependents may be eligible for coverage under the Health Care, Dental Care, Vision Care, Dependent Life Insurance, Spending Account and Employee Assistance Programs. Dependent eligibility under the Tuition Assistance Program depends on your position and consecutive years of service requirements at Smith College (see page 27).

Spouse: Your spouse is a person to whom you are married. The laws of the Commonwealth of Massachusetts must recognize the marriage.

Ex-Spouse: For Health Care, Dental Care and/or Vision Care only, an ex-spouse is a person to whom you were married. The laws of the Commonwealth of Massachusetts **must** have recognized the marriage. You may enroll up to one Spouse or Ex-Spouse at any time. **Ex-spouses are ineligible for other coverage including Dependent Life Insurance.**

Children: The term *children* include your natural children, legally adopted children, foster children, children who are placed in your home for adoption and stepchildren who are primarily supported by you, including children of your spouse. It also includes children that you are required to cover under the terms of a Qualified Medical Child Support Order (see page 28).

***Retroactive coverage cannot be paid for on a pre-tax basis in the event of marriage, loss of coverage, change in employment status and change in student status. Therefore, if you do not enroll in the Health Care, Dental Care or Vision Care plan before your deductions are taken, the retroactive deductions must be taken on an after-tax basis.*

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This chart summarizes eligibility for dependent children. Please refer to the plan insurer's certificate or summary for further information.

Plan	Dependent Child Eligibility
Health Care Plan Dental Care Plan Vision Care Plan Dependent Life Insurance Employee Assistance Program	A child must be a biological, adopted, or stepchild of yours or your spouse. The child may also be the subject of a court order that requires you to provide health insurance for the dependent (a copy of the court order must be filed with the Benefits department). The child must be under age 26. Children age 26 or older may be eligible if they are unmarried and incapable of supporting themselves because of mental or physical impairment, provided that impairment began before age 26. If a covered dependent child gives birth, the newly born grandchild may be covered. Coverage for any offspring of your dependent child would end when your dependent child's coverage ends. Note: Dependent Life Insurance excludes grandchildren.
Healthcare and Dependent Care Spending Accounts Health Savings Accounts	The child must be a federal income tax dependent. See page 21 for additional details.
Tuition Assistance Program	The child must be unmarried and under age 24 and must qualify as your dependent for tax purposes in the current tax year.

Exclusions

Parents, ex-spouses (unless required under state law), 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 page32).

Notification

You are responsible for notifying Human Resources within 30 days in the event of divorce, or in the event your child ceases to meet the eligibility requirements for benefit coverage.

Documentation of Dependents

The College maintains the right to request documentation from you at any time to ensure that your dependents meet the 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 that you enroll. For others, coverage is automatic.

Enrollment Required	Coverage Is Automatic
▪ Health Care ▪ Dental Care ▪ Vision Care ▪ Healthcare Flexible Spending Account ▪ Dependent Care Flexible Spending Account ▪ Health Savings Account ▪ Supplemental Life Insurance ▪ Dependent/Spouse Life Insurance ▪ Identity Theft Protection	▪ Basic Life Insurance ▪ Accidental Death & Dismemberment (AD&D) Insurance ▪ Basic Long-Term Disability ▪ Travel Accident Insurance ▪ Employee Assistance Program (EAP) ▪ Massachusetts Paid Family Medical Leave (MA PFML)

When you begin working at the College and have completed required onboarding tasks such as the I-9 task assigned in Workday, you will receive the necessary enrollment task(s) via Workday. Be sure to complete the task(s) within 30 days of your date of hire. Otherwise, coverage will not be available until the next annual open enrollment period or upon certain qualified status changes. If you enroll in Supplemental Life and Spouse/Dependent Life Insurance more than 30 days after you are first eligible, or in amounts that exceed the guaranteed issue amount for new hires, medical documentation and approval by the carrier will be required.

Please note that retroactive coverage cannot be provided on a pre-tax basis. Therefore, if you do not enroll in the Health Care or Dental Care plan before your first deductions are taken, the retroactive deductions must be taken on an after-tax basis.

You also need to indicate a Life/Accident Death beneficiary. This is to be completed via Workday. Your beneficiary designation will apply to your Basic Life, AD&D, Supplemental and Travel Accident Insurance. You may change your beneficiary at any time in Workday.

Rehired Employees or Changes in Benefit Eligible Status

If your employment ends and you are then rehired within 30 days of your termination date, you will not be permitted to make new pre-tax elections without a corresponding change in status (see page 8-9). Also, if your position becomes non-benefit eligible for a period of 30 days or less, your benefits will be reinstated with no option to make new pre-tax elections when your position becomes benefit eligible again. You may not change your elections unless you have had a qualified status change (see page 8-9).

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

If you are declining enrollment for yourself or your dependents (including your spouse/ex-spouse) because of other health insurance, dental insurance and/or vision insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided you complete enrollment via Workday within 30 days after your other coverage ends. In addition, if you have anew dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you complete enrollment via Workday within 30 days after the marriage, birth, adoption, or placement for adoption.

Changing Coverage

Annual Enrollment

The annual enrollment period is held each November/December for a January 1 effective date. During annual enrollment, you may change your Health Care coverage, Dental Care coverage, Vision Care coverage and your Spending Account contributions without the normal restrictions that apply at other times of the year.

Status Changes

Under certain circumstances, known as qualified status changes, you may:

- Change your Health Care, Dental Care or Vision Care coverage, or
- Change Healthcare or Dependent Care Spending Account contributions

If you want to change your elections as a result of a qualified status change, you must do so via Workday within 30 days of the date of the qualified status change. Otherwise, you may not change your coverage until the next annual enrollment period or until you experience another qualified status change.

Following is a list of qualified status changes and a general summary of the plans under which you may make election changes. Your election change must be *on account of and consistent with* the event that caused your qualified status change. For example, if you get married, you may add your spouse to your Smith College Health Care coverage or drop your coverage to join your spouse's plan.

If this status change occurs...	*You may change your elections for these plans...*		
	Health Care, Dental Care or Vision Care Plan	Healthcare Spending Account	Dependent Care Spending Account
Change in marital status, including marriage, divorce, legal separation or annulment	Yes	Yes	Yes
Change in number of dependents, including birth, adoption, placement for adoption, death of a dependent or assuming primary support of the child of an unmarried dependent child	Yes	Yes	Yes
Change in your employment status or that of your spouse or dependents that results in gain or loss of coverage	Yes	Yes	Yes
Change in the eligibility of a covered dependent, such as age or student status	Yes	N/A	Yes
Moving outside your current health care coverage area	Yes	Yes, if moving to or from HDHP	N/A
Issuance of a family relations judgment, decree or order, such as a Qualified Medical Child Support Order	Yes	Yes	N/A
Change in your eligibility or that of your spouse or covered dependents for Medicare or Medicaid	Yes	Yes	N/A
Change in dependent care provider, cost of dependent care or number of hours worked by care provider	N/A	N/A	Yes

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 you do not enroll in the Health Care, Dental Care or Vision Care plan before your first deductions are taken, the retroactive deductions must be taken on an after-tax basis.

When Coverage Ends

The table below shows when your health and welfare plan coverage ends if your employment with Smith College terminates. Coverage may end sooner if you cease to be in an eligible position (for example, if you reduce to less than half-time), you fail to make required payments or the plan is discontinued for your class of employee. Your health and welfare plan coverage will not end if your hours are reduced (even to zero) as a result of a furlough.

When your Health Care, Dental Care, Vision Care, Healthcare Spending Account and EAP coverage end, you may be eligible to continue them under COBRA (see page 32).

Plan	When Coverage Ends On …
Health Care Plan	Termination date
Dental Care Plan	Termination date
Vision Care Plan	Termination date
Life Insurance ▪ Basic ▪ Supplemental ▪ Dependent ▪ AD&D	Termination date
Travel Accident Insurance	Termination date
Long Term Disability Insurance	Termination date
Massachusetts Paid Family Medical Leave (MA PFML)	Termination date, unless eligibility requirements are met before the termination date in which case associated benefits may be requested within 26 weeks of the termination date
Healthcare or Dependent Care Flexible Spending Accounts	Termination date
Employee Assistance Program	Termination date
Tuition Assistance Program	Termination date (Approved courses that are completed before your termination date may be eligible for reimbursement.)

When Dependent Child Coverage Ends

A dependent child's coverage generally ends on the date that the child no longer meets the plan's definition of an eligible dependent. Following are the specific provisions for the Health Care, Vision Care and Dental Care Plans:

Health Care, Dental Care or Vision Care Plan coverage ends on the last day of the month in which a child turns age 26.

Certification of Health Care Coverage

Upon request, when you or your dependents' health care coverage ends, Smith College will give you and/or your dependent(s) a "coverage certification," a written record of the coverage you received under the health care plan and under COBRA, if applicable. You and/or your dependent(s) can receive a coverage certification when your coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if your new employer's plan has a preexisting condition limitation, the employer may be required to reduce the duration of the limit by one day for each day of your prior coverage (subject to certain requirements). You may also need to present the coverage certification to your insurer if you are buying individual coverage.

Health Care Plan

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

- Blue Cross Blue Shield of Massachusetts Preferred Provider Organization (PPO) Plan
- Blue Cross Blue Shield of Massachusetts Health Maintenance Organization (HMO)
- Blue Cross Blue Shield of Massachusetts Value Health Maintenance Organization (Value HMO)
- Blue Cross Blue Shield of Massachusetts High Deductible Health Plan with Health Savings Account (HDHP)
- OptumRx (Pharmacy Program)

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

Paying for Your Coverage

You and Smith College share the cost of the Health Care Plan. The college-paid premium is prorated at 75% of the full-time benefit if your appointment is more than half-time but less than full-time. You pay your share of the cost on a before-tax basis (except for retroactive coverage for status changes other than birth of child, adoption and placement for adoption or if you are not receiving any pay during a furlough), which means that your share of the cost is deducted from your pay before taxes are calculated. This results in tax savings for you. Paying for your coverage with before-tax money may slightly reduce your Social Security retirement benefit.

Participating Providers

If you enroll in the PPO or HDHP, you receive a higher level of benefits when you use Blue Cross Blue Shield of Massachusetts participating providers. If you enroll in the HMO or Value HMO, you receive coverage *only* when your care is provided or authorized by your primary care physician (PCP), except when you need emergency or urgent care. Blue Cross Blue Shield of Massachusetts' participating providers include doctors, hospitals, laboratories and other health care professionals and facilities.

Blue Cross Blue Shield of Massachusetts determines and maintains the list of providers. You may access this via Blue Cross Blue Shield of Massachusetts website or calling them.

You may only switch between health plan options during the annual enrollment period (see page 8), or if you move out of the service area.

*Note: Unless otherwise communicated, your elections **will** carry over from year to year. You do not need to re-enroll every year that you want to participate.*

Patient Protection Disclosure

Smith College's health care plans typically require the designation of a primary care provider. You 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 you or your covered dependents. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health insurance carrier. For children, you may designate a pediatrician as the primary care provider.

You 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 health care professional in the respective Blue Cross Blue Shield network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health insurance carrier.

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 health care 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 applicable plan deductibles, coinsurance and copayments.

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)**.

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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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov	Website: http://dss.sd.gov

Phone: 1-888-549-0820	Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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

Dental Care Plan

Smith College offers a choice of two dental plans:

- Delta Dental High Plan
- Delta Dental Value Plan

This booklet describes Smith College's eligibility and enrollment provisions, certain rights you have under the dental care plan and other important information. Along with this booklet, a summary from Delta Dental that describes what is covered, the advantages of using participating dentists and how to receive plan benefits is available online.

Paying for Your Coverage

You and Smith College share the cost of the Dental Care Plan. The college-paid premium is prorated at 75% of the full-time benefit if your appointment is more than half-time but less than full-time. You pay your share of the cost on a before-tax basis (except for retroactive coverage for status changes other than birth of child, adoption and placement for adoption or if you are not receiving any pay during a furlough), which means that your share of the cost is deducted from your pay before taxes are calculated. This results in tax savings for you. Paying for your coverage with before-tax money may slightly reduce your Social Security retirement benefit.

*Note: Unless otherwise communicated, your elections **will** carry over from year to year. You do not need to re-enroll every year that you want to participate.*

Vision Care Plan

This booklet describes Smith College's eligibility and enrollment provisions, certain rights you 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 online.

Paying for Your Coverage

You pay the cost of the Vision Care Plan. You pay the cost on a before-tax basis (except for retroactive coverage for status changes other than birth of child, adoption and placement for adoption or if you are not receiving any pay during a furlough), which means that your share of the cost is deducted from your pay before taxes are calculated. This results in tax savings for you. Paying for your coverage with before-tax money may slightly reduce your Social Security retirement benefit.

*Note: Unless otherwise communicated, your elections **will** carry over from year to year. You do not need to re-enroll every year that you want to participate.*

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 Lincoln Financial Group. For the travel accident plan, see the Travel Accident Insurance & Travel Services Program Summary of Coverage.

The College pays the cost of Basic Life Insurance, Accidental Death & Dismemberment and Travel Accident Insurance. You pay the cost of Supplemental and Dependent Life Insurance, if you elect these coverages.

Basic Life Insurance

Basic Life Insurance coverage provides a benefit equal to your 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 Basic Life Insurance benefit is $500,000.

Basic annual earnings include the salary you would normally earn at the College in a fiscal year. "Basic annual earnings" do not include overtime, stipends, etc. Your Basic Life Insurance coverage is adjusted automatically to conform to any changes in your 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

If you die or suffer certain injuries as a result of an accident, you or your beneficiary may be eligible for AD&D benefits. AD&D benefits are payable in addition to Basic and Supplemental Life Insurance.

If you die as the result of an accident, the AD&D benefit will be an amount equal to yourBasic Life Insurance. If you suffer certain injuries as a result of an accident, you mayreceive a percentage of the AD&D death benefit.

Travel Accident Insurance

Twenty-four-hour life and disability insurance coverage is provided while you are on College business if you are required to leave the corporate limits of the city or town in which you live or to which you are regularly assigned for employment duties. Coverage begins at the start of an anticipated trip whether it is from your place of employment, your home, or other locations. Coverage terminates when you return to your home or to the College, whichever occurs first.

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

Supplemental Life Insurance

You may elect Supplemental Life Insurance equal to an additional one, two, three, four or five times your basic annual earnings (up to $700,000), rounded to the next highest $1,000. If you enroll within 60 days of hire, proof of good health is not required for the lesser of up to an additional three times your basic earnings or $475,000. If you enroll after 60 days or you elect four or five times your basic annual earnings, you must submit proof of good health and obtain acceptance of the requested change from the insurance company.

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

Dependent Life Insurance

In addition to coverage for yourself, you may elect Dependent Life Insurance coverage for your spouse and/or eligible dependent children (see page 5).

You may purchase from $10,000 to $150,000 in life insurance for your spouse and $5,000 or $10,000 for each of your children. If you elect over $40,000 in coverage for your spouse, you must submit proof of their good health acceptable to the insurance company. You pay the full cost of Dependent Life Insurance through payroll deduction on an after-tax basis.

Beneficiary Designation

It is important that you name a beneficiary or beneficiaries in Workday and that you keep this information up-to-date. If you wish to change your beneficiary, you may do so at any time in Workday.

If you do not indicate a beneficiary in Workday, or if no beneficiary is surviving at the time of your death, life insurance benefits would be payable as described in the Certificate of Insurance. This certificate provides that Lincoln Financial may pay benefits to the first of the following survivors in the following order: your spouse, your children or your parents. Lincoln Financial will make this determination depending on the circumstances surrounding the claim. For this reason, it's important that you indicate a beneficiary or beneficiaries in Workday. This is especially true if you want your domestic partner to receive your life insurance benefits in the event of your death.

Accelerated Benefit

Accelerated benefits may be payable if you, your spouse or your child becomes terminally ill and has a medical prognosis of 12 months or less to live. This option allows you to receive a portion of your or your dependent's life insurance while living.

Please contact Human Resources or see your Certificate of Insurance if you need further information 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 you with salary continuation in the event that illness or injury prevents you 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 you 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 your Employee Handbook to determine how your other benefits are affected while you are receiving LTD benefits.

If you are eligible for LTD insurance, you will be enrolled (60% coverage) on your first day of work. 60% coverage is provided by the College at no cost to you. The value of the LTD premium is considered imputed income for tax purposes so that any benefit received while on LTD will be tax-free to the employee.

Pre-existing Condition Limitations

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

Healthcare and Dependent Care Flexible Spending Accounts

The Healthcare and Dependent Care Spending Accounts offer you the opportunity to save tax dollars on your eligible out-of-pocket medical/dental/vision and employment-related dependent care costs. Here's how these accounts work: You make contributions to the spending accounts on a before-tax basis. This results in tax savings for you. Paying for your coverage with before-tax money may slightly reduce your Social Security retirement benefit. You are then reimbursed from your account for qualifying expenses—tax-free. Because of the tax advantages that these 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 you have under the spending accounts and other important information.

Healthcare Flexible Spending Account

You may use this account to pay for out of pocket (not covered by an insurance plan) medical, dental, vision and other health-related expenses that you pay for yourself and your family (see page 5 for information on dependent eligibility) during a calendar year. Some examples of qualifying expenses include copays, deductibles, coinsurance payments, medical, dental, or vision services and supplies, certain over-the-counter drugs, as well as certain surgical procedures. Some expenses are not eligible for reimbursement, such as expenses reimbursable by other plans, premiums for health insurance and Medicare, or medically unnecessary cosmetic treatments or procedures.

You may set aside voluntary contributions up to the IRS established annual maximum on a tax-free basis. You may submit expenses for yourself and for the dependents you claim on your federal income tax return. When your Healthcare Spending Account

coverage ends, you may be eligible to continue participation under COBRA. For more information on COBRA, see page 32.

Dependent Care Flexible Spending Account

This account allows you to pay for the first $5,000 of annual employment-related dependent care (child or adult) expenses tax-free. Additional limits apply depending on your marital status:

- If you are married and filing separate returns, your contributions are limited to $2,500.
- If you are married, your spouse must work or be actively seeking work. Special rules apply if your spouse is a full-time student or disabled.
- Your contribution cannot exceed your or your spouse's annual income. If your spouse is a full-time student or disabled, the IRS assumes their income is $250 month ($3,000 per year) if you have one dependent and $500 per month ($6,000 per year) if you have two or more dependents.

You may use the Dependent Care Flexible Spending Account to pay for eligible expenses for a dependent child who you are entitled to claim on your federal tax return, who lives in your home for at least eight hours a day and who is:

- Under age 13, or
- Over age 12 and physically or mentally incapable of self-care (spouse, child or dependent adult).

Eligible expenses generally include dependent care expenses that allow you (and your spouse, if you are married) to work. Some expenses are not eligible for reimbursement, such as care provided by a relative under age 19, expenses that your provider does not report as taxable income, sleep away camp, and babysitting for social occasions.

In many instances, the Dependent Care Flexible Spending Account may result in a greater tax savings than you could get through the IRS Dependent Care Tax Credit. You cannot, however, use the spending account and the Tax Credit for the same expenses. If you need help determining which is best for you, we suggest that you consult a personal tax advisor.

Signing up for Spending Accounts

You may be eligible to set up a Healthcare and/or Dependent Care Spending Account during the College's annual open enrollment period in November/December or within 30 days ofyour date of hire. You must complete enrollment online via Workday to indicate the specific amount you want to have withheld from your pay for the reimbursement of out-of-pocket healthcare or dependent care expenses.

Your elections do <u>not</u> carry over from year-to-year. You must re-enroll in Workday during the Open Enrollment Period every year that you want to participate.

Important!
Be sure to estimate your expenses conservatively. 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.

Payment of Claims

You must submit claims to Voya for reimbursement of eligible expenses. Claim forms are available at https://myhealthaccountsolutions.voya.com or by calling 833-232-4673.

Your claim must be accompanied by detailed bills or receipts for expenses you 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). You will forfeit any money remaining inyour account at the end of the plan year if you have not filed a claim for it by the end ofthe Run-Out Period. For example, claims for the 2024 plan year must be postmarked or submitted online or faxed no later than March 31, 2025.

The amount that you will be reimbursed for eligible expenses under the Dependent Care Spending Account will be limited to the balance in your account.

Grace Period

Smith College has established a "grace period" for the Health Care and Dependent Care Spending Accounts that follows the end of the Plan Year (January 1 through December 31) during which amounts you have allocated to the applicable spending account(s) that are unused at the end of the Plan Year may be used to reimburse eligible expenses (with respect to the applicable spending account) incurred during the grace period.

The grace period will begin on the first day of the next Plan Year and will end two and a half months later. For example, if the Plan Year ends December 31, 2024, the grace period begins January 1, 2025 and ends March 15, 2025.

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 PlanYear to which the grace period relates, or
- A Qualified Beneficiary who is receiving COBRA coverage under the HealthFSA 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 2024 Plan Year and further assume that you have elected to allocate $2,400 to the Health FSA for the 2025 Plan Year. If you submit for reimbursement an Eligible Medical Expense of $500 that was incurred on January 15, 2025, $200 of your claim will be paid out of the unused amounts remaining in your Healthcare FSA from the 2024 Plan Year and the remaining $300 will be paid out of amounts allocated to your Healthcare FSA for 2025.

- 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.

- You may not use Healthcare FSA amounts to reimburse Eligible Day Care Expenses (and if the grace period is offered under the Dependent Care FSA, Dependent Care FSA amounts may not be used to reimburse eligible medical expenses).

- 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.

Health Savings Account

The Health Savings Account (HSA) offers you the opportunity to pay for eligible medical expenses with pre-tax dollars. Here's how these accounts work: You and/or your employer make contributions to the savings account on a pre-tax basis. Contributions and interest grow tax-free and qualified withdrawals are tax-free. Because of the tax advantages that these accounts offer, they are subject to certain IRS restrictions.

To be eligible to enroll in the HSA, you must be enrolled in a qualified HDHP, such as the one Smith offers. You cannot be enrolled in another medical plan (some exclusions apply (examples include plans exclusively for dental, vision, long term care, and employee assistance, etc.). You cannot be enrolled in a healthcare flexible spending account (FSA) in the same year individually or under a spouse’s plan, and you cannot have *any* funds available in an FSA to be eligible to contribute to or receive contributions to an HSA. You cannot be enrolled in any part of Medicare and you cannot be claimed as a dependent on another person’s tax return.

You may use this account to pay for medical, dental, vision and other qualified health-related expenses that you pay for yourself and for your qualified dependents (see page 5

for information on dependent eligibility). These expenses may include deductibles, coinsurance payments, medical, dental, or vision services and supplies, certain over-the-counter drugs, as well as certain surgical procedures. Some expenses are not eligible for reimbursement such as expenses reimbursable by other plans or medically unnecessary cosmetic treatments or procedures.

You may set aside voluntary contributions up to the IRS established annual maximum on a tax-free basis; the employer and your contribution count towards these maximums. If you are age 55 or older, you may make an additional catch up contribution up to the IRS established maximum annually to your HSA. You may submit expenses for yourself and for the dependents you claim on your federal income tax return.

HSAs roll over year-to-year and the HSA stays with you when you change jobs or terminate employment. You can continue to pay for qualified expenses tax-free from funds in your account even if you become ineligible to contribute to your HSA.

Employee Assistance Plan

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 a range of emotional well-being services including anxiety, grief, communication problems, drinking or drug use, domestic violence, marital/family concerns, mood swings, depression, parenting, stress suicidal thoughts and more. In addition, the EAP offers legal consultation & referrals and financial consultation and referrals.

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. The only exceptions to this confidentiality provision are threats of violence, evidence of abuse to a child or senior, and risk of suicide.

Accessing EAP Services

The EAP is administered by ComPsych. EAP services may be provided in person or over the telephone. When you first contact the EAP, intake staff will ask where you live and where you work and will make arrangements for you to connect with an EAP counselor based on your needs. 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, you and the EAP counselor may decide that other kinds of expertise would be helpful. Your EAP counselor can make recommendations about follow-up assistance and will refer you to the most appropriate resources. If a referral beyond the EAP is made, any charges relating to those outside services will be explained to you (your health plan may cover the cost of additional

services). The EAP counselor will follow up with you to ensure that you are on your way toward successful resolution of the problem.

To reach an EAP counselor call toll-free 855-784-2056 - 24 hours a day, 7 days a week.

When Your EAP Coverage Ends

Your EAP coverage ends on your termination date or you cease to be an eligible employee (for example, if you reduce to less than half-time). When your EAP coverage ends, you may be eligible to continue coverage under COBRA (see page 32).

Tuition Assistance Program

The chart below shows eligibility for tuition assistance benefits for you, your spouse and your dependent children, which depends on your employment status.

Benefit Plan	Waiting Period	Employment Status	
		Regular (Full-Time & Part-Time)*	**Fixed-Term** (Full-Time & Part-Time)***
Employee taking courses at Smith College	One year	Eligible	Eligible
Employee taking courses at another college	One year	Eligible	Eligible
Employee's spouse taking courses at Smith College	One year	Eligible	Ineligible
Employee's children attending the Center for Early Childhood Education (CECE)	None	Eligible	Eligible (if role is for 3+ consecutive yrs.)
Employee's children attending Smith College	Hired prior to 7/1/2010: Three years Hired 7/1/2010 and after: Five years	Eligible	Ineligible
Employee's children attending another college	Hired prior to 7/1/2010: Three years Hired 7/1/2010 and after: Five years	Eligible	Ineligible

* *Includes employees regularly scheduled to work at least 17.5 hours per week. Benefits are pro-rated at 75% of the full-time benefit for part-time employees.*

** *A fixed-term employee is one who is hired for a specified period of more than five months and up to two years and who is scheduled to work 17.5 or more hours per week. A fixed-term position that is grant-funded may be extended for longer than two years contingent on renewed grant funding. For purposes of CECE tuition assistance, fixed term roles must exceed three consecutive years to qualify for eligibility.*

If You Are Rehired

If you terminated employment and are rehired, you will not have to satisfy a new waiting period for tuition assistance benefits if you are rehired within twelve months (one year) of your termination date.

This booklet contains just a brief summary of the Tuition Assistance Program and certain rights you have under this program. You'll find detailed information about this program in your Employee Handbook.

Qualified Medical Child Support Order

Your medical 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 you will be notified.

You may obtain a copy of the QMCSO procedures from Human Resources, upon request.

Coverage During Leave of Absence

You may generally continue your participation in the College's Health Care 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 you had continued to work. If your leave is unpaid, you will be billed for your share of the premiums.

Healthcare Spending Account participation may continue during your leave of absence**.** You may not continue participation in the Dependent Care Flexible Spending Account during a leave of absence. However, dependent care expenses incurred before your leave began will be eligible for reimbursement.

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 your 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 your Employee Handbook.

If you take an approved Family and Medical Leave of Absence (FMLA), you may be eligible to continue certain benefits.

You may continue participation in the health program during your FMLA. The College will continue its contribution toward the cost of coverage during your FMLA. If your FMLA is paid, your cost for coverage will continue to be deducted from your pay. If your leave is unpaid, you will be billed for your share of the cost.

You may also continue participation in the Healthcare Spending Account during your leave (but not in the Dependent Care Flexible Spending Account). If your FMLA is paid, your contributions will continue to be deducted from your pay. If your FMLA is unpaid, the contributions that you missed will be withheld from your pay when you return to work.

If you choose not to continue your Healthcare Spending Account during your FMLA, claims incurred during your FMLA will not be eligible for reimbursement. You may resume participation if you return to work after your FMLA. If you return in the same plan year, you will have two options:

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

Military Leave of Absence

If you are a member of the National Guard or a military reserve unit and are called to active military duty during a national, state or local emergency, you 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 your Employee Handbook.

If you are on an active military leave, you 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 your cost for health, dental, life, long-term disability and EAP plans for up to 12 weeks, and you will be billed for your share of the premium. After 12 weeks, you may continue

coverage under the health, dental, life, long term disability and EAP plans, but the College will discontinue its contributions, and you must pay the full cost.

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

You may also continue participation in the Healthcare Spending Account during your military leave (but not in the Dependent Care Flexible Spending Account). The contributions that you miss during your leave will be withheld from your pay when you return to work.

If you choose not to continue your Healthcare Spending Account during your leave, claims incurred during your leave will not be eligible for reimbursement. You may resume participation if you return to work after your leave of absence. If you return in the same plan year, you will have two options:

1. Resume coverage at the same annual contribution amount as before and make up the contributions that you missed during your 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 your Employee Handbook.

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

If you take an approved Paid Family and Medical Leave (PFML), you may be eligible to continue certain benefits. You may continue participation in the health program during your PFML. The College will continue its contribution toward the cost of coverage during your PFML. As long as you are receiving compensation under PFML, your cost for coverage will continue to be deducted from your pay. If your leave is unpaid, you will be billed for your 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.

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

Long Term Disability Leave

If you are approved for Long Term Disability (LTD) benefits, you 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 your LTD leave. Your life insurance will continue at the salary level in effect at the time your LTD leave began. You remain subject to the specific terms of each insurance contract. The College will continue to pay its share of premiums for these coverages and you must continue to pay your share.

After two years, you may qualify for Medicare benefits. You may also be entitled to continue participation in health care, dental care, vision care and EAP coverage under COBRA. You may also have the option to convert your life insurance to non-group life insurance policies.

You continue to be eligible for tuition benefits for up to two years from the beginning of an LTD leave.

You are not eligible for the spending accounts or Travel Accident Insurance during an LTD leave. You may, however, continue your Healthcare Spending Account coverage under COBRA (see page 32).

Continuing Coverage Under COBRA

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

You may also, under certain circumstances, be eligible to continue your participation in a Healthcare Flexible Spending Account by making after-tax payments. Healthcare Flexible Spending Account continuation under COBRA is generally available only if you have unclaimed money remaining in your account when the qualifying event occurs. If you already claimed all the money you had contributed to your account, you would not be eligible to continue participation under COBRA.

You may not continue your Dependent Care Flexible Spending Account participation under COBRA.

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

Eligibility for COBRA

For You

If you are enrolled in the medical plan (including the carved-out pharmacy benefit), dental plan, vision plan, EAP and/or Health Care Spending Account, you become eligible to continue your coverage through COBRA when one of the following qualifying events causes you to lose coverage:

- Your employment ends for any reason other than gross misconduct, or
- Your scheduled work hours are reduced so that you are no longer eligible for coverage.

For Your Spouse

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

- Your employment ends or your scheduled hours are reduced so that you are no longer eligible for coverage,
- You become entitled to Medicare
- You become legally separated or divorced, or
- You die.

For Your Dependent Children

Your covered dependent children may be eligible to continue coverage through COBRA if their coverage ends for any of the reasons listed under "For Your Spouse" above. Also, if your dependent children no longer meet the plan's definition of an eligible dependent, they may be eligible for COBRA continuation coverage.

How Long COBRA Coverage Lasts

Continuation for 18 Months

You and your covered family members may continue health care, dental care, vision care and EAP coverage under COBRA for up to 18 months if your coverage ends because of any of thefollowing qualifying events:

- Your employment ends for any reason other than gross misconduct, or
- Your scheduled work hours are reduced so that you are no longer eligible for coverage.

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

Continuation for 36 Months

Your covered spouse and covered children may continue health care, 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:

- You become legally separated or divorced,
- You become entitled to Medicare (see page 36), or
- You die.

Your covered dependent children may also continue health care, 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.

In the Case of Disability

If the Social Security Administration determines that you 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. You 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. You must also notify Voya within 30 days of a determination that the disabled person is no longer disabled.

Multiple Qualifying Events

If your spouse or children experience 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 you terminate employment on December 31, 2022, and you are eligible to continue coverage for 18 months (until June 30, 2024). Your child ceases to be an eligible dependent (a second qualifying event) on December 31, 2023. Your child is then eligible to extend coverage, up to a maximum of 36 months from the date of the original qualifying event. In this case, your child may continue coverage through December 31, 2025, which is 36 months from December 31, 2022, the date of your termination of employment (the original qualifying event).

To be eligible for extended coverage after a second qualifying event, you 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 health care, dental care, vision care, EAP and/or Health Care Spending Account coverage to all employees,
- The COBRA participant begins participation in other group health care, dental 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 health care, 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 your and your dependents' COBRA coverage.

How to Continue Coverage

If your qualifying event is termination of employment or a reduction in your work hours, Voya will notify you and your covered dependents of your right to continue coverage. If you die, Voya will send the COBRA notification to your covered dependents.

Smith College and Voya will not, however, be aware of all qualifyingevents - such as divorce or a child no longer qualifying as a dependent. It is your responsibility to notify Smith College's Human Resources within 60 days of the qualifying event. A COBRA notice will be sent to your covered family members after Smith College receives notification of your qualifying event. This COBRA notice will explain their right to continue coverage.

You and your 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. If you do not elect COBRA within 60 days, you will not be eligible to continue coverage through COBRA, and your coverage will end according to the plan's normal provisions.

Your Cost

You will receive monthly bills for your COBRA coverage from Voya. You must pay your bill 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.

Your cost for COBRA coverage is determined as follows:

- **Health care, dental care, vision care and EAP coverage.** You and your covered dependents are required to pay the full cost of health care, dental care, vision care and EAP coverage, which includes Smith College's full cost for providing your coverage, plus an additional 2% of that amount to cover the cost of administrative services. If Smith College's cost for providing coverage changes, your cost will also change.
- **Healthcare Flexible Spending Accounts.** If you are eligible to continue contributing to a Healthcare Flexible Spending Account under COBRA, you must make your contributions on an after-tax basis. You are also required to pay an administrative fee for continuing your participation. This fee is equal to 2% of your contribution.

Changing Your COBRA Coverage

Health Care, Dental Care, Vision Care and EAP Coverage

While you are continuing coverage under COBRA, you and your covered dependents may change your health care, dental care, vision care and EAP coverage during the annual enrollment period. If you did not elect COBRA during the 60-day election period (see *How to Continue Coverage*, page 34), you may not elect it during a subsequent annual enrollment period.

You may also make certain qualified status changes to your coverage, such as:

- Adding a new spouse or a newborn, a newly adopted child or a child that is placed for adoption to your health care, dental care, vision care or EAP coverage,
- Adding an eligible dependent who loses other health care, dental care, vision care or EAP coverage,
- Adding a dependent to your health care, dental care, vision care or EAP coverage if required by a Qualified Medical Child Support Order, and
- Changing your health care plan if you move out of your current plan's coverage area.

You must contact Voya within 60 days of the event that causedthe status change in order to change your 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 you are continuing participation in the Healthcare Flexible Spending Account under COBRA, you may submit eligible expenses for your new spouse or newborn or newly adopted child for reimbursement from your account.

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

Newborn and Adopted Children

If you have a baby, adopt a child or a child is placed with you for adoption, the child will be a "qualified beneficiary" with independent election rights and multiple qualifying event rights.

If one of your covered dependents 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 health care, dental care, vision care and/or EAP coverage under COBRA. The child of your covered dependent will not, however, be considered a qualified beneficiary with independent election rights and multiple qualifying event rights.

If You Become Entitled to Medicare

If you become entitled to Medicare while you are an active employee and you later experience a qualifying event (for example, terminate your employment or reduction in work hours), you and your dependents may be eligible for continued health care coverage when the qualifying event occurs. In this case, you may continue coverage for up to 18 months following the qualifying event. Your spouse and covered dependents may continue coverage for the longer of: 18 months from the qualifying event or 36 months from the date of your Medicare entitlement.

If you become entitled to Medicare after you elect to continue coverage under COBRA, your continued coverage will end on the date of your Medicare entitlement. Your covered dependents, however, may be eligible for up to 36 months of continued COBRA coverage from the date of the original qualifying event.

If You Have Questions About COBRA Coverage

If you have questions about your 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 and Appeal Process

If you, your beneficiary or your authorized representative feel that the plan has made an error concerning your benefits, you, your beneficiary or your authorized representative has the right to request reconsideration under the Plan in accordance with the following procedure. All requests for reconsideration shall be submitted in writing to the claims administrator (see addresses at the end of this document).

The claims administrator, plan administrator and any reviewing committees have full discretion and authority to determine all claims under the plans. Any action or determination in the review procedure will be final, conclusive and binding on the claims administrator, plan administrator, the College, you and your family members.

Health Care Plan, Dental Care Plan, Vision Care Plan and Healthcare Spending Account

Claim Review Procedures

For information on how to file your 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 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.

Inquiries and/or Claim Problems or Concerns

Most problems or concerns can be handled with a phone call. 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 as quickly as possible.

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.

Appeal and Grievance Review Process for Blue Cross Blue Shield

Internal Formal Review

How to Request an Internal Formal Appeal or Grievance Review

To request an internal formal appeal or grievance review, you (or your authorized or legal representative) have three options:

- **To write or send a fax.** The preferred option is for you to send your request for an appeal or a grievance review in writing to: **Member Appeal and Grievance Program, Blue Cross Blue Shield of Massachusetts, One Enterprise Drive, Quincy, MA 02171 2126.** Or, you may fax your request to 1-617-246-3616. Blue Cross Blue Shield will let you know that your request was received by sending you a written confirmation within 15 calendar days. When you send your request, be sure to include any documentation that will help the review.

- **To send an e-mail.** You may send your request for an appeal or a grievance review to the Blue Cross Blue Shield Member Appeal and Grievance Program e-mail address grievances@bcbsma.com. Blue Cross Blue Shield will let you know that your request was received by sending you a confirmation immediately by e-mail. When you send your request, be sure to include any documentation that will help the review.

- **To make a telephone call.** You may call the Blue Cross Blue Shield Member Appeal and Grievance Program at 1-800-472-2689.

Before you make an appeal or file a grievance, you should read "What to Include in an Appeal or Grievance Review Request" that shows later in this section.

Once your appeal or grievance request is received, Blue Cross Blue Shield will research the case in detail. Blue Cross Blue Shield will ask for more information if it is needed and let you know in writing of the review decision or the outcome of the review. If your request for a review is about termination of your coverage for concurrent services that were previously approved by Blue Cross Blue Shield, the disputed coverage will continue until this review process is completed. This continuation of your coverage does not apply to services: that are limited by a day, dollar, or visit benefit limit and that

exceed the benefit limit; that are non-covered services; or that were received prior to the time you requested the formal review. It also does not apply if your request for a review was not received on a timely basis, based on the course of the treatment.

All requests for an appeal or a grievance review must be received by Blue Cross Blue Shield within 180 calendar days of the date of treatment, event, or circumstance which is the cause of your dispute or complaint, such as the date you were told of the service denial or claim denial.

What to Include in an Appeal or Grievance Review Request
Your request for an internal formal appeal or grievance review should include: the name, ID number, and daytime phone number of the member asking for the review; a description of the problem; all relevant dates; names of health care providers or administrative staff involved; and details of the attempt that has been made to resolve the problem.

- **Appealing a Coverage Decision.** A "coverage decision" is a decision that Blue Cross Blue Shield makes about your coverage or about the amount your group health plan will pay for your health care services or drugs. For example, your doctor may have to contact Blue Cross Blue Shield and ask for a coverage decision before you receive proposed services. Or, a coverage decision is made when Blue Cross Blue Shield decides what is covered and how much you will pay for services you have already received. In some cases, Blue Cross Blue Shield might decide a service or drug is not covered or is no longer covered for you. You can make an appeal if you disagree with a coverage decision made by Blue Cross Blue Shield.

  When you make an appeal about a medical necessity coverage decision, Blue Cross Blue Shield will review your health plan contract and the policies and procedures that are in effect for your appeal along with medical treatment information that will help in the review. Some examples of the medical information that will help Blue Cross Blue Shield review your appeal may include: medical records related to your appeal, provider consultation and office notes, and related lab or other test results. If Blue Cross Blue Shield needs to review your medical records and you have not provided your consent, Blue Cross Blue Shield will promptly send you an authorization form to sign. You must return this signed form to Blue Cross Blue Shield. It will allow for the release of your medical records. You have the right to look at and get copies (free of charge) of records and criteria that Blue Cross Blue Shield has and that are relevant to your appeal, including the identity of any experts who were consulted.

  If you disagree with how your claim was paid or you are denied coverage for a specific health care service or drug, you can make an appeal about the coverage decision. Blue Cross Blue Shield will review the health plan contract that is in

effect for your appeal to see if all of the rules were properly followed and to see if the service or drug is specifically excluded or limited by your health plan. The appeal decision will be based on the terms of your health plan contract. For example, if a service is excluded or limited by your health plan contract, no benefits can be provided even if the services are medically necessary for you. For this reason, you should be sure to review all parts of your health plan contract for any coverage limits and exclusions. These parts include this benefit booklet, your Schedule of Benefits, and riders (if there are any) that apply for your health plan contract.

- **Filing a Grievance.** You can file a grievance when you have a complaint about the care or service you received from Blue Cross Blue Shield or from a healthcare provider who participates in your health care network. Some examples of these types of problems are: you are unhappy with the quality of the care you have received; you are having trouble getting an appointment or waiting too long to get care; or you are unhappy with how the customer service representative has treated you. If you submit a formal grievance about the quality of care you received from a Blue Cross Blue Shield provider, Blue Cross Blue Shield will contact you to obtain your permission to contact the provider (if your permission is not included in your formal grievance). For this type of grievance, Blue Cross Blue Shield will investigate the grievance with your permission, but the results of any provider peer review are confidential. For this reason, you will not receive the results of this type of investigation.

Choosing an Authorized Representative
You may choose to have another person act on your behalf during the appeal or grievance review process. Except as described below, you must designate this person in writing to Blue Cross Blue Shield.

If your claim is for urgent care or emergency medical care services, a health care professional who has knowledge about your medical condition may act as your authorized representative. In this case, you do not have to designate the health care professional in writing. If you are not able to designate another person to act on your behalf, then a conservator, a person with power of attorney, or a family member may act as your authorized representative. Or, he or she may appoint someone else to act as your authorized representative.

Who Handles the Appeal or Grievance Review
All appeals and grievances are reviewed by professionals who are knowledgeable about Blue Cross Blue Shield and the issues involved in the appeal or grievance. The professionals who will review your appeal or grievance will be different from those who participated in Blue Cross Blue Shield's prior decisions regarding the subject of your review, nor will they work for anyone who did. When a review is related to a medical necessity denial, at least one reviewer will be an individual who is an actively practicing health care professional in the same or similar specialty who usually treats the medical condition or performs the procedure or provides treatment that is the subject of your review.

Response Time for an Appeal or Grievance Review
The review and response for an internal formal appeal or grievance review will be completed within 30 calendar days. Every reasonable effort will be made to speed up the review for requests that involve health care services that are soon to be obtained by the member.

Blue Cross Blue Shield may extend the 30-calendar day time frame to complete a review when both Blue Cross Blue Shield and the member agree that additional time is required to fully investigate and respond to the request. Blue Cross Blue Shield may also extend the 30-calendar day time frame when the review requires your medical records and Blue Cross Blue Shield needs your authorization to get these records. The 30-day response time will not include the days from when Blue Cross Blue Shield sends you the authorization form to sign until it receives your signed authorization form. If Blue Cross Blue Shield does not receive your authorization within 30 working days after your request for a review is received, Blue Cross Blue Shield may make a final decision about your request without that medical information. In any case, for a review involving services that have not yet been obtained by you, Blue Cross Blue Shield will ask for your permission to extend the 30-day time frame if it cannot complete the review within 30 calendar days of receipt of your request for a review.

If your appeal or grievance review began after an inquiry, the 30-day response time will begin on the day you tell Blue Cross Blue Shield that you disagree with Blue Cross Blue Shield's answer and would like an internal formal review.

Written Response for an Appeal or Grievance Review
Once the review is completed, Blue Cross Blue Shield will let you know in writing of the decision or the outcome of the review. If Blue Cross Blue Shield continues to deny coverage for all or part of a health care service or supply, Blue Cross Blue Shield will send an explanation to you. This notice will include: information related to the details of your appeal or grievance; the reasons that Blue Cross Blue Shield has denied the request and the applicable terms of your coverage in this health plan; the specific medical and scientific reasons for which Blue Cross Blue Shield has denied the request; any alternative treatment or health care services and supplies that would be covered; Blue Cross Blue Shield clinical guidelines that apply and were used and any review criteria; and how to request an external review.

Appeal and Grievance Review Records
You have the right to look at and get copies of records and criteria that Blue Cross Blue Shield has and that are relevant to your appeal or grievance. These copies will be free of charge. Blue Cross Blue Shield will maintain a record of all formal appeals and grievances, including the response for each review, for up to seven years.

Expedited Review for Immediate or Urgently-Needed Services
In place of the internal formal review as described above in this section, you have the right to request an "expedited" review right away when your situation is for immediate or urgently-needed services and waiting for a response under the review time frames

described above would seriously jeopardize your life or health or your ability to regain maximum function as determined by Blue Cross Blue Shield or your physician, or if your physician says that you will have severe pain that cannot be adequately managed without the care or treatment that is the subject of the review. If you request an expedited review, Blue Cross Blue Shield will review your request and notify you of the decision within 72 hours after your request is received, or such shorter time period as required by federal law.

External Review

You must first go through the Blue Cross Blue Shield internal formal appeal and grievance review process as described above. The Blue Cross Blue Shield review decision may be to continue to deny all or part of your coverage in this health plan. In this case, you may be entitled to a voluntary external review. You are not required to pursue an external review. Your decision whether to pursue an external review will not affect your other coverage. If you receive a denial letter from Blue Cross Blue Shield in response to your internal appeal or grievance review, the letter will tell you what steps you can take to file a request for an external review. **If you decide to request an external review, you must file your request within the four months after you receive the denial letter from Blue Cross and Blue Shield.** Blue Cross and Blue Shield will work closely with you to guide you through the external review process.

You (or your authorized or legal representative) have the right to file an "expedited" external review at the same time that you file a request for an internal expedited review. This right applies to a member who is in an urgent care situation or to a member receiving an ongoing course of treatment. See below for more information about requesting an expedited external review.

How to Request an External Review

To request an external review, you must complete the external review request form that is provided with the denial letter you receive from Blue Cross Blue Shield. Once your external review request form is completed, you must send it to Blue Cross Blue Shield as shown on the form.

- You (or your authorized or legal representative) have the right to request an expedited review when your situation is for immediate or urgently-needed services as follows:
- When your request concerns medical care or treatment for which waiting for a response under the standard (non-expedited) external review time frames would seriously jeopardize your life or health or your ability to regain maximum function; or
- When your request concerns an internal formal review final adverse benefit determination for an admission, availability of care, continued stay, or health care services for which you received emergency services, while you are an inpatient.

External Review Process

When Blue Cross Blue Shield receives your request for an external review, your case will be referred to an external review agency to complete your external review. You (or

your authorized or legal representative) will be notified by the external review agency of your eligibility and acceptance for an external review. In some cases, the review agency may need more information about your situation. If this is the case, they will request it from Blue Cross Blue Shield, you, or your authorized or legal representative.

The review agency will consider all aspects of the case and send a written response of the outcome. They will send the response to you (or your authorized or legal representative) and to Blue Cross Blue Shield within 45 days of receiving the request. If the agency determines additional time is needed to fully and fairly evaluate the request, the agency will notify you and Blue Cross Blue Shield of the extended review period. In the case of an expedited review, you will be notified of their decision within 72 hours. This 72 hour period starts when the external review agency receives your case.

If the review agency overturns Blue Cross Blue Shield's decision in whole or in part, Blue Cross Blue Shield will send you (or your authorized or legal representative) a notice of the review decision made by the agency. This notice will confirm the decision of the review agency. It will also tell you (a) what steps or procedures you must take (if any) to obtain the requested coverage or services; (b) the date by which Blue Cross Blue Shield will pay for or authorize the requested services; and (c) the name and phone number of the person at Blue Cross Blue Shield who will make sure your appeal or grievance is resolved.

The decision made by way of the external review process will be accepted as final.

You have the right to look at and get copies of records and criteria that Blue Cross Blue Shield has and that are relevant to your appeal or grievance. These copies will befree of charge.

Life Insurance, Travel Accident Insurance, Dependent Care Flexible Spending Account and Tuition Assistance

Claim Review Procedures

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

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 followingan 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 49) following an adverse benefit determination on review

Long Term Disability

Claim Review Procedures

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

After you file a claim for LTD benefits, the claims administrator will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if an extension is necessary to process your claim due to matters beyond the control of the LTD Plan. A written notice of the extension, the reason for the extension and when the LTD Plan expects to decide your claim, will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original extension (for a total of 105 days) if the claims administrator sends an additional written notice.

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
- Reference 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 description of the LTD plan's appeals procedures and applicable time limits
- If the denial is based on medical necessity, experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in making the decision
- 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 that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances
- A statement of your right to bring a civil action under ERISA (see page 49) 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 180 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 claim appeal decision will be made by a party who was not involved in the initial benefit determination and is not the subordinate of those involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the party reviewing your appeal will consult with a healthcare professional who has

appropriate training and experience in the field of medicine involved in the medical judgment, was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination.

The party reviewing your claim appeal will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended for an additional 45 days if special circumstances require an extension of time. 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 45-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
- If the denial is based on medical necessity, experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in making the decision
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances
- A statement of your right to bring a civil action under ERISA (see page 49) following an adverse benefit determination on review

The claims administrator, plan administrator and any reviewing committees have full discretion and authority to determine all claims under the plans. Any action or determination in the review procedure will be final, conclusive and binding on the claims administrator, plan administrator the College, you and your family members.

Your 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). ERISA provides that all plan participants 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 health care coverage for yourself, your spouse, or your 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 (pension, welfare) benefit or 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 claims 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
42 West Street
Northampton, MA 01063

Smith College
Wraparound Health & Welfare SPD

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.

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
Health Care 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	Lincoln Financial 55 Capital Blvd Rocky Hill, CT 06067	Insured; claims paid by third-party administrator	College pays premiums for basic coverage; employees pay premiums for supplemental coverage	510

Smith College
Wraparound Health & Welfare SPD

Plan	Type of Plan	Plan Insurer/Claims Administrator	Type of Administration	Funding	Plan Number
Life Insurance ▪ Basic ▪ AD&D ▪ Supplemental ▪ Dependent	Welfare—Life Insurance	Lincoln Financial 55 Capital Blvd Rocky Hill, CT 06067	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	Lincoln Financial 55 Capital Blvd Rocky Hill, CT 06067	Insured; claims paid by third-party administrator	College pays premiums	510
Health Care Spending Account and Dependent Care 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
Health Spending Account	Welfare – Health Spending Account	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
Tuition Assistance Program	Educational Assistance Program	Smith College	Self-administered	College pays out of general assets	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
Health Care 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	Lincoln Financial	www.lincolnfinancial.com	413-585-2260
Life Insurance	Lincoln Financial	www.lincolnfinancial.com	413-585-2260
Travel Accident Insurance	Lincoln Financial	www.lincolnfinancial.com	413-585-2260
Health Care or Dependent Care Spending Accounts	Voya Financial	https://myhealthaccountsolutions.voya.com	833-232-4673
Health Savings Account (after 01/01/25)	Voya Financial	https://myhealthaccountsolutions.voya.com	833-232-4673
Health Savings Account (terminated 12/31/24)	HealthEquity	www.my.healthequity.com	866-346-5800
Employee Assistance Program	Compsych	www.guidanceresources.com	855-784-2056
Tuition Assistance Program	Smith College	hrbenefits@smith.edu	