Hampshire College

2025

EMPLOYEE BENEFITS GUIDE

Hampshire College

WELCOME!

Hampshire College appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefits plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

Benefit eligibility is subject to hours worked and FTE status. Part-time employees working half time or more, with a continuous employment period of six months or more are eligible to participate in some or all of our employee benefits programs.

This guide is not your only resource, of course. Any time you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) at https://www.hampshire.edu/hr/benefits-summary.

Here's where to find ...

CHANGES FOR 2025

Medical

- There are no plan design changes to the medical plans.
- There is a slight increase to medical contributions. Hampshire continues to pay the majority of the cost for our medical plans, and you pay a smaller portion.

Dental

- Good news! There is a slight decrease to the dental contributions.

There are no plan changes or contribution changes for all other plans

<u>No action required unless you</u>:

- Want to elect 2025 Health Care and/or Dependent Care Flexible Spending Account.
- Want to elect 2025 Health Savings Account.
- Wish to make a change to your current benefits.
- Need to elect benefits for the first time.

ENROLLING IN BENEFITS

You can sign up for benefits or change your benefit elections at the following times:

- Within 31 days of your initial eligibility date (as a newly-hired employee). Coverage will be effective on the 1st of the month after hire date.
- During the annual benefits open enrollment period.
- Within 31 days of experiencing a qualifying life event.

The choices you make at that time will remain in effect through the end of the plan year (December 31st). If you do not sign up for benefits during your initial eligibility period or during the open enrollment period, you will not be able to elect coverage until the following plan year.

Changing Your Benefits During the Year

Hampshire College allows you to pay your portion of the medical, dental, and vision plan costs, and fund the flexible spending accounts, on a pre-tax basis. Thus, due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual open enrollment period. The only exception is if you experience a qualifying life event. ***Election changes must*** be consistent with your life event.

Eligible Dependents

- Spouse, ex-spouse
- Domestic Partner
- Biological and stepchildren up to the age of 26

Qualifying life events include, but are not limited to:

- Birth, legal adoption or placement for adoption.
- Marriage, divorce or legal separation.
- Dependent child reaches age 26.
- Spouse gains or loses employment or eligibility with current employer.
- Death of spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program.
- Change in residence that changes coverage eligibility.
- Court-ordered change.

The IRS requires that you make changes to your coverage within 31 days of your qualifying life event. You'll need to provide proof of the event, such as marriage certificate, divorce decree, birth certificate or loss-of-coverage letter.

IRS Tax Requirements:

If you elect medical, dental or vison coverage for a domestic partner and/or their children, contributions are subject to federal, state and payroll taxes. In addition, Hampshire College's share of the premium for medical is treated as taxable income to you.

Terms you'll see in this guide:

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've paid your plan's deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage. Hampshire's PPO Saver Plan has 10% coinsurance in-network.

COPAY: A fixed amount you pay for a specific medical service (typically an office visit) at the time you receive the service. The copay can vary depending on the type of service. Copays cannot be included as part of your annual deductible, but they do count toward your out-of-pocket maximum.

DEDUCTIBLE: The amount you pay for healthcare services before your health insurance begins to pay. For example, if your plan's deductible is $2,000, you'll pay 100 percent of eligible healthcare expenses until the bills total $2,000 for the year. After that, you share the cost with your plan by paying coinsurance.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You'll pay less when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the medical plan agreement. You'll pay more when you use out-of-network providers.

There is no out-of-network coverage, other than emergency care, if you enroll in the HMO plan.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

MEDICAL & PRESCRIPTION BENEFITS

Blue Cross Blue Shield

Hampshire College is committed to helping you and your dependents maintain your health and wellness by providing you with access to the highest levels of care. We will continue to offer you a choice of two medical plan options for 2025:

- HMO Blue New England
- Preferred Blue PPO Saver HSA

Summary of Coverage	HMO Blue New England *In-Network*	Preferred Blue PPO Saver HSA *In-Network*[1]
Medical Deductible		
Employee Only	$1,500	$2,000
Family Coverage	$3,000	$4,000
Out of pocket maximum ***(includes deductible)***		
Employee Only	$2,000	$4,500*
Family Coverage	$4,000	$9,000*
Physician Office Services		
Preventive care	No Charge	No Charge
Office visit - Primary Care Physician[2]	$30 Copay	10% coinsurance, after deductible
Office visit - Specialist[3]	$40 Copay	10% coinsurance, after deductible
Urgent Care	$40 Copay	10% coinsurance, after deductible
Hospital Services		
Inpatient	$0, after deductible	10% coinsurance, after deductible
Outpatient/Ambulatory Surgery	$0, after deductible	10% coinsurance, after deductible
Emergency Room	$200 Copay	10% coinsurance, after deductible
Lab/X-Ray		
Diagnostic Lab and X-ray - Outpatient	$0, after deductible	10% coinsurance, after deductible
High Tech Services (MRI, CT scans, etc.)	$0, after deductible	10% coinsurance, after deductible
Prescription drugs		
Pharmacy Deductible		
Employee Only	$250	
Family Coverage	$500	Combined with Medical Deductible
Retail Prescription Drugs	**After Deductible**	**After Deductible**
Generic - 30 days	$10 Copay	$10 Copay
Preferred Brand - 30 days	$25 Copay	$25 Copay
Non-Preferred Brand - 30 days	$40 Copay	$40 Copay
Preferred Brand Specialty - 30 days [4]	$50 Copay	$50 Copay
Non-Preferred Brand Specialty - 30 days [4]	$65 Copay	$65 Copay

[1]Out-of-Network coverage is available under the PPO; please refer to your SBC for additional plan details.

[2]PCP is required.

[3]Referral is required to see a specialist under the HMO plan.

[4] Specialty prescription drugs are covered through in network retail specialty pharmacies - visit https://www.bluecrossma.org/medication/

*These amounts only apply if you use a provider that is outside of the BCBS network. Once the medical deductible is met on the HSA plan, in-network medical services will be covered at 10% co-insurance, prescriptions will be charged at a copay. These items will track toward the out-of-pocket maximum.

HealthEquity

HEALTH SAVINGS ACCOUNT (HSA)

Take Charge of Your Healthcare

Take charge of your healthcare spending with a **health savings account (HSA),** which works alongside the PPO Saver High Deductible Plan. An HSA is a personal healthcare bank account that you can use to pay out-of-pocket health expenses with pre-tax dollars.

HSA Overview

The contributions made to your HSA are tax-free, and the money remains in the account for you to spend on eligible expenses, no matter where you work or if you remain enrolled in an HDHP. HSAs allow you to control your own money, year in and year out.

You are eligible to open and fund an HSA if:

- You are covered by an HSA-eligible high-deductible health plan (like the **Hampshire's PPO Saver**).
- You are not covered by another medical plan or your spouse's health care flexible spending account or a health reimbursement arrangement (HRA).
- You are not receiving Social Security benefits.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE for Life.
- You have not received Veterans Administration benefits.

Your HSA account can be used for your expenses and those of your spouse and tax dependents, even if they are not covered by the HDHP. Note: HSA funds cannot be used for expenses of domestic partner or adult children unless they are also a tax dependent.

Examples of eligible expenses include doctor's office visits, eye exams, prescription expenses, and LASIK surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found at https://www.irs.gov/.

HSA Funding and Limits

The 2025 IRS maximum contributions, are:

- Employee only - $4,300
- All other tiers - $8,550
- HSA Catch up (Age 55 or older) - $1,000

You are responsible for keeping track of all contributions to ensure your account does not exceed the IRS limit.

Individually Owned Account

You own and administer this HSA. You determine how much you will contribute to your account, when to use the money to pay for eligible medical expenses, and when to reimburse yourself. Like a bank account, you must have a balance in order to be reimbursed. Although receipts are not required for reimbursement, we recommend that you keep receipts for tax documentation. HSAs allow you to save and "roll over" money if you do not spend it in the calendar year. The money in this account is always yours, even if you change health plans or jobs. There are no vesting requirements or forfeiture provisions.

Medical/Rx Employee Payroll Contributions

Effective January 1, 2025

The cost to full-time employees is listed below. Amounts are prorated for eligible part-time employees.

Bi-weekly (24 pay periods) contributions		
	HMO Blue New England	Preferred Blue PPO Saver HSA
Employee	$81.00	$50.00
Employee + One	$230.00	$172.00
Family	$360.00	$268.00

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plans.

Blue Cross Blue Shield Resources

Fitness Benefit

Get reimbursed for three consecutive months of membership fees from a qualified health club or for up to 10 fitness classes taken at a qualified health club or qualified virtual classes.

Additional eligible expenses for reimbursement :

- Bicycles that are purchased for recreational use and bicycle helmets.
- Athletic shoes designed to be worn for sports, exercising, or recreational activity.
- Sports activity fees including (but not limited to): ski passes, fees for sports leagues (such as town sports, tennis, golf, or basketball), and race participation fees.

Fitness Benefit

Weight Loss Benefit

Get reimbursed for up to three months of participation in a qualified weight-loss program.

Weight Loss Benefit

Blue 365

Enjoy exclusive members-only savings on healthy products, along with discounts on health and fitness clubs, equipment, weight-loss programs, healthy travel and food, and much more.

- Get weekly deals via email and save with just one click
- Take advantage of ongoing healthy offers
- Save on premium brands, locally and nationally
- Earn rewards when you refer other members

Blue 365

Reproductive Health Travel Benefit

BCBS offers the ability to get reimbursed for certain travel and lodging expenses if participant needs to travel 100 + mile to obtain access to abortion services; surgical or medication-assistance.

- Up to $5,000 annual benefit maximum per member.
- No maximum for daily travel.

Reimbursement Form

Living Healthy Naturally

Save up to 30 percent on acupuncture, massage therapy, and nutrition counseling.

Living Healthy Naturally

Quit Smoking

It's never too late to quit tobacco. People who quit, regardless of age, live longer and healthier lives than people who don't. Be one of them. We're here to help. Use this guide to learn more about smoking cessation programs offered through Blue Cross and breathe easy again.

Quit Tobacco Now Brochure

Nurse Hotline

Call the toll-free Blue Care Line for answers to your health care questions 24 hours a day at 1-888-247-BLUE (2583).

Blue Care Line

Pregnancy and Baby

Have questions about getting pregnant, pregnancy, labor, and what to expect during baby's first year? We're here to help you with a full range of maternity programs and benefits. We encourage you to explore all your benefits for starting and growing your family.

Living Healthy Babies

Disease Management

If you're living with a chronic condition, you may be able to benefit from the Blue Care Connection® chronic condition management program. This comprehensive program is designed to help you understand the day-to-day management of your condition, support your doctor's plan of care, and improve your quality of life. It also provides individual self-assessment and educational tools, and, when appropriate, support by phone from a nurse coach, to help you to take a more active role in your own health management. Nurse coaches use evidence-based guidelines to determine what education and support may be helpful.

Program Benefits and Advantages

The program is designed to:

- Increase your understanding of your condition.
- Improve your ability to follow your treatment plan.
- Help reduce complications.
- Deliver educational materials.
- Offer 24-hour phone and online educational support.

Our chronic condition management program offers support to individuals with the following conditions:

- Asthma
- COPD (chronic obstructive pulmonary disease)
- Coronary artery disease
- Diabetes
- Heart failure
- Inflammatory bowel disease

To learn more or to see if you're eligible for Blue Care Connection chronic condition management program, please call 800.392.0098, and choose option 2.

Care Management

Specialized Support for Members with Complex or Chronic Health Conditions

Our comprehensive group of Blue Care Connection® Care Management programs services are designed to give members with chronic conditions, complicated medical issues, or behavioral health concerns assistance to support their health. Care Management is available to all our members at no additional cost.

We pair members with a care manager—a registered nurse, specialized health coach, or behavioral health clinician—who provides expert support and helps coordinate care.

Care Management Cover

- Diabetes
- Substance Use Conditions
- Oncology
- Coronary Artery Disease
- Congestive Heart Failure
- Brain/Spinal Injury
- Rare Diseases
- Pediatric conditions
- Behavioral Health
- High-Risk Pregnancies
- Asthma
- And any other complicated medical issues

Let's Work Together

If you decide to try our Care Management program, a personal care manager will work with you, your family, caregivers, and doctors to help you make informed decisions about your health. Participation in this program is completely optional and won't affect your benefits. If you wish to stop using Care Management, you can opt-out of the program at any time.

Want to Get Started?

Call us at 800.392.0098 Monday through Friday, 8:30 a.m. to 4:30 p.m. ET.

FLEXIBLE SPENDING ACCOUNTS

A Flexible Spending Account (FSA) allows you to set aside pre-tax dollars to pay for eligible health care and dependent care expenses not covered by insurance. The money you deposit is exempt from both federal income and Social Security taxes.

Hampshire offers you a choice of two Health Care Reimbursement Account plans and a Dependent Care Account:

- Limited Purpose Health Care Reimbursement Account (LPFSA)
- Health Care Flexible Spending Account (HFSA)
- Dependent Care Flexible Spending Account (DCFSA)

The HFSA is NOT available to employees who participate in the PPO Saver/HSA. The LPFSA is available to HSA participants

How the FSA Program Works

When you enroll, estimate conservatively how much money you expect to spend out-of-pocket for health/dependent care, then divide this amount by 24 pay periods to calculate your bi-weekly pretax amount.

FSAs must be elected every year!

- If you do not re-enroll, you will not have the deductions taken out in 2025.

As you incur eligible expenses, you have three ways to access your FSA funds:

- Benefits Strategies Flex Debit Card: Gives you instant access to your FSA account at physician and dental offices.
- Paper Reimbursement Request Form: Submit completed form along with detailed documentation of your expenses to Voya.
- Online Reimbursement Request: Use your personal login screen to file claims online.

Enrollment Considerations

- Your coverage effective date will be your date of hire, the date of your qualifying event, or January 1st if elected during open enrollment.
- If you do not use all the money in your dependent care FSA by December 31, 2025, you will lose it!
- For the health care FSA, you may roll over up to $660 unused funds to the next plan year.
- All health care FSA claims incurred during the plan year must be submitted by March 31, 2026.
- You cannot claim expenses paid through the reimbursement account as tax deductions or tax credits.
- DCFSA: $2,500 if single or married filing a separate tax return; $5,000 if married and filing joint return, head of household, you're a single parent or a custodial parent who claims dependent for tax purpose.

	Limited Purpose Health Care Reimbursement Account (LPFSA)	Health Care Flexible Spending Account (HFSA)	Dependent Care Flexible Spending Account (DCFSA)
Minimum & Maximum Plan Contributions	Minimum: $1 00 Maximum: $3,300	Minimum: $1 00 Maximum: $3,300	• Maximum reimbursement is $5,000 per year ($2,500 if married filing separately)

BLUE CROSS BLUE SHIELD DENTAL VOLUNTARY DENTAL PLAN

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less for treatments because your share of the cost will be based on negotiated discount fees. With out-of-network dentists, the plan will pay the same percentage, but the reimbursement will be based on out-of-network rates. You may be billed for the difference.

Dental exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious.

View covered services, claim status or your account balance, find a dentist, update your information, and much more at **bluecrossma.com**.

	In-network	Out-of-Network
Deductible		
Employee only	$25	
Family coverage	$75	
Is the deductible waived for preventive and diagnostic services?	Yes	
Annual plan maximum (per member)	$2,000	
Diagnostic and preventive		
Oral exams, x-rays, cleanings, fluoride, space maintainers, sealants	100%	100%*
Basic		
Oral surgery, fillings, endodontic treatment, periodontics treatment, repairs of dentures and crowns	80%	80%*
Major		
Crowns, jackets, dentures, bridge implants	50%	50% *
Orthodontia		
Children and Adults	100%	100%*
Lifetime orthodontia plan maximum (per individual)	$1,000	$1,000*

- Subject to maximum plan allowance. Plan participant may be balance billed for difference.

Employee Payroll Contributions

Effective January 1, 2025

Contribution	Bi-weekly (24 pay periods)
Employee	$22.21
Employee + one	$48.15
Family	$81.49

- You can elect the BCBS dental plan regardless of whether you are enrolled in the medical or vision plan.
- You will not receive a dental ID card because you typically do not need to present one when visiting your dentist. To print an ID card, log in to **bluecrossma.com**.

DAVIS VISION VOLUNTARY VISION PLAN

Davis Vision's vision care benefits include coverage for eye exams, standard lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the Davis Vision network. When you use an out-of-network provider, you will have to pay more for vision services.

Eye exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious.

Locating a Davis Vision provider

In-network providers include private practitioners as well as selected chains. To locate a provider, visit **www.davisvision.com**.

Summary of Coverage	In-Network	Out-of-Network
Eye exam with dilation as necessary (once per 12 months)	$10 Copay	Up to $90 reimbursement
Frames (once per 24 months, in lieu of contact lenses	Covered in Full[1] after $25 copay OR $130 allowance + 20% discount on remaining balance	Up to $104 reimbursement
Standard lenses (once per 12 months)		
Single vision	$25 Copay	Up to $57 reimbursement
Bifocal	$25 Copay	Up to $92 reimbursement
Trifocal	$25 Copay	Up to $115 reimbursement
Lenticular	$25 Copay	Up to $215 reimbursement
Contact Lenses (once per 12 months, in lieu of eyeglasses)		
Medically necessary	Covered in Full	Up to $240 reimbursement
Elective	Covered in Full[2] OR $130 allowance + 15% discount on remaining balance	N/A

[1] Any Fashion or Designer level from Davis Vision's Collection (retail value up to $175).
[2] From Davis Vision's Collection, up to 2 boxes Planned Replacement or 8 boxes Disposable.

Employee Payroll Contributions – no change!

Effective January 1, 2025

Contribution	Bi-weekly (24 pay periods)
Employee	$2.80
Employee + one	$5.04
Family	$7.83

- You can elect the Davis Vision plan regardless of whether you are enrolled in the medical or dental plan.
- You will not receive a vision ID card. However, you can print an ID card on **www.davisvision.com**.

Lucet | Employee Assistance Program

WORK/LIFE EMPLOYEE ASSISTANCE PROGRAM (EAP)

We all know that life can be challenging at times. Issues like illness, debt and family problems can leave us feeling worried or anxious and not able to be at our best. The employee assistance program (EAP), sponsored by Lucet Health (previously New Directions) provides confidential support and resources for you and your dependents at no charge. You can seek expert guidance for any kind of issue, from everyday matters to more serious problems affecting your well-being.

Here's what the program offers:

- EAP: three visits with experienced clinicians (per occurrence), without any per-session cost to you.
- Legal resources: Call to be connected to a free, 30-minute consultation with an advice attorney for most legal matters. Should your matter be more complex in nature, you will be referred to an attorney at a 25% discounted rate.
- Financial resources: Unlimited phone access to financial professionals for information regarding personal finance and related issues.
- Family/caregiving resources and referrals: Information and referrals on child care, elder care, adoption, prenatal/fertility, parenting, educational programs, special needs programs and pet care and other personal convenience matters.
- Health risk assessments: Online access to a health risk assessment survey and a variety of health management tools and information.
- Convenience services: Referrals to local vendors and resources to assist with everyday tasks such as: chore services, moving and relocation, electricians and plumbers, event and party planners, consumer comparisons, volunteer opportunities and travel and safety.
- Website: Log on to access the savings center, legal and financial resource center, articles, free webinars, searchable databases, monthly newsletters and more!

The EAP provides counseling on all aspects of life, including:

- Difficulties in relationships.
- Emotional/ psychological issues.
- Stress and anxiety issues with work or family.
- Alcohol and drug abuse.
- Personal and life improvement.
- Legal or financial issues.
- Depression.
- Childcare and elder care issues.
- Grief issues.

Assistance around the clock

Whenever you need assistance with a work/life issue, the EAP is there for you, 24 hours a day. Specialists are available for confidential 24/7 assistance and support.

Lucent

For more information and resources:

Call: 800.624.5544 |

Go online: eap.lucethealth.com
Username: Hampshire College
Password: guest

GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Hampshire College's comprehensive benefits package includes financial protection for you and your family in the event of an accident or death.

In the event of your death, the life insurance policy provides a benefit to the beneficiary you designate. If your death is the result of an accident or if an accident leaves you with a covered debilitating injury, you are covered under the AD&D insurance for the same amount.

Basic Life and AD&D Insurance

Hampshire College automatically provides basic life and AD&D insurance through Transamerica to all benefits-eligible employees at no cost. Benefited full-time and part-time employees are enrolled on the first day of the month following or coinciding with date of employment.

Group Term Life and AD&D	100% Paid by the Employer

Two times your annual salary up to a maximum of $150,000 (Employee).

Age reduction schedule For Basic and Supplemental Life:

- Age 70: Benefit decrease to 65% of original benefit.
- Age 75+: Benefit decrease to 50% of original benefit.

Supplemental Life and AD&D Insurance

Hampshire College provides you the option to purchase supplemental life and AD&D insurance for yourself, your spouse and your dependent children through Transamerica. You must purchase supplemental coverage for yourself in order to purchase coverage for your spouse and/or children. Supplemental rates are age-banded (listed below).

Supplemental Life and AD&D *100% Paid by the Employee*	
Employee increments;	up to 5x salary in 10k maximum of $500,000. GI: $150,000.
Spouse*	$10,000, $30,000 or $50,000; GI: $30,000
Child(ren)* *	$10,000 (GI)

*The dependent life benefit may not exceed 50% of the employee's supplemental life election.
**Child benefit is life insurance only, no AD&D.

Age reductions for supplemental life (employee & spouse):
Age 70: Benefit decrease to 65% of original benefit.
Age 75+: Benefit decrease to 50% of original benefit.

Supplemental Life and AD&D	
Employee Age Band	Rate/$1,000
0–24	$0.040
25–29	$0.040
30–34	$0.050
35–39	$0.060
40–44	$0.110
45–49	$0.170
50–54	$0.330
55–59	$0.500
60–64	$0.520
65–69	$0.940
70–74	$2.480
75–79	$2.480
80–99	$2.480
Child Life Rate	$2.00 per child unit

Here are some helpful insurance terms:

AGE REDUCTION:

The group term basic life and AD&D insurance coverage are subject to a reduction in benefit amount as you age.

GUARANTEE ISSUE (GI)

If you elect coverage when first eligible, you may purchase up to the guaranteed issue amounts without completing a medical questionnaire. If you do not enroll when first eligible and choose to enroll during a subsequent annual open enrollment period, you will be required to complete evidence of insurability for any amount of coverage. Coverage will not take effect until approved by Transamerica.

PORTABILITY AND CONVERSION:

Portability and conversion are available if your employment with Hampshire College ends. Portability allows you to continue your term life coverage while the conversion option allows you to convert your term life policy into an individual whole life policy. Applies to Supplemental Life only.

LONG-TERM DISABILITY PLAN

Hampshire College offers a company-paid long-term disability plan through Transamerica to provide financial assistance in case you become disabled or unable to work.

Long-term disability (LTD) plan

Hampshire College provides LTD to benefit eligible employees after one year of service. This benefit offers financial protection to you when you need it most — if you become disabled and can no longer work. The plan will also help you to return to work, if appropriate.

If you become totally disabled, you will receive 60 percent of your monthly pre-disability earnings, up to $7,500 monthly, after you have satisfied the 180-day waiting period for benefits. Your benefit amount may be offset by other benefits you are receiving, such as Social Security (to you and your dependents), workers' compensation, unemployment income and other income. Your monthly benefits are subject to federal income tax and may be subject to state and local taxes.

Long-term disability eligibility	
Full-time employees	100% paid by the employer

Monthly benefit amount	60%
Monthly benefit maximum	$7,500
Benefits begin	180 days
Benefits duration	Up to Social Security Normal Retirement Age if you are disabled prior to age 65. If you are 65+ and become disabled, benefits are payable based on an age-based schedule. Refer to the benefit booklet for additional information.
Pre-existing condition exclusion 3/12	

You have a pre-existing condition if both 1. and 2. are true:
1.(a) You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available; or
(b) you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage.
2.Your disability begins within 12 months of the date your coverage under the plan becomes effective.

Paid Family and Medical Leave (PFML)

Hampshire College employees are covered under Massachusetts' Paid Family and Medical Leave (PFML) program, which provides paid time off for family or medical reasons. Apply for MA PFML through the state website linked here Massachusetts Paid Family and Medical Leave Application. Human Resources has created a visual guide in the Employee Leave Programs booklet, illustrating how various medical leaves (FMLA, PFMLA, Parental Leave, Workers Comp, etc.) interact at Hampshire College.

RETIREMENT PLAN HIGHLIGHTS

Overview

Hampshire College maintains a 403(b) Retirement Plan. For eligible employees, there are two different ways to make contributions; elective deferrals subject to the annual IRS limit, and mandatory contributions after an employee has reached age 30 and been with the College for 12 months. Highlights of contributions and other elements of the Retirement Plan are below. For more detailed information about the 403(b) Retirement Plan, please contact Human Resources. In the event of a discrepancy between this information package and the plan document, the plan document provisions prevail.

Eligibility

Pre-Tax Elective Deferrals	Participants will be eligible to make Pre-Tax Elective Deferrals immediately upon their hire date. Participants in the following classes will be excluded for Pre-Tax Elective Deferral purposes. • Students performing services for Trustees of Hampshire College and where they are pursuing a course of study with Trustees of Hampshire College. • Employees who normally work less than 20 hours per week.
Mandatory Pre-Tax Contributions	Participants will be eligible to make Mandatory Pre-Tax Contributions on the first day of the calendar month next following the day they meet the following requirements. • The Participant completes 1,000 hours of service in a 12-month period. • Mandatory contribution requirements apply to individuals who have reached age 30. Participants in the following classes will be excluded for Mandatory Pre-Tax Contribution purposes. • A leased employee. • casual employees and adjuncts, unless such individuals complete one Year of Service.

Retirement Plan Highlights, cont.

Contributions	
Pre-Tax Elective Deferrals ***(2025 contribution limits have not been released yet)***	The max Pre-Tax Elective Deferrals a participant may make is 100% of compensation or the 402(g) limit ($23,000 for 2024). This dollar limit is indexed; therefore, it may increase each year for cost-of-living adjustments. A Participant may make or change their deferral election by: written, VRU, or electronic election. Age 50 catch-up contributions are allowed ($7,500 in 2024). This limit is indexed as well. **Starting in 2025**, individuals aged 60 to 63 can make additional catch-up contributions to their workplace retirement plans. The special catch-up limit is the greater of $10,000 or 150% of the regular catch-up amount in effect for the taxable year. Special long service catch-up contributions are allowed.
Mandatory Pre-Tax Contributions	For employees aged 30 and above who meet the one-year service requirement, 3% of Compensation if the Participant has less than 3 Years of Service, and 5% of Compensation if the Participant has 3 or more Years of Service. For purposes of determining the amount of the mandatory contribution, years of service are as defined for purposes of eligibility but exclude service with any predecessor employer.
Rollover Contributions	Employees eligible to participate in the Plan can rollover money from any plan that is eligible to be rolled into the Plan. While there are exceptions this generally includes rollovers from a qualified retirement plan (i.e., 401(k), defined benefit), another 403(b) plan, a governmental 457(b) plan and pre-tax assets held in a traditional IRA.

Vesting	
Elective Deferrals, Voluntary After-Tax Contributions, Mandatory Pre-Tax Contributions and Matched Contributions	Participants are always fully vested in Elective Deferrals, Voluntary After-Tax Contributions, Mandatory Pre-Tax Contributions and Matched Contributions.

Retirement Plan Highlights, cont.

Distribution and Loans	
Termination of Employment	Distributions after termination of employment can be taken immediately after their employment terminates.
In-Service Distributions	The following in-service distributions are available from fully vested account balances. • Elective Deferral, Voluntary After-Tax Contribution and Rollover Contribution account balances at normal retirement age (age 65). • Elective Deferral, Voluntary After-Tax Contribution and Rollover Contribution account balances at age 59.5. • Voluntary After-Tax Contribution and Rollover Contribution at any time. • Qualified Reservist Distribution. • Deemed Severance. • Hardship Distribution.
Loans	The maximum number of loans outstanding is 3.

Investments	
Investments	Participants can invest in annuity contracts and custodial accounts. Participants can direct the investment of all or some of their account balances. The Plan intends to meet the requirements of 404(c) by: • Providing participants a broad range of investment options. • Allowing participants to exercise control over their accounts. • Offering diversified investment options with materially different risk and return characteristics. • Furnishing specific disclosure and investment information to participants

Contact Information	
Plan Sponsor and Plan Administrator	The Plan Sponsor and the Plan Administrator is Trustees of Hampshire College. Address: 893 West Street, Amherst, MA 01002 Phone number: 413-559-5495 Fax number: 413-559-5695

OTHER BENEFITS

Paid time off policies for exempt & non-exempt employees

Vacation

All eligible exempt and non-exempt staff are awarded vacation on July 1, the beginning of the fiscal year, to be used by June 30th. Any vacation award not used is forfeited. Vacation time is pro-rated for those whose employment starts after July 1. All vacation is taken and scheduled at the discretion of the supervisor. Employees may rollover up to five vacation days each year.

- Full time, bi-weekly paid, non-exempt staff are awarded vacation based on the following eligibility schedule:

Years of Service	Working Days Per Year
Up to 3 of years	10 (2 weeks)
3 years up to 8 years	15 (3 weeks)
8 or more years	20 (4 weeks)

- Full time, exempt staff are awarded 4 weeks' vacation.
- Part-time, benefits-eligible staff and benefits-eligible staff who work fewer than 12 months a year earn a prorated share of the days shown above.

Personal Days

Personal days are pro-rated for those whose employment starts after July 1.

- Non-exempt staff are awarded 3 working days on July I to be used by June 30th.
- Exempt staff are awarded 1 working day on July I to be used by June 30th.
- Part-time, benefits eligible staff will receive prorated personal days.
- On July 1, following the completion of 15 years of service, both Exempt & Non-exempt employees receive an additional paid personal day each year.

Holidays

Hampshire College recognizes the following holidays:

- Martin Luther King Jr. Day
- Spring Day
- Memorial Day
- Juneteenth Day
- Independence Day
- Labor Day
- Indigenous People day or Veterans day, or another day selected by employee (subject to prior approval of the supervisor)*
- Thanksgiving: 2.5 days
- December Break: 7.5 days at the end of the calendar year int include both Christmas day and New Year Day (dates to be determined each year by HR and the President)

Additional days may be authorized by the President of the College.

Sick Time Benefits

All Hampshire College full-time staff members earn one day per month of paid sick time, totaling 12 workdays per year. Unused sick leave may be accrued from year to year to a maximum of 130 days. Staff earn sick time from their first day of employment and may use any sick time they earn as needed but may not borrow against sick time not yet accrued. Paid Family and Medical Leaves and or/sick leave laws may also apply depending on employee's work state.

Sick time may also be used for medical, dental and other health-related appointments if these appointments cannot be scheduled during off-hours. Appointments occurring during the workday should be scheduled in consultation with the staff's supervisor. Part-time staff (those who work half-time or more for 6 months or more) earn sick time on a pro-rated basis.

Parental Leave

Once you have completed the initial 90-day probationary period, you will be eligible for Hampshire's Parental Leave. Benefit eligible employees will be granted an eight-week paid leave by the College for birth, adoption of placement of a foster child.

This paid leave will run concurrent with other unpaid, job protections (i.e. MA Parental Leave Act, FMLA) and paid state leaves laws (i.e. MA PFML) where applicable.

Additional Benefits and Information

Hampshire College Recreation Facilities

Hampshire College benefited faculty and staff members may use the College's many recreational facilities, including the indoor pool, tennis courts, indoor track and gymnasiums. Employees may use their ID cards to access the many services of the recreational facilities, College library, and the College bookstore.

For more information, please contact the OneCard office at ext. 6151 or at onecard@ hampshire.edu.

Educational Opportunities

Benefited employees and their spouses/ certified domestic partners are eligible to enroll in courses, tuition-free at Hampshire College after one year of service and on a space available basis.

Tuition grants (other colleges), tuition remission (Hampshire College), and the tuition exchange program (www.tuitionexchange.org) are available to dependent children of full-time benefited employees who have completed one year of employment.

A degree program at Hampshire College is available to employees who qualify academically after completing two calendar years of employment.

For more information on educational opportunities for you and your family visit the Tuition Benefits section of the Human Resources website ,https://www.hampshire.edu/hr/tuition-benefits-summary

SAVI

Savi offers a special service, called Savi Essential, which can help you navigate the complex rules and procedures of the PSLF program, making it easier to stay on track for loan forgiveness. Hampshire College will cover the cost of $60/year for all benefit eligible employees while the experts at Savi will support you with various PSLF tasks.

Visit TIAA.org/Hampshire/student

Hampshire College Employee Policy Manual

The Hampshire College policy manual, which outlines pay practices, leave policies, and our grievance policy, as well as numerous other College policies, is available on the Intranet at https://intranet.hampshire.edu/ under "Employee Resources".

Dining Common Meals

All benefits-eligible employees will be eligible for five meal tokens per semester (10 meal tokens per year) free of charge. Each token can be exchanged for a meal at the Dining Commons during the regular meal periods.

To get your free meal tokens, you must bring your Hampshire College ID with you to the Dining Commons front desk Monday through Friday during one of the regular meal periods.

Rosetta Stone

Is English not your primary language and you'd like to improve, or do you want to learn another language? Hampshire College is pleased to support you on that journey by providing you access to Rosetta Stone where you'll get to choose from 24 different languages. If interested, email hr@hampshire.edu.

Additional Benefits and Information

BenefitHub

Hampshire College has partnered with BenefitHub which is an online discount marketplace. You can find discounts on pet insurance, home/car insurance, shopping, travel, entertainment, and so much more!
It's easy to access:

1. Go to hampshirecollege.benefithub.com
2. Enter the referral code: 2XGQWT
3. Complete the registration

Other Benefits

Hampshire College offers a wide variety of other benefits, incentives, and discounts available to eligible employees. These other benefits can be found on our website. Please note that many of the listed benefits are not administered by the human resources office and are administered by either other departments on campus or outside organizations.
https://www.hampshire.edu/hr/other-benefits

Campus Emergencies/Weather Hotline

For information on weather related delays or closings, dial 559-5508. This number is also used to keep staff informed in case of any unusual or emergency situations on campus. Sign up for the Hampshire College Emergency Mass Notification System (EMNS) on TheHub via the Employee Menu.

Hampshire Directories

You can search our online College Directory for phone numbers, departments and email addresses of all Hampshire faculty, staff, and students at https://directory.hampshire.edu/

Address Changes

To update your home address and phone number and emergency contact, please access TheHub and choose the Employee Menu, to Personal Information and select My Profile/Address information.

CONTACTS

Medical plan & prescription services

Blue Cross Blue Shield of MA
Member services: 800.358.2227
Website: www.bluecrossma.com

Retirement 403(b)

T I AA
Customer service: 800.842.2776
Website: www.tiaa.org/hampshire

Health care & Dependent care flex spending account

Voya
Customer service: 888.401.3539
Website: www.benstrat.com

Health Savings Account

Health Equity
Member services: 866.346.5800
Website: www.healthequity.com

Voluntary dental

Blue Cross Blue Shield of MA
Member services: 800.358.2227
Website: www.bluecrossma.com

Voluntary vision

Davis Vision
Customer service: 800.999.5431
Website: www.davisvision.com

EAP

Lucent Health EAP
Customer service: 800.624.5544
Website: www.eap.lucenthealth.com

Life/AD&D

Transamerica
General customer service: 855-244-8318 or email: selfadminclaims@transamerica.com
Claims: 855-244-8318 or email: selfadminclaims@transamerica.com

Long-term disability

Transamerica
General customer service: 888-862-6256 or email: taclaims@disabilityrms.com
Claims: 888-862-6256 or email: taclaims@disabilityrms.com

Final notes

This summary of benefits is not intended to be a complete description of Hampshire College's insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan. This guide constitutes the Summary Material Modifications.

In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although Hampshire College maintains its benefit plans on an ongoing basis, Hampshire College reserves the right to terminate or amend each plan in its entirety or in any part at any time.

For questions regarding the information provided in this overview, please contact your Hampshire College human resources representative.

IMPORTANT NOTICE FROM HAMPSHIRE COLLEGE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Your employer has determined that the prescription drug coverage offered by our employer sponsored group health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current employer-sponsored group health plan coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored group health plan coverage, be aware that you and your dependents will not be able to get this coverage back until the plan's next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

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

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

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

For more information about Medicare prescription drug coverage:

• Visit www.medicare.gov

• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: January 1, 2025

Name of Entity/Sender: Hampshire College HR Department
Contact—Position/Office: Sr. Director of Human Resources
Address: 859 West Street, Amherst, MA 01002
Phone Number: 413-559-5605

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan

Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the self-funded health plan(s) (the "Plan") sponsored by Hampshire College (“Plan Sponsor”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and subsequent amending regulations (“HIPAA Privacy Rule”). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this HIPAA Privacy Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the individual listed at the end of this notice.

Our Responsibilities

The Plan Sponsor is required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your Protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised HIPAA Privacy Notice electronically or by first class mail to the last known address on file.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. We may share or discuss your PHI with your family members or others involved in your care or payment for your care, unless you object in writing and provide the objection to the Plan's HIPAA contact listed at the end of this Notice. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. In any of these cases, we will disclose only the information necessary to resolve the issue at hand.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone 14 able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

• to prevent or control disease, injury, or disability;

• to report births and deaths;

• to report child abuse or neglect;

• to report reactions to medications or problems with products;

• to notify people of recalls of products they may be using;

• to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

• to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law enforcement official:

• in response to a court order, subpoena, warrant, summons, or similar process;
• to identify or locate a suspect, fugitive, material witness, or missing person;
• about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
• about a death that we believe may be the result of criminal conduct; and
• about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: • the individual identifiers have been removed; or when an institutional review board or • privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
- treating such person as your personal representative could endanger you; and in the
- exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the individual listed at the end of this Notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the individual listed at the end of this Notice.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the individual listed at the end of this Notice. You must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit it in writing to the individual listed at the end of this Notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must send your request in writing the individual listed at the end of this notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing the individual listed at the end of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website which is listed at the end of this notice. To obtain a paper copy of this notice, contact the individual listed at the end of this notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact to the individual listed below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Privacy Officer

The Plan's Privacy officer, the person responsible for ensuring compliance with this notice, is:
Sr. Director of Human Resources
413-559-5605

HAMPSHIRE COLLEGE EMPLOYEE HEALTH CARE PLAN
NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *31 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *31 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:
Sr. Director of Human Resources
413-559-5605

*** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.**

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Hampshire College's HMO plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBS of MA Health Plan at (800) 358-2227.

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

You do not need prior authorization from Hampshire College Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Hampshire College Employee Health Care Plan at:
Sr. Director of Human Resources
413-559-5605

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.
If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Sr. Director of Human Resources 413-559-5605.

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Hampshire College Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The Hampshire College Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your Policy Booklet or contact your Plan Administrator at:
Sr. Director of Human Resources
413-559-5605

Mental Health Parity & Addiction Act

The Mental Health Parity and Addiction Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at Sr. Director of Human Resources at 413-559-5605

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 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 Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/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 Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

New Health Insurance Marketplace Options and Your Health Coverage

Form Approved

OMB No. 1210-0149
(expires 12-31-2026)

Part A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% [1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

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

Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

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

When Can I enroll in Health Insurance Coverage Through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Sr. Director of Human Resources at 413-559-5605.

*The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.*

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

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **Hampshire College has determined that the prescription drug coverage offered by the Hampshire College Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.
However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Hampshire College coverage will be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your current Hampshire College coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Hampshire College and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information 413-559-5605. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Hampshire College changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

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

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

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

Date:	September 6, 2024
Name of Entity/Sender:	Hampshire College HR
Contact--Position/Office:	Sr. Director of Human Resources
Address:	893 West Street, Amherst, MA 01002

General Notice of COBRA Continuation Coverage Rights
** Continuation Coverage Rights Under COBRA**

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Hampshire HR Department.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Voya (COBRA administrator)

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

For more information visit https://www.medicare.gov/medicare-and-you.
https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information : Name of Entity/Sender: Hampshire College HR Department, Sr. Director of Human Resources 859 West Street, Amherst, MA 01002 & Phone Number: 413-559-5605

Hampshire College