2025

EMPLOYEE BENEFITS GUIDE

HENDRIX COLLEGE

Compiled by Stephens Insurance, LLC

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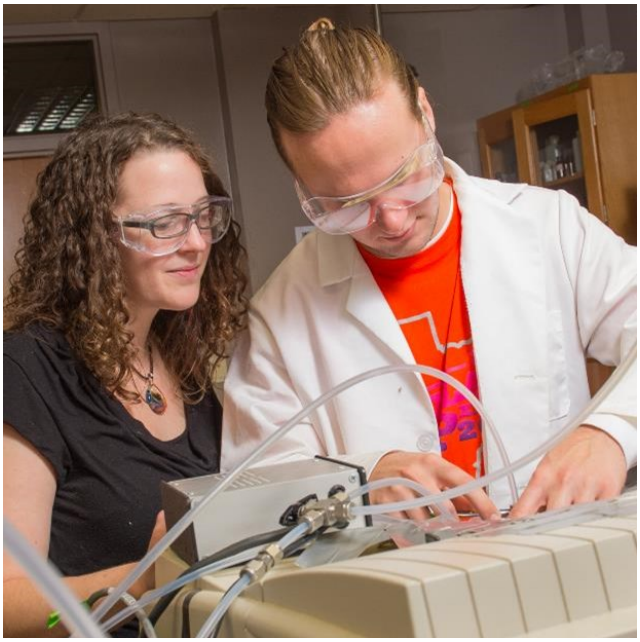
The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by the employer. This is not a guarantee of coverage. The text contained in this Summary was taken from various summary plan descriptions and benefit information. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.



INSIDE YOUR BENEFITS

Welcome to your 2025 Benefits Guide! As a valued employee, Hendrix College strives to support the needs of you and your family by offering a comprehensive and competitive benefits program.

This guide serves as a general and brief overview of the benefits available to you. Refer to each plan's benefit summary and certificate for complete details regarding benefits, limitations, and exclusions. We encourage you to review each option so you can decide what coverage is right for you and your family.

Who is Eligible?

All full-time employees are eligible to enroll in the benefits described in this guide.
The following family members are also eligible for coverage:

- Spouse
- Domestic Partner as defined in the Hendrix College Health Benefit Plan SPD
- Dependent Children up to age 26

How to Enroll

During open enrollment, use the online enrollment platform to add or delete enrollment in any of the plans, add or delete family members, enroll in the FSA's or HSA, etc. If you are a new employee or newly eligible, Human Resources will provide you with information regarding the online enrollment platform. Once this is provided, please make your benefit selections. Keep in mind that you will not be able to make changes to your benefits until the next open enrollment period unless you have a qualified change in status.

When to Enroll

Open Enrollment period begins October 28, 2024 and ends November 8, 2024.

If you are a new employee, your initial enrollment period will begin when you first become eligible, which is the first of the month following, or coinciding with, your date of full-time employment for all benefits offered, other than Medical insurance. Medical insurance eligibility begins on the date of full-time employment.

When to Make Changes

As mentioned above, you cannot make changes to your benefit selections until the next open enrollment period unless you have a qualified change in status. These include: marriage; divorce; legal separation; birth or adoption of a child; change in child's dependent status; death of spouse, child, or other qualified dependent; or change in residence due to an employment transfer for you. **You must notify Human Resources within 30 days of the qualifying event or your change must wait until the next open enrollment period.** No exceptions can be made.

MEDICAL & PRESCRIPTION COVERAGE

Making informed decisions today could significantly enhance your health and wellbeing tomorrow! Hendrix offers a choice of two Medical plans: a traditional PPO plan and a Qualified High Deductible Health Plan. Both are through Blue Advantage Administrators.

PPO Plan

Plan Features	In-Network	Out-of-Network
Deductible		
Individual	$1,500	$3,000
Family	$3,000	$6,000
Coinsurance	20%	40%
Out-of-Pocket Maximum		
Individual	$6,500	$13,000
Family	$13,000	$26,000
Office Visits		
Preventive Care, Screenings, Immunizations	No charge	No charge
Primary Care	$20 copay	40% after deductible
Specialist	20% after deductible	40% after deductible
Prime Care & Conway Regional Urgent Care	$20 copay	40% after deductible
Other Urgent Care Centers	20% after deductible	20% after deductible
Emergency Room Visit	20% after deductible	20% after deductible
Inpatient Services	20% after deductible	40% after deductible
Outpatient Services	20% after deductible	40% after deductible
Prescription Drug Copays	**Standard**	**Specialty**
Generic Drugs	$10 copay	20% up to
Preferred Brand Drugs	$30 copay	$250 max,
Non-preferred Brand Drugs	$50 copay	no deductible

Your Cost Per Month	Support Staff & Dining Service	Admin Staff & Faculty	Other Admin Staff & Other Faculty	Senior Leadership Team
Employee Only	$116.48	$184.08	$234.00	$255.84
Employee + Spouse	$246.48	$383.76	$491.92	$538.72
Employee + Child(ren)	$204.88	$320.32	$409.76	$449.28
Employee + Family	$351.52	$549.12	$702.00	$768.56

MEDICAL & PRESCRIPTION COVERAGE

If enrolled in the High Deductible Health Plan, you may qualify to contribute to a Health Savings Account. If you open an HSA through Consolidated Admin Services, Hendrix College will match the first $250 of your contributions during 2025.

High Deductible Health Plan

Plan Features	In-Network	Out-of-Network
Deductible Individual Coverage Family Coverage	 $2,500 $5,000 (individual max $2,500)	 $4,000 $8,000 (individual max $4,000)
Coinsurance	20%	40%
Out-of-Pocket Maximum Individual Family	 $7,400 $11,800 (with $7,400 individual)	 $10,000 $30,000 (with $10,000 individual)
Office Visits Preventive Care, Screenings, Immunizations Primary Care Specialist Urgent Care	 No charge $30 copay after deductible 20% after deductible 20% after deductible	 No charge 40% after deductible 40% after deductible 40% after deductible
Emergency Room Visit	20% after deductible	20% after deductible
Inpatient Services	20% after deductible	40% after deductible
Outpatient Surgical	20% after deductible	40% after deductible
Prescription Drug Copays Generic Drugs Preferred Brand Drugs Non-preferred Brand Drugs	**Standard** $10 copay after deductible $30 copay after deductible $50 copay after deductible	**Specialty** 20% up to $250 max, no deductible

Your Cost Per Month	Support Staff & Dining Service	Admin Staff & Faculty	Other Admin Staff & Other Faculty	Senior Leadership Team
Employee Only	$75.92	$125.84	$167.44	$191.36
Employee + Spouse	$156.00	$260.00	$346.32	$383.76
Employee + Child(ren)	$130.00	$216.32	$292.24	$334.88
Employee + Family	$216.32	$361.92	$491.92	$540.80

This is a brief recap of the two Medical and Prescription plans offered. Refer to the benefit summaries and Plan Document for complete details regarding benefits, limitations, and exclusions

FLEXIBLE SPENDING ACCOUNTS (FSA)

A Flexible Spending Account (FSA) lets you take home a larger paycheck by reducing your taxable income. Contributions to your FSA come out of your paycheck before any taxes are taken out. This means you don't pay federal income tax, Social Security taxes, or state and local income taxes on the portion of your paycheck you contribute to your FSA. This is offered through Consolidated Admin Services.

Health Care FSA	Limited Expense FSA	Dependent Care FSA
This allows employees to set aside pre-tax dollars to pay for qualified medical, dental and vision expenses such as deductibles, coinsurance amounts, copays, glasses, contacts, and other expenses that are described in IRS Publication 502 – Medical and Dental Expenses. Premiums for health and other insurance are not eligible expenses. Websites like fsastore.com also show what FSA funds can be used for. Some things will surprise you.	This allows employees to set aside pre-tax dollars to pay for only qualified dental and vision expenses such as deductibles, coinsurance amounts, copays, braces, glasses, contacts, and other expenses that are described in IRS Publication 502 – Medical and Dental Expenses.	This allows employees to set aside pre-tax dollars to pay for qualified dependent care services. (Not to be used for dependent medical expenses.) See the complete list in IRS Publication 503 – Child and Dependent Care Expenses.
Annual Contribution Limit: $3,300	**Annual Contribution Limit:** $3,300	**Annual Contribution Limit:** $5,000 per family; or $2,500 each for married filing separately.
Eligible Employees: All benefits eligible employees except those enrolled in the High Deductible Health Plan	**Eligible Employees:** Only employees enrolled in the High Deductible Health Plan	**Eligible Employees:** All benefits eligible employees

Use Your FSA

Your FSA account can be used throughout the year on qualified medical, dental, or vision or qualified dependent care expenses—reducing your out-of-pocket costs. Your entire annual contribution amount is available on the first day of the plan year with the Health Care FSA and Limited Expense FSA. With the Dependent Care FSA, the funds are available as they're deducted from your pay check.

What Happens if I Have FSA Funds Left at the End of the Plan Year?

The Health Care FSA, Limited Expense FSA, and Dependent Care FSA all include a 2 1/2 month grace period. Any amounts remaining at the end of the year may be used for expenses that you incur during the first 2 1/2 months of the next year. All claims for reimbursement for expenses incurred during the calendar year and during the following 2 1/2 month grace period must be submitted by 15 days after the end of the grace period.

For example, you have $300 left in your Health Care FSA on December 31, 2024. You only have $200 of eligible 2024 expenses to submit for reimbursement, but you get new glasses in February, 2025 and the Vision plan covers all but $100. You have until March 30, 2025 to submit reimbursement claims for the $200 of 2024 expenses and the $100 of 2025 expenses.

Note: FSAs do not automatically renew. You must re-enroll each year to participate. The amount you elect for the year will be divided into equal amounts and deducted through payroll before taxes.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA), administered through Consolidated Admin Services, is a unique, tax-advantaged account that can be used to pay for current or future healthcare expenses. When combined with a Qualified High Deductible Health Plan (HDHP), it offers savings and tax advantages that a copay plan can't duplicate. With an HSA, you will have:

- A savings account used for eligible medical expenses as well as deductibles, co-insurance, prescriptions, dental care, glasses, contacts, etc. The IRS list of eligible expenses is extensive. Websites like hsastore.com show what HSA funds can be used for.
- Unused funds will roll over year to year; no “use it or lose it” penalty
- The potential to build more savings through investing; members choose from a variety of self-directed investment options when the HSA balance reaches $2,000
- Additional retirement savings; after age 65, funds can be withdrawn for any purpose without penalty, but may be subject to income tax if not used for IRS-qualified medical expenses

Are You Eligible for an HSA?

- You must be enrolled in a Qualified High Deductible Health Plan
- You can’t be enrolled in any other non -qualified health plan
- You can’t be enrolled in Medicare
- You’re at least 18 years old and not claimed as a dependent on someone else’s tax return

How Much Can I Contribute?

The IRS provides inflation-adjusted contribution limits each year. The 2025 limits are shown in the chart below. These limits include not just your own contributions, but also those made by Hendrix College and any other persons, such as family members or friends. The IRS doesn’t restrict who can contribute to your HSA, just how much can be contributed each

20245HSA Contributions Limits	
Self-only Coverage	$4,300
Family Coverage	$8,550
Catch-Up Contribution (age 55+)	$1,000

DENTAL BENEFITS

Regular dental visits not only keep your teeth and gums in excellent health but can also potentially detect early signs of other health issues. Protect your smile by choosing benefits through Arkansas BlueCross and BlueShield.

Dental Xtra

The Dental plan includes a program called **Dental Xtra**. This program allows additional Dental services for persons with certain medical conditions. If you're enrolled in the Hendrix Medical plan, the Medical and Dental plans work together to review medical claims to identify persons with eligible medical conditions and enroll them automatically. You can also contact Customer Service to enroll.

Two additional preventive visits, plus periodontic scaling covered 100%, *are allowed for persons with these conditions:*

Chronic Obstructive Pulmonary Disease
Coronary Artery Disease
Diabetes
End-stage Renal Disease
Metabolic Syndrome
Pregnancy
Stroke

Two additional preventive visits, plus cancer screenings and fluoride treatments, *are allowed for persons with these conditions:*

Head and neck Cancers
Oral Cancer
Sjögren's Syndrome
Stroke

Learn more at :
arkbluecross.com/dental-xtra

Services	In-Network	Out-of-Network
Deductible for Minor & Major Services Individual Family Maximum	 $50 $150	 $50 $150
Preventive Services: Exams, Cleanings, X-rays, Fluoride Treatment, Sealants	0%	10%
Minor Services: Fillings, Extractions, Non-Surgical Periodontics, Root Canals, Oral Surgery, Anesthesia	20%	30%
Major Services: Surgical Periodontics, Inlays, Onlays, Crowns, Partials, Dentures, Implants	50%	40%
Annual Maximum Benefit Per Individual	$1,500	$1,000
Your Cost Per Month		
Employee Only	$39.28	
Employee + 1 Dependent	$68.54	
Employee + 2 or More Dependents	$98.18	

VISION BENEFITS

Improving your eyesight can directly impact your quality of life and lower your costs down the line. Take advantage of the benefits offered to you through VSP so you can keep an eye on your health!

You can choose to see a VSP network doctor or an out-of-network provider. But just like the Medical and Dental plans, you'll have lower out-of-pocket costs when using a provider that's in the network.

Services	In-Network	Out-of-Network Reimbursement
Eye Exam—every 12 months	$10 copay	Up to $50
Prescription Glasses	$25 copay	See frames and lenses
Lenses—every 12 months		
Single Vision	Included in copay	Up to $50
Lined Bifocal	Included in copay	Up to $75
Lined Trifocal	Included in copay	Up to $100
Polycarbonate lenses for children	Included in copay	Up to $50
Lens Enhancements		
Standard progressive lenses	$0	Up to $75
Premium progressive lenses	$80—$90	Up to $75
Custom progressive lenses	$120—$160	Up to $75
Average savings of 35-40% on other lens enhancements		
Frames		
$130 allowance for a wide selection of frames	Included in copay	Up to $70
$150 allowance for featured frame brands	Included in copay	Up to $70
20% savings on the amount over your allowance		
Contact Lenses (in lieu of glasses) every 12 months	$130 allowance	Up to $75
Contacts lenses, fitting, and evaluation		
Copay does not apply		

Your Cost Per Month	
Employee Only	$9.64
Employee + Spouse	$15.42
Employee + Child(ren)	$14.74
Employee + Family	$25.38

Prefer to shop online? Your favorite eyewear brands and contact lenses are also available at Eyeconic. VSP offers Exclusive Member Extras like discounts on the LASIK procedure, contacts, and hearing aids, as well as other special offers. Details are available at www.vsp.com.

DISABILITY COVERAGE

Disability coverage through Symetra helps protect your financial health by providing benefits when you're unable to work due to an extended **illness or injury**. Both the STD and LTD plans include benefits for partial disability as well as total disability. You pay 100% of the premium for this coverage through payroll deductions, using after-tax dollars. Because you pay taxes on the premium, **any benefits you receive are non-taxable income**.

If you didn't enroll in the STD and/or LTD plans when you first became a full-time employee, **you can enroll now at open enrollment**. However, an **Evidence of Insurability form** (health questionnaire) has to be completed and submitted to Symetra for underwriting review. No coverage is in effect unless, and until, the underwriter approves the health questionnaire

Short-Term Disability

- **STD** pays **60% of your weekly salary**, up to a maximum benefit of $700 per week (the maximum covered salary is $1,167 per week, or $60,6320 annually).
- Your STD benefits **begin on the 15th day** following an accident or illness. You may receive this benefit for **up to 24 weeks**.
- Faculty are not eligible to enroll in the STD plan.

Monthly Rate: $0.34 per $10 of weekly benefit

To calculate your monthly premium:

_____ x 0.6 = _____ / 10 x 0.34 = _____
weekly salary* weekly benefit monthly premium

Example: $1,000 x 0.6 = $600 / 10 = $60 x 0.34 = $20.40
monthly premium

*Use $1,167 if your weekly salary exceeds that amount.

Salary amounts are verified by Human Resources.

Long-Term Disability

- **LTD** pays **60% of monthly salary,** up to maximum benefit of $6,000 per month (the maximum covered salary is $10,000 or $120,000).
- Your LTD benefits will **begin on the 181st day** of disability. You may receive this benefit up to your **Social Security Normal Retirement Age.**

Monthly Rate: $0.469 per $100 of covered monthly salary

To calculate your monthly premium:

_____ / 100 x 0.469 = _____
monthly salary * monthly premium

Example: $4,333 / 100 X 0.469 = $20.32
monthly premium

*Use $4,333 if your monthly salary exceeds that amount.

Salary amounts are verified by Human Resources.

LIFE AND AD&D COVERAGE

Hendrix College offers two Life/AD&D plans: **Basic Life/AD&D** and **Supplemental Life/AD&D** . Both plans are with Symetra. **Hendrix** provides the **Basic Life/AD&D** coverage **at no cost to you**; they pay 100% of the cost. You can enroll in additional coverage for you, your spouse, and your dependent children through the Supplemental Life/AD&D plan. **You pay 100%** of the cost for any **Supplemental coverage** through payroll deductions.

Do you need to update your beneficiary? Those changes can be made at any time throughout the year.

Basic Life/AD&D - Hendrix pays 100% of the premium	
Benefit Amount	1 x annual salary, rounded to the next higher $1,000, to a maximum benefit of $500,000
Guaranteed Issue	Full benefit amount
Age Reduction Schedule	Reduces to 65% of the original benefit at age 65, to 40% at age 70, and to 25% at age 75
Supplemental Life/AD&D - You pay 100% of the premium	
Employee Life/AD&D	
Benefit Amount	When first eligible, $10,000 increments to the maximum of the lesser of $500,000 or 5 x annual salary
Guaranteed Issue	$100,000; any benefit over this amount requires approval of an Evidence of Insurability form
Open Enrollment Option	First-time enrollees: any number of increments of $10,00, up to the lesser of $100,000 or 5 annual salary Currently enrolled: any number of increments of $10,000, with the current benefit and open enrollment benefit combined not exceeding the lesser of $100,000 or 5 x annual salary
Age Reduction Schedule	Reduces to 65% of the original benefit at age 65, to 40% at age 70, and to 25% at age 75
Spouse Life/AD&D—You must be enrolled in Supplemental Life/AD&D to enroll your spouse	
Benefit Amount	When first eligible, $5,000 increments to a maximum of the lesser of $250,000 or 50% of the employee supplemental benefit amount
Guaranteed Issue	$50,000; any benefit over this amount requires approval of an Evidence of Insurability form
Open Enrollment Option	First-time enrollees: any number of increments of $5,000, up to the lesser of $50,000 or 50% of the employee supplemental benefit amount Currently enrolled: any number of increments of $5,000, with the current benefit and open enrollment benefit combined not exceeding the lesser of $50,000 or 50% of the employee supplemental amount
Age Reduction Schedule	Reduces to 65% of the original benefit at age 65, to 40% at age 70, and to 25% at age 75
Child Life—You must be enrolled in Supplemental Life/AD&D to enroll your child(ren)	
Benefit Amount	$10,000, covers all eligible children from birth to age 26
Monthly Rates	Employee and Spouse, per $1,000 of benefit: < age 25 $0.09 40-44 $0.19 60-64 $1.06 25-29 $0.09 45-49 $0.30 65-69 $1.90 30-34 $0.11 50-54 $0.44 70-74 $2.68 35-39 $0.13 55-59 $0.65 75+ $5.75 Child(ren) rate per $10,000 unit (not rate per child, covers all eligible children)

CRITICAL ILLNESS COVERAGE

Help protect your financial health during life's most critical moments.

The Symetra Critical Illness plan **helps protect your financial health** during life's most critical moments. The plan provides **lump-sum benefits** when covered illnesses and conditions occur, such as Cancer, Stroke, Loss of Sight/Hearing/Speech, Major Organ Failure, End State Renal Failure, Paralysis, Severe Burns, Multiple Sclerosis, ALS, and Coma**. Complete benefit information and rates are available on the online enrollment platform.**

You pay 100% of the premium for Critical Illness coverage.

Voluntary Critical Illness Coverage	
What is it?	Provides cash benefits if you or a covered family member are diagnosed with a critical illness or event.
Employee Coverage Options	$5,000; $10,000; $15,000, and $20,000
Spouse Coverage Amount	50% of the Employee coverage amount. Employee coverage is required.
Child(ren) Coverage Amount	25% of the Employee coverage amount. Employee coverage is required.
Is this plan portable?	Yes! Can you take the plan with you if you leave employment.
Are there exclusions?	Please see Symetra Critical Illness Insurance flyer and benefit certificate for more complete info.
Wellness Benefit	$50 per covered person. You receive a cash benefit every year you and any of your covered family members complete a single covered exam, screening or immunization.

ACCIDENT COVERAGE

Hendrix College wants to ensure that you are covered for whatever life may throw your way. Accidents don't need to be big to be expensive. Even common injuries like a broken arm can have a significant impact on employee finances.

That's why **Accident insurance** through Symetra can be an important part of your benefit selections. Accident insurance pays **set dollar amounts** for medical services received due to an accident. The plan is **in addition to your other coverage**. It doesn't coordinate with the Hendrix medical plan, or any other coverage you have. **Claim payments are sent directly to you** rather than to the doctor, hospital, lab, etc.

You pay 100% of the premium for Accident coverage.

Voluntary Accident Coverage	
What is it?	Provides cash benefits if you or a covered family member are accidentally injured while off the job.
Examples of covered treatment and benefit paid	Ambulance—$250 ground, $1,500 air; Emergency Room—$200; Major Diagnostic Testing—$150; Hospital Admission—$1,250; Hospital Confinement—$250 per day; ICU—$500 per day; Dislocations—$125 to $4,000; Fractures—$300 to $4,000; Surgery—$300 to $2,000
Is this plan portable?	Yes! Can you take the plan with you if you leave employment.
Are there exclusions?	Please see the Symetra flyer and benefit certificate for more complete info.
Wellness Benefit	$75 per covered person. You receive a cash benefit every year you and any of your covered family members complete a single covered exam, screening or immunization.
Monthly Rates	Employee Only $16.20 Employee & Spouse $23.16 Employee & Child(ren) $30.90 Employee & Family $37.86

CONTACT INFORMATION

Refer to this list when you need to contact one of your benefit carriers or vendors. For general information, please contact Human Resources at hr@hendrix.edu or 501-450-1494.

Plan	Carrier	Phone	Website
Medical	Blue Advantage Administrators	800-370-5852	blueadvantagearkansas.com
Prescription	Blue Advantage Administrators	800-370-5852	blueadvantagearkansas.com
FSAs, HSA	Consolidated Admin Services	877-941-5956	consolidatedadmin.com
Dental	Arkansas Blue Cross Blue Shield	888-223-4999	arkansasbluecross.com
Vision	VSP	800-877-7195	vsp.com
Disability	Symetra	877-377-6773	symetra.com
Basic & Supplemental Life/AD&D	Symetra	877-377-6773	symetra.com
Accident	Symetra	877-377-6773	symetra.com
Critical Illness	Symetra	877-377-6773	symetra.com

Your Stephens Insurance Account Team is available should you have any questions regarding your insurance benefits, or need assistance with a claim.

Donna Rutland
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(501) 377-6302
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Stephens
Stephens Insurance, LLC

HENDRIX COLLEGE

Important Notices from Hendrix College Regarding the Hendrix College Health Benefit Plan

Hendrix College is required by applicable law to provide you with certain notices each year to inform you of your rights and responsibilities with respect to the company's health plan (the "Plan"). Please read these notices carefully, share them with your covered dependents as applicable, and keep a copy for future reference.

If you have any questions regarding any of these notices, please contact:

General Contact: Human Resources Department

Phone: 501-329-6811

Email: hr@hendrix.edu

Mailing Address: 1600 Washington Avenue
Conway, AR 72032

Plan Administrator: Hendrix College

Phone: 501-329-6811

Email: hr@hendrix.edu

Mailing Address: 1600 Washington Avenue
Conway, AR 72032

Distribution Date: October 28, 2024

These notices are available online or via paper, free of charge, upon request to the Plan Administrator.

2024 Medicare Part D Notice of Creditable Coverage

Important Notice About Your Prescription Drug Coverage and Medicare

To: All Plan Participants Who Have Medicare or Will Become Eligible for Medicare in the Next 12 Months

This notice is applicable to Medicare eligible participants ONLY. If you or one of your covered dependents is not Medicare eligible or will not be within the next 12 months, you can disregard this notice.

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

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

1. Medicare prescription drug coverage is available 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. Hendrix College has determined that the prescription drug coverage offered by its 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. (For most people, your first chance to join Medicare, including Medicare Part D, is when you turn age 65.) You can also join a Medicare Part D plan each year after you turn 65 from October 15 through December 7. Please note that the annual enrollment period for Medicare Part D is different than the general enrollment period for Medicare Part B (which is from January 1 to March 31, with coverage effective the following July 1).

If you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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?

Plan Participants who also are eligible for Medicare have the following three options concerning prescription drug coverage:

1. You may stay in the Plan and not enroll in the Medicare prescription drug coverage at this time. You will be able to enroll in the Medicare prescription drug coverage at a later date without penalty, either (1) during a Medicare prescription drug open enrollment period (October 15–December 7 of each year); or (2) if you lose Plan coverage. This is the best option for most Plan participants who are eligible for Medicare.

2. You may stay in the Plan and also enroll in Medicare prescription drug coverage. The Plan will pay prescription drug benefits as the primary payer in most instances. Medicare Part D will pay benefits as a secondary payer, and thus the value of your Medicare prescription drug coverage will be greatly reduced. Your current coverage under the Plan pays for other health benefits as well as prescription drugs and will not change if you choose to enroll in Medicare prescription drug coverage.

3. You may reject all coverage under the Plan and choose coverage under Medicare as your primary and only payer for all medical and prescription drug expenses. If you do so, you will not be able to receive coverage under the Plan, including prescription drug coverage, unless and until you are eligible to reenroll in the Plan at the next open or special enrollment period for which you are eligible, if any. Your current coverage pays for other types of health expenses, in addition to prescription drugs, and you will not be eligible to receive any of your current health and prescription drug benefits if you reject coverage under the Plan and choose to enroll in Medicare, including a Medicare prescription drug plan, as your primary and only payer.

If your coverage is an HDHP plan, once you enroll in Medicare, you and your employer will not be eligible to make any further contributions to your Health Savings Account, although you will still be able to make withdrawals. And under the Plan coverage, you must meet the high-deductible amounts before the Plan will pay for most prescription drugs.

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

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

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through 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.

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).

Contact; Human Resources Department

Address: 1600 Washington Ave., Conway, AR 72032

Phone: 501-329-6811

Women's Health and Cancer Rights Act Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 501-329-6811 for more information.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 5011-329-6811.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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*

myalhipp.com/
1-855-692-5447

Alaska *Medicaid*

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

Arkansas *Medicaid*

myarhipp.com/
1-855-MyARHIPP (855-692-7447)

California *Medicaid*

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

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

Health First Colorado
healthfirstcolorado.com/
1-800-221-3943/ State Relay 711
CHP+
colorado.gov/pacific/hcpf/child-health-plan-plus
1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI)
mycohibi.com/
1-855-692-6442

Florida *Medicaid*

flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
1-877-357-3268

Georgia *Medicaid*

GA HIPP
medicaid.georgia.gov/health- insurance-premium-payment-program-hipp
678-564-1162, Press 1
GA CHIPRA
medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
(678) 564-1162, Press 2

Indiana *Medicaid*

Health Insurance Premium Payment Program
All other Medicaid
in.gov/medicaid/
in.gov/fssa/dfr/
Family and Social Services Administration
1-800-457-4584
Member Services
1-800-457-4584

Iowa *Medicaid and CHIP (Hawki)*

Medicaid
Iowa Medicaid | Health & Human Services
1-800-338-8366
Hawki
dhs.iowa.gov/Hawki
1-800-257-8563
HIPP
Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
1-888-346-9562

Kansas *Medicaid*

kancare.ks.gov/
1-800-792-4884
HIPP
1-800-967-4660

Kentucky *Medicaid*

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
1-855-459-6328
KIHIPP.PROGRAM@ky.gov
KCHIP
kynect.ky.gov
1-877-524-4718
Kentucky Medicaid
chfs.ky.gov/agencies/dms

Louisiana *Medicaid*

medicaid.la.gov or ldh.la.gov/lahipp
1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

Maine *Medicaid*

Enrollment
mymaineconnection.gov/benefits/s/?language=en_US
1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium
maine.gov/dhhs/ofi/applications-forms
1 -800-977-6740
TTY: Maine relay 711

Massachusetts *Medicaid and CHIP*

mass.gov/masshealth/pa
1-800-862-4840
TTY: 711
masspremassistance@accenture.com

Minnesota *Medicaid*

mn.gov/dhs/health-care-coverage/
1-800-657-3672

Missouri *Medicaid*

dss.mo.gov/mhd/participants/pages/hipp.htm
573-751-2005

Montana *Medicaid*

dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
1-800-694-3084
HHSHIPPProgram@mt.gov

Nebraska *Medicaid*

ACCESSNebraska.ne.gov
1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada *Medicaid*

dhcfp.nv.gov
1-800-992-0900

New Hampshire *Medicaid*

dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
603-271-5218
HIPP
1-800-852-3345, ext 15218
DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey *Medicaid and CHIP*

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

New York *Medicaid*

health.ny.gov/health_care/medicaid/
1-800-541-2831

North Carolina *Medicaid*

medicaid.ncdhhs.gov/
919-855-4100

North Dakota *Medicaid*

hhs.nd.gov/healthcare
1-844-854-4825

Oklahoma *Medicaid and CHIP*

insureoklahoma.org
1-888-365-3742

Oregon *Medicaid*

healthcare.oregon.gov/Pages/index.aspx
1-800-699-9075

Pennsylvania *Medicaid*

pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-

payment-program-hipp.html
1-800-692-7462
CHIP
Children's Health Insurance Program (CHIP) (pa.gov)
1-800-986-KIDS (5437)

Rhode Island *Medicaid and CHIP*

eohhs.ri.gov/
1-855-697-4347, or
401-462-0311 (Direct Rite Share Line)

South Carolina *Medicaid*

scdhhs.gov
1-888-549-0820

South Dakota *Medicaid*

dss.sd.gov
1-888-828-0059

Texas *Medicaid*

Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
1-800-440-0493

Utah *Medicaid and CHIP*

Utah's Premium Partnership for Health Insurance (UPP)
medicaid.utah.gov/upp/
upp@utah.gov
Adult Expansion
medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program
medicaid.utah.gov/buyout-program/
CHIP
chip.utah.gov/

Vermont *Medicaid*

Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
1-800-250-8427

Virginia *Medicaid and CHIP*

coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP: 1-800-432-5924

Washington *Medicaid*

hca.wa.gov/
1-800-562-3022

West Virginia *Medicaid and CHIP*

dhhr.wv.gov/bms/
mywvhipp.com/
Medicaid: 304-558-1700
CHIP: 1-855-MyWVHIPP
(1-855-699- 8447)

Wisconsin *Medicaid and CHIP*

dhs.wisconsin.gov/badgercareplus/p-10095.htm
1-800-362-3002

Wyoming *Medicaid*

health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
1-800-251-1269

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
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)

Notice of HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you of your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. You have the right to request special enrollment (outside of the plan's annual enrollment period) for yourself and your eligible dependents under the following circumstances.

Loss of Other Coverage (Except Medicaid or a State Children's Health Insurance Program). If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 30 days after the marriage, birth, adoption, or placement for adoption.

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

If you decline coverage, the Plan may require you to fill out a form used for employees who decline coverage.

To request special enrollment or obtain more information, contact Human Resources, hr@hendrix.edu, 501-329-6811.

Continuation Coverage Rights Under COBRA

Introduction

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. 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 Plan Administrator.

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

What is COBRA continuation coverage?

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

If you're an employee, 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Hendrix College, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;; or
- 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 the COBRA administrator along with the appropriate supporting documentation.

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. The Social Security determination of disability notice must be provided to the COBRA administrator prior to 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, 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 **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 **medicare.gov/medicare-and-you**.

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 **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 **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

Human Resources Department

hr@hendrix.edu

501-329-6811

For the Department of Labor's Employer Exchange/Marketplace Notice information, please click the link below:

dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice

Health Insurance Marketplace Coverage 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% 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.

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.

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[1] Indexed annually; see 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.

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 healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

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

PART B: Information About Health Coverage Offered by Your Employer

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

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - [X] Some employees. Eligible employees are: active full-time employees working 30 or more hours per week
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are: legally married spouses, domestic partners as defined in the Hendrix College Health Benefit Plan SPD, children under age 26
  - ☐ We do not offer coverage.

3. Employer name Hendrix College	**4. Employer Identification Number (EIN)** 71-0236897	
5. Employer address 1600 Washington Avenue	**6. Employer phone number** 501-329-6811	
7. City Conway	**8. State** AR	**9. ZIP Code** 72032
10. Who can we contact about employee health coverage at this job? Human Resources Department		
11. Phone number (if different from above)	**12. Email address** hr@hendrix.edu	

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

•An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)