Lafayette College

Health and Welfare Plan

And

SUMMARY PLAN DESCRIPTION

Amended and Restated
Effective

January 1, 2020

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended, and summarizes the welfare benefits offered under Lafayette College Health and Welfare Plan.

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1. INTRODUCTION

Lafayette College (the **"College"**), (the **"Employer"**), or (the **"Plan Sponsor"**) maintains the Lafayette College Health and Welfare Plan (the **"Plan"**) for the exclusive benefit of its full-time employees, their Spouses, same-sex Domestic Partners, Eligible Retirees (medical (including prescription drugs) and dental benefits only), visiting faculty (not eligible for life insurance and disability coverage), Interns and 1-year Appointments (medical (including prescription drugs), voluntary dental and flexible spending account plan benefits only) and their Dependents.

Lafayette College fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason with the appropriate required notification requirements.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminates, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force.

Purpose of the Plan Document
Lafayette College is providing this document to address certain information that may not be addressed in the attached group insurance contracts previously delivered to you. This document, together with the group insurance contract issued by the insurance company, is the Plan document required by ERISA. This Plan document is not intended to give any substantive rights to benefits that are not already provided by the attached group insurance contracts.

The Plan provides benefits through the following component benefit programs:

Attachment # 1	**Capital Blue Cross – medical (including prescription drugs)** Standard PPO Group Number: 00528332 www.capbluecross.com
Attachment # 2	**Capital Blue Cross – medical (including prescription drugs)** Qualified High Deductible Health Plan with Health Savings Accounts Group Number: 00528332 www.capbluecross.com
Attachment # 3	**Capital Blue Cross – medical (including prescription drugs)** Low Deductible PPO Group Number: 00528332 www.capbluecross.com
Attachment # 4	**Highmark Blue Shield – medical (including prescription drugs)** Freedom Blue Post-65 Retiree Medical Program Group Number: 01783226, 01783227, 01783225 www.highmark.com
Attachment # 5	**BlueCross Dental – Voluntary Dental** Group Number: 00528332 www.capbluecross.com
Attachment # 6	**National Vision Administrators ("NVA") – Voluntary Vision** Group Number: 09980783 www.nva.com
Attachment # 7	**Mutual of Omaha – Basic Group Life Insurance (including supplemental / optional coverage for Employees)** Group Number: G000BGRR www.mutualofomaha.com
Attachment # 8	**Mutual of Omaha – Short and Long-Term Disability** Group Number: G000BGRR www.mutualofomaha.com

Attachment # 9	**Lloyds of London – Business Travel Accident** Group Number: GLMN10876515
Attachment # 10	**Flexible Spending Account Plan (including medical and dependent care spending accounts) – Self-Insured with Administrative Services Provided by: Discovery Benefits** Group Number: 23956 Mail Claims to: Discovery Benefits, Inc., P.O. Box 2926, Fargo, ND 58108 Participant Services Phone Number: 1-866-451-3399 www.discoverybenefits.com
Attachment # 11	**Employee Premium Contribution Rate Requirements** **Rate Sheet Provided in the Open Enrollment Guide and at Date of Hire**

Federal Extensions Due to Coronavirus
The Federal government has declared a National Emergency lasting from March 1, 2020 through October 22, 2020 (Outbreak Period) due to the Coronavirus (COVID-19) pandemic. All group health plans, disability and other Employee welfare benefit plans subject to the Employee Retirement Income Security Act ("ERISA") or the Internal Revenue Code ("IRC") must disregard the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency or December 22, 2020 for all plan participants, beneficiaries or claimants in determining the following dates:

1. The 30-day or 60-day period to request special enrollment - Special Enrollment Periods.
2. The 60-day election period for COBRA continuation coverage - COBRA.
3. The date for making COBRA premium payments - COBRA.
4. The date for individuals to notify the plan of a qualifying event or determination of disability - Claim Procedures.
5. The date within which individuals may file a benefit claim under the plan's claims procedures - Claim Procedures.
6. The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedure.
7. The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination – Claim Denial and Appeal.
8. The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete – Claim Denial and Appeal.

The agencies of the Federal government will continue to monitor the effects of the Outbreak and may provide additional relief as warranted.

See the Human Resources Department for more information related to the Coronavirus Outbreak, the COVID-19 National Emergency, and/or any special leave provisions.

Grand Fathered Status under the Patient Protection and Affordable Care Act
Lafayette College medical plan(s) are "non-grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. However, your health plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and dependent coverage to age 26, and no cost-sharing on preventive care services. Questions regarding which protections apply to a non-grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

The Lafayette College Health and Welfare Plan is an employee welfare benefit plan within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document and its Attachments constitute the summary plan description for each of the component plans as required by ERISA Section 102.

The Plan is intended to qualify as a "cafeteria plan" under Internal Revenue Code Section 125, and regulations issued shall be interpreted to accomplish that objective.

The purpose of the Plan is to provide Employees with the opportunity to choose among those benefits available to them in the Plan. All Eligible Employees contribute towards the premium cost of medical (including prescription drugs). Eligible Employees who elect voluntary dental, voluntary vision (post-tax dollars only), flexible spending account plan (including medical and dependent care spending accounts) benefits are required to pay the full cost of participation on a pre–tax basis through salary reduction. Supplemental insurance programs are also available to Eligible Employees and the full premium is paid by the Employee on a post-tax basis through payroll deduction. Pre or Post tax premium requirements can be found in Attachment # 11. A copy of Attachment # 11 has been previously provided to you and is on file in the Human Resources Office and made available to you with your written request.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description or another governing document prepared by the insurance company. A copy of each booklet, summary or other governing document is addressed in this document as Attachment # 1 to # 10 as noted above. ***Copies of all documents for the Plan, including those provided by third party administrators have been previously made available to you and are on file at Lafayette College's Human Resources Office and can be provided to you with your written request.***

Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, the Plan Sponsor, and the insurance company with his or her current address. If required by the insurance company, each employee who is a Participant shall be responsible for providing the insurance company with the address of a covered spouse and each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The insurance company, the Plan Administrator, and the Plan Sponsor shall have no obligation or duty to locate a Participant.

Section 125 Cafeteria Plan Benefits

When you elect to make contributions to the medical or dependent care spending account in the Flexible Spending Account Program or if you elect to pay premiums under the Medical Plan or Voluntary Dental Plan with before-tax payroll reductions, you save the federal income tax and the Social Security tax that would ordinarily be deducted from your paycheck as a result of that compensation.

If your compensation is greater than the Social Security taxable wage base in any year ($137,700 indexed for 2020), you will have lower Social Security tax savings. This is because the old age portion of the Social Security tax (6.2% out of 7.65%) is not applied to compensation in excess of the taxable wage base for a year. The Medicare portion of Social Security tax (1.45% out of 7.65%) continues to apply to compensation in excess of the taxable wage base for the year. Therefore, your tax "savings" are reduced with respect to compensation in excess of the taxable wage base. However, you will still save federal income tax and possibly state and local income tax (see below).

Most states do not impose an income tax on employee before-tax contributions to plans such as the Cafeteria Plan. The exceptions are Pennsylvania and New Jersey. In Pennsylvania, you will pay state taxes on payroll reductions that are allocated to the Dependent Care Flexible Spending Account. You should consult your tax advisor on whether these amounts are taxable by municipal taxing authorities.

Examples of Tax Advantages When Participating in the Plan

You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay $2,400 in premiums ($400 for your share of the Employee-only premium, plus $2,000 for family coverage under the Employer's major medical insurance plan). You earn $35,000 and your Spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan		If you do not participate in the Cafeteria Plan
1. Gross Income	$35,000		$35,000
2. Salary Reductions for Premiums	($2,400) (pretax)		$0
3. Adjusted Gross Income	$32,600		$35,000

4. Standard Deduction	($24,000)		($24,000)
5. Exemptions	$0		$0
6. Taxable Income	$8,600		$11,000
7. Federal Income Tax (Line 6 x applicable tax schedule)	0		0
8. FICA Tax (7.65% x Line 3 Amount)	($2,494)		($2,678)
9. After-tax Contributions	($0)		($2,400)
10. Pay After Taxes and Contributions	$30,106		$29,922
11. Take Home Pay Difference	$184		

Wages which are reported to the Social Security Administration (SSA) will not include your payroll reductions under the Section 125 Cafeteria Plan. Wages reported to the SSA are eventually used to determine the average compensation on which your Social Security benefit is based. Consequently, you may have a slightly reduced Social Security retirement or disability benefit. This will happen if your taxable wages after before-tax contributions are less than the Social Security taxable wage base ($137,700 indexed for 2020). However, the current tax advantages should more than offset any reduction in your Social Security benefit.

COVID-19 Guidance Under Section 125 Cafeteria Plans

In response to the 2019 Novel Coronavirus outbreak (COVID-19), the Internal Revenue Service has provided Notice 2020-29 offering increased flexibility with respect to mid-year elections under Section 125 Cafeteria Plans to medical (including prescription drugs) coverage and flexible spending account program grace periods on unused amounts. The following provisions will apply until December 31, 2020:

1. Mid-year elections during calendar year 2020 will permit Employees who are eligible to make salary reduction contributions under the Plan to:
    a. Employer sponsored medical (including prescription drugs);
        i. Make a new election on a prospective basis, if the Employee initially declined to elect Employer-sponsored medical (including prescription drugs) coverage;
        ii. Revoke an existing election and make a new election to enroll in a different health plan sponsored by the same employer on a prospective basis; and
        iii. Revoke an existing election on a prospective basis, provided the Employee attests in writing that the Employee is enrolled, or immediately will enroll, in other health coverage not sponsored by the Employer.
2. Revoke an election, make a new election, or decrease or increase an existing election applicable to a health FSA on a prospective basis; and
3. Revoke an election, make a new election, or decrease or increase an existing election regarding a dependent care FSA on a prospective basis.

Note: With respect to health FSAs and Dependent Care FSAs, Lafayette College may limit mid-year elections to amounts no less than those amounts that have already been reimbursed.

2. DEFINITIONS

Claim Fiduciary means having the authority and responsibility to adjudicate claims in accordance with the provisions of the Plan. In the event a member appeal for review of a denied claim, the Claim Fiduciary makes the final determination as to whether the claim is covered. Lafayette College cannot overrule this determination.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code means the Internal Revenue Code of 1986, as amended.

Dependent –- means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren)) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010.

A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability and considered to be totally disabled, and who was covered under the Plan prior to reaching the limiting age or due to other loss of dependent's eligibility and who lives with the employee, will remain eligible for coverage under the Plan beyond the date coverage would otherwise end.

To cover a child under this provision, the Plan Administrator must receive proof of incapacity within 31 days after coverage would otherwise terminate. The Plan Administrator may require at reasonable intervals during the two (2) years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.

After the two (2) year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such dependent examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity and disability.

Domestic Partner means an eligible full-time Employee may enroll their same-sex Domestic Partner in the Lafayette College medical (including prescription drugs) program by having their same-sex Domestic Partner complete, sign, and date the Certification of Domestic Partner Form and returning it to the Office of Human Resources.

Eligible Employee means any full-time individual employed by the Employer or Affiliated Employer as a common law employee. An individual shall be considered to be employed by the Employer or Affiliated Employer as a common-law employee only if the Employer or Affiliated Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer or Affiliated Employer, and such individual is determined by the Employer or Affiliated Employer to be a common-law employee for purposes of the Employer's or Affiliated Employer's payroll records. It is expressly provided that any individual who is treated as an independent contractor, seasonal, temporary or part-time by the Employer or Affiliated Employer and any other common-law employee not described above is not an Employee and is not eligible to participate in this Plan. Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law employee" of the Employer or Affiliated Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as a common-law employee by the Employer or Affiliated Employer.

Eligible Retiree means an Employee who has reached the age of 55 and who has 10 years continuous full-time service at the time of such retirement and who was hired prior to July 1, 1996. Eligible Retirees, their Spouses and Dependents can continue to participate in the medical (including prescription drugs) and dental benefits only. Once an Eligible Retiree reaches the age of 65, they will continue to be eligible for benefits, but coverage providers will change. Please see the Human Resources Office for more information regarding benefits and eligibility.

Employer means the College, any of its Affiliates, and any other persons, firms, or organizations that have expressly adopted this Plan with the consent of the College.

Enrollment Period means such period of time prior to the beginning of the Plan Year as may be specified by the Administrator and communicated to Eligible Employees during which Eligible Employees and Participants may elect, or reject, to participate in the Plan, provided however, that with the exception of the initial plan year such period shall be no less than the 31 day period beginning on the first day of the last month of the Plan Year.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

GINA means the Genetic Information Nondiscrimination Act of 2008.

Highly Compensated Individual means an individual defined under Code § 105(h), 125(e) or 414(q), as amended, as a "highly compensated individual" or a "highly compensated employee."

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurer means any insurance company selected by the Employer to provide component benefit coverage. The Employer may change insurance companies from time to time and at any time without the prior notice to or necessity of consent of any Employee or Participant. Any dividends, retroactive rate credits or other refunds which may become payable under any agreement with an Insurer shall be retained by the Employer.

Key Employee means an individual who is a "key employee" as defined in Code § 125(b)(2), as amended.

Life Event or Change in Election Event Under Section 125 means, and is limited to: (a) a change in an Employee's marital status; (b) the addition of an Employee's dependent (as defined in the Health Insurance Policy); (c) loss of a dependent (as defined in the Health Insurance Policy) of an Employee; (d) commencement or termination of employment by an Employee's Spouse and gain or loss of health coverage by an Employee's Spouse under employee welfare benefit plans sponsored by the Spouse's employer; (e) termination of employment by an Employee; (f) status change from full to part time or part to full time by an Employee or Spouse and the subsequent gain or loss of health coverage by the Employee or Spouse; or, (g) a significant change in the health coverage of an Employee or Spouse due to such coverage attributable to the Spouse.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Participant means an Eligible Employee who has met the requirements of a component benefit in the Plan and participates in the Plan.

Plan means Lafayette College Health and Welfare Plan.

Plan Administrator means Lafayette College as stated in the General Information section of this document.

Plan Year means the period beginning and ending on July 1st to June 30th.

Policy Year means the period beginning and ending on January 1st to December 31st for Medical (including prescription drugs), Voluntary Dental and Vision, the Flexible Spending Account Plan, Life Insurance, Supplemental Life Insurance, and Short and Long Term Disability benefits, and the period beginning and ending on July 1st to June 30th for Business Travel Accident benefits.

Post-Tax Payroll Deduction means employees who have elected to waive their rights to contribute on a pre-tax basis with post-tax premium costs deducted from their pay check or employees electing supplemental insurance coverage.

Qualified COBRA Beneficiary means an individual, on the day before a Qualifying Event, is a Spouse or dependent child of an Employee and who is covered under the Health Insurance Program. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event is an Employee.

Qualifying COBRA Event means any of the following events: (a) death of an Employee; (b) the voluntary or involuntary termination (other than by reason of gross misconduct) of an Employee; (c) a change in an Employee's status to a part-time Employee; (d) divorce or legal separation of an Employee from his or her Spouse; (e) an Employee's commencement of entitlement to coverage under Medicare or a similar governmental benefit plan; (f) a dependent child ceasing to be a dependent child under the terms of the Employer's Health Insurance Policy.

Spouse means the Spouse is an Employee's a husband or wife married under a legally valid marriage. The term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or

(b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

Statutory Leave means an unpaid leave of absence under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time or war or emergency.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994.

Variable Hour Employee means, based on facts and circumstances, it cannot be determined the Employee is reasonably expected to work on average at least 30 hours per week.

Welfare Program means a written arrangement (including any insurance contract between an employer and an insurance company, health maintenance organization (HMO), administrative services organization (ASO), or other similar organization to provide benefits, a plan document or other instrument under which a welfare plan is established and operated ("welfare program document")) incorporated into this Plan that is offered by the Company and/or an employer which provides any employee benefits that would be treated as an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately.

Welfare program also means any plan established pursuant to Section 125 of the Code, incorporated herein. Each welfare program under the Plan is identified in this document. The Plan Administrator may add or remove a welfare program from the Plan by amending the Plan.

WHCRA means the Women's Health and Cancer Rights Act of 1998, as amended.

3. GENERAL INFORMATION ABOUT THE PLAN

Employer Name:	Lafayette College
Plan Name:	Lafayette College Health and Welfare Plan
Employer Address:	12 Markle Hall Easton, PA 18042
Employer's Telephone Number:	610.330.5060
Plan Number(s):	509
Policy Years:	
Business Travel Accident:	July 1st to June 30th
Medical (including prescription drugs), Voluntary Dental and Vision, Flexible Spending Account Plan, Life Insurance, Supplemental Life, and Short and Long Term Disability:	January 1st to December 31st
ERISA Plan Year:	July 1st to June 30th
Employer's Federal Tax Identification Number:	24-0795686
Plan Sponsor:	Lafayette College 12 Markle Hall Easton, PA 18042
Plan Administrator:	Lafayette College 12 Markle Hall Easton, PA 18042 Associate Director of Human Resources/Benefits
Agent for Service of Legal Process:	Associate Director of Human Resources/Benefits and General Counsel Lafayette College 12 Markle Hall Easton, PA 18042

Funding Medium and Type of Plan Administration:

The following benefits under the Plan are fully insured through insurance contracts:

Medical (including prescription drugs):	Capital Blue Cross and Highmark
Voluntary Vision Insurance:	National Vision Administrators (NVA)
Voluntary Dental Insurance:	Capital BlueCross - BlueCross Dental
Basic Group Life:	Mutual of Omaha
Supplemental Life Insurance:	Mutual of Omaha
Long Term Disability Insurance:	Mutual of Omaha
Business Travel Accident:	Lloyds of London

The insurance companies, not the College, are responsible for paying claims with respect to these programs. The College shares responsibility with the insurance companies for administering these program benefits.

The following benefits under the Plan are partially insured with premiums paid to the insurance company and from the general assets of the College. Benefits are partially funded by the College and partially by the insurance company.

Short Term Disability Insurance (advice to pay)	Mutual of Omaha and Lafayette College

The following benefits under the Plan are self-insured and paid through pre-tax salary reductions and/or the general assets of the employer:

Flexible Spending Account Plan (including medical and dependent care spending accounts):	Self-Insured with Administrative Services Provided by: Discovery Benefits, Inc.

Insurance premiums for employees and their eligible family members are paid in part by the College out of its general assets and in part by employees' pre and post-tax payroll deductions. Required employee pre and post-tax contributions for the Plan can be found in Attachment # 11.

Discretion of the Plan Administrator
In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

4. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

Eligibility for benefits includes coverage for full-time Employees (.75 – 1.0 FTE), Eligible Retirees[1] (medical (including prescription drugs) and voluntary dental benefits only), visiting faculty (not eligible for life insurance and disability coverage), Interns and 1-year Appointments (medical (including prescription drugs), voluntary dental and flexible spending account plan benefits only), Spouses, same-sex Domestic Partners and their Dependents.

Component Benefit	Eligibility
Medical (including prescription drugs), Voluntary Dental, Voluntary Vision, Flexible Spending Account Plan (including medical and dependent care spending accounts), Basic Group Life Insurance, Supplemental Life, Short and Long-Term Disability and Business Travel Accident	**Full-time** Employees working at least 1413 hours per year, or equivalent to .75 FTE and above.

You are not eligible to participate if you are employed by the Employer on a part-time, per diem, or contingent basis; if you are providing services to the Employer pursuant to an agreement with a third party leasing organization; if you are an independent contractor who is not on an Employer payroll.

Employees must be enrolled in benefits prior to enrolling their eligible family members. To determine if you or your eligible family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Attachments for the applicable component benefit programs or you may contact the Human Resources Office if you have any questions regarding your eligibility.

Component Benefit	When Participation Begins
Medical (including prescription drugs), Voluntary Dental, Voluntary Vision, Flexible Spending Account Plan (including medical and dependent care spending accounts), Basic Group Life Insurance, Supplemental Life, Short and Long Term Disability, and Business Travel Accident	1st of the month following or concurrent with date of hire, change in eligibility, or rehire and upon completion of applicable enrollment forms

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The Patient Protection and Affordable Care Act (Health Care Reform) requires employers who sponsor group health plans (including prescription drugs) to define eligibility as any Employee who works an average of 30 or more hours per week. Eligibility determinations are made on the basis of hours worked within a certain timeframe. For additional information regarding eligibility and hourly requirements in the medical (including prescription drug) benefits program see the Human Resources Office.

Benefit Continuation for Furloughed Employees Due to the Coronavirus (COVID-19) Pandemic

The Federal government has declared a National Emergency lasting from March 1, 2020 through October 22, 2020 (Outbreak Period) due to the Coronavirus (COVID-19) pandemic. If as a result of the COVID-19 pandemic you are temporarily furloughed, see the Human Resources Department information related to the continuation of Plan benefits.

Health Care Reform – Termination and Subsequent Rehire

If you were a participant in the Plan at your date of termination of employment, if you are subsequently rehired, you will eligible to participate as if you were a newly hired Employee.

For purposes of the Affordable Care Act (Health Care Reform) and eligibility for medical (including prescription drugs) coverage, the Employer can treat a rehired Variable Hourly Employee as a new Employee if the Employee did not have an hour of service for at least 13 consecutive weeks before the Employee returns to work. The Employer may treat an Employee as rehired after a short period of at least four consecutive weeks during which no hours of service were credited if that period exceeds the number of weeks that the Employee originally worked for the Employer.

[1] Note the definition of Eligible Retirees can be found in the definitions section of this document.

Participant/Spouse Employment

If both you and your Spouse are eligible employees of Lafayette College you may be covered under the Plan as an eligible employee or as a dependent of your Spouse (if the eligible employee is considered a full-time (.75- 1.0 FTE) employee). Your dependent children may be covered under the Plan either by you or your Spouse or same-sex Domestic Partner, but not both.

Leased or Temporary Employment

Leased employees or persons classified by Lafayette College as temporary employees of Lafayette College (as determined by the employer) are not eligible for benefits under this Plan. A person who is not characterized by Lafayette College as an employee of Lafayette College but who is later characterized by a regulatory agency or court as being an employee will not be eligible for the period during which he or she is not characterized as an employee by Lafayette College.

Special Enrollment Periods

Special Enrollment Rights – Health Insurance Portability and Accountability Act - 1996. If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in your Employer's Health Insurance Plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within **31 days** after the applicable event. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and newly-acquired Dependent, provided that you request enrollment within **31 days** after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights – Children's Health Insurance Program Reauthorization Act - 2009. If you and your Dependents are eligible but not enrolled for coverage under your employer's group health plan you may enroll in two circumstances: 1) you or your dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; and 2) you or your dependent becomes eligible for a Subsidy under Medicaid or CHIP (if offered by your state). You or your dependent(s) must request coverage within **60 days** after you or your dependent is terminated from, or determined to be eligible for such assistance.

Change in Election Events

If a Change in Election Event (including a Change in Status) occurs, you must inform the Human Resources Office and complete a new election form within **31 days** of the occurrence. Your election will be effective as of the first of the month after the election form is completed and received by Human Resources. Special enrollments in the event of birth, adoption, or placement for adoption will be effective back to the date of the birth, adoption, or placement for adoption, as long as timely notice is given to the Plan.

Generally, you cannot change your election to participate or waive participation in the medical (including prescription drugs), dental, vision, and flexible spending account plan benefits in the Plan or vary the salary reduction amounts you have selected during the Plan Year (known as the irrevocability rule). Your election will terminate if you are no longer working for the Employer. You can change your elections for benefits and salary reductions prior to January 1st during the open enrollment period for medical (including prescription drugs), voluntary dental and vision, and flexible spending account plan benefits but that will apply only for the upcoming Plan Year.

Before the beginning of each Plan Year, the Employer will make election forms available, along with a schedule showing the cost of coverage. If you do not enroll or confirm your enrollment in benefit programs in the on-line enrollment platform, you will not have coverage in the upcoming Plan Year. See the Human Resources Department for more information on open enrollment periods and the on-line enrollment platform.

You must make and affirmative election in the flexible spending account program each year to have coverage in the subsequent Plan Year.

Changes may be made to your Health Savings Account election on a monthly basis.

You may change your election in the voluntary vision program at any time. Your new benefit election in the voluntary vision plan will be effective the 1st of the month following after your change in election.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events.* "Change in Election Events" include the following events, as more fully described below: FMLA leave, Change in Status, certain judgments, decrees and orders; Medicare and Medicaid: Change in Cost, and Change in Coverage. *(Change in Status, Cost and Coverage* are defined below). However, the Change in Election Events do not apply to all benefits in the Plan, exclusions apply. Examples are described below for each such Event.

1. **FMLA Leave.** You may change an election under the Plan upon commencement of or return from FMLA leave.
2. **Change in Status**. If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:
   - A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). *"Spouse"* means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code *(Code)*;
   - A change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). *"Dependent"* means your tax dependent under the Code:
   - Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility including (this Plan or other employee benefit plan of you, your Spouse, or your Dependents). Such events include any of the following changes in employment status, termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, switching from salaried to hourly paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of Employment; or any other similar change which makes the individual become (or cease to be) eligible for benefits; and
   - An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age, student status, or similar circumstance).
   - **Change in Status-Other Requirements**. If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

   - *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For health benefits (here, the medical insurance under the Health Insurance Plan), a special rule governs which type of election changes are consistent with the Change of Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

     Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee -plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the Plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

Gain of Coverage Eligibility under another Employer's Plan. For a Change in Status in which you, your Spouse or your Dependent gains eligibility for coverage under another employer's cafeteria plan (qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

3. **Certain Judgments, Decrees and Orders**. If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.
4. **Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's health coverage under the Health Insurance Plan. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may subject to the terms of the underlying plan, elect to begin or increase that person's health coverage.
5. **Change in Cost.** If the Administrator notifies you that the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if there is no option available under the Plan that provides similar coverage; (d) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.
6. **Change in Coverage.** You may also change your election for the Plan if one of the following events occurs:
   - *Significant Curtailment of Coverage.* If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another Plan option that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of benefit coverage, then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage.
   - *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the component Plan.
   - *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health coverage sponsored by a government or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
   - *Change in Election under another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.
7. **Dependent Care.** You may make an election change to the contribution to your Dependent Care FSA that is due to a change in the provider of dependent care. You may also make an election change to the contribution to your Dependent Care FSA that is due to a change in cost of dependent care; so long as the provider of dependent care is not your relative.

A change must be "on account of and correspond with" a Change in Status Event. To meet this requirement, the change that you wish to make must be on account of and correspond with a Change in Status Event that affects eligibility for coverage under the Plan. This rule is satisfied as to the Dependent Care Spending Account in the Flexible Spending Account Plan if the Change in Status Event affects expenses under that Account, such as when the child become 13 years old and is no longer a qualifying individual. The determination of whether a requested change is "on account of and consistent with" a Change in Status Event will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service. You must report a qualifying change in election event to the Human Resources Department within 30 days of the occurrence.

If the employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year or coverage period (as determined by the Plan Sponsor), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

Additionally, the Administrator may modify your election(s) in the medical (including prescription drugs), dental, vision, flexible spending account (including health care and medical spending accounts), and health savings account benefits of the Plan downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Internal Revenue Code), if necessary, to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Benefits for Adopted Children / Guardianship Agreements

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption or a child under guardianship under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Employee Participants who currently cover eligible dependents under a Guardianship Agreement will be required, upon enrollment and subsequent requests, to show proof of continued guardianship in order to continue coverage in the Plan for dependent child(ren).

Termination of Participation

Your participation in the Plan ordinarily ends when you are no longer actively employed by the Employer or you otherwise cease to meet the eligibility requirements in the Plan. Cessation of active employment includes separation from employment, absence due to disability or other cause, retirement, and any other separation from active work (for any reason, whether voluntary or involuntary, permanent or temporary), except that cessation of active employment does not include vacation or holidays.

Medical (including prescription drugs), Dental and Vision	End of the month following the date employment ends
Flexible Spending Account Plan (including medical and dependent care spending accounts) and the Health Savings Account Program[2]	Last day of the pay period in which employment terminates (assuming a contribution has been made). You may submit claims for expense incurred up to the date of your termination of employment within 90 days of your date of termination.
Group Term Life Insurance, Supplemental Life, Short and Long Term Disability and Business Travel Accident	Date employment ends

Please refer to the plan summaries or booklets for the applicable component benefit in the event of your termination of employment.

Coverage may also terminate if:

- ✓ Your hours drop below any required hourly threshold;
- ✓ With respect to any coverage requiring Participant contributions and with respect to which Participant contributions are discontinued, the last day of the period for which contributions by the Participant are paid;
- ✓ You submit false claims; or
- ✓ If Lafayette College discontinues the plan for any reason.

Coverage will end at:

- ✓ The end of the month in which an eligible dependent ceases to be an eligible dependent in the medical (including prescription drugs), vision and dental programs;

[2] Your Health Savings Account is considered "portable" and when you terminate your employment with Lafayette College, you may continue to contribute to your account if you are enrolled in a High Deductible Health Plan. If you are no longer enrolled in a Qualified High Deductible Health Plan, you are not permitted to contribute to your account, but you can spend the money in your account for qualified and non-qualified expenses.

- ✓ Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an active eligible employee of Lafayette College unless otherwise specified (see the Termination of Participation provisions above); or
- ✓ Except to the extent required by law, the first day of the month following the date on which the participant reports for active duty as a member of the armed forces of any country, in the case of the Plan's medical (including prescription drugs), vision or dental coverage and the day on which the participant reports for such active duty, with respect to the Plan's life, AD&D, short and long-term disability.

Uniformed Services Employment and Re-employment Rights Act

Regardless of any provision described above, if you take a leave of absence from employment with Lafayette College because of military service, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for you and your covered Spouse or Dependents or you may extend benefits through COBRA.

You have the following rights under USERRA:

1. If your military leave period is for 30 days or less, you have the right to continue health coverage for yourself and dependents that were covered under the group health plan for up to 30 days, at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is for 31 days or more, you have the right to elect USERRA continuation coverage for yourself and your dependents that were covered under the health plan. The maximum period is 24 months.

You will be required to pay up to the 102% of the applicable premium whether you elect continuation coverage under USERRA or COBRA.

If you extend your coverage through USERRA, such coverage will end on the earlier of: (1) the last day of the 24-month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with Lafayette College. See the COBRA section of this document for more information on continuation of coverage through COBRA.

If you elect USERRA continuation coverage, the Plan is under no further obligation to offer COBRA election rights when the USERRA continuation coverage expires. However, if your Spouse or Dependent child would lose USERRA continuation coverage because of another qualifying event, such as your death or divorce, or because the Dependent ceases to be an eligible Dependent, then the Plan must offer your Spouse or Dependent child the right to continue coverage for 36 months measured from the date you entered active military service.

If you take military leave, but your coverage under the Plan is terminated – for instance, because you do not elect the extended coverage, when you return to work, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies. Please contact the Plan Administrator if you have questions about coverage during periods of military service.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

The Employer reserves the right to terminate coverage for you, your Spouse, your Domestic Partner, and Dependent(s) prospectively without notice for cause or if you, your Spouse, your Domestic Partner, or Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you, your Spouse, your Domestic Partner, or Dependent(s) commit fraud or intentional misrepresentation in an application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, the Plan Administrator may terminate your, your Spouse's or Dependent's coverage retroactively to the date of the fraud or misrepresentation upon 30 day notice. Failure to inform the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, as applicable, that you, your Spouse, your Domestic Partner, or Dependent(s) is covered under another plan constitutes fraud under the Plan.

When you enroll a family member in the Plan, you represent the following:

- The individual is eligible under the terms of the plan; and
- You will provide evidence of eligibility on request.

Further, you understand that:

- The Plan is relying on your representation of eligibility in accepting the enrollment of your family members;
- Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
- Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual becomes ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on rescission of coverage.

If the medical (including prescription drugs), voluntary dental, or voluntary vision program undertakes an eligibility audit and finds ineligible dependents enrolled in the Plan, the Plan may cancel coverage for such dependents prospectively without violating the prohibition on rescission rules of the Patient Protection and Affordable Care Act (Health Care Reform). A termination of coverage with prospective effect is not considered a rescission and may be permitted without proof of fraud or misrepresentation.

In order to cancel coverage retroactively, however, the Plan must make a showing of fraud or intentional misrepresentation of a material fact and provide advance written notice of the rescission.

Qualified Medical Child Support Orders

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA Section 609(a)). The Plan will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA Section 609(c).

In order for this Plan to recognize a Qualified Medical Child Support Order it must satisfy the following criteria:

It must be a judgment, decree or other court order relating to health benefits coverage for a Dependent Child of a covered Employee, and the order must specify:

a. the name and address of the Employee or their designee;
b. the order must indicate who will pay for the Alternate Payee's coverage (required contributions towards premium, deductibles, coinsurance, copayments or other benefit payments);
c. statement that acknowledges the Plan's right to terminate coverage under the Order for which payment is not made on a timely basis as required;
d. the name and mailing address of each dependent child covered by the order;
e. a reasonable description of the type of coverage offered by the Plan;
f. a beginning period for which the order applies;
g. an end date for which the Alternate Payee would no longer be eligible for coverage;
h. social security number of each dependent child covered by the order; and
i. the name and address of each Alternate Payee, which means the Spouse, former Spouse, legal guardian of the dependent child or the child of an Employee.

Upon receipt of a medical child support order, the Plan Administrator shall promptly notify the Employee and Alternate Payee. The Plan Administrator shall determine whether an order received meets the criteria and promptly notify the Employee and each Alternate Payee. In the event of a dispute regarding any medical child support order furnished to the Plan Administrator, the Employee or Alternate Payee shall promptly notify the Plan Administrator in writing.

Coverage shall commence upon either the date specified in the order or the date the Employee becomes eligible for coverage, if later.

Any order that requires the Plan to provide any type of benefit or increased benefits not otherwise provided by this Plan, other than under COBRA, will not be recognized as a Qualified Medical Child Support Order.

Please see the Plan Administrator for questions regarding Qualified Medical Child Support Orders.

COBRA Rights

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. Your Employer is subject to COBRA.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

If you or your eligible family members qualify for such continuation coverage, the medical (including prescription drugs), voluntary dental, voluntary vision and flexible spending account plan medical spending account benefits will be treated as individual plans for purposes of COBRA.

There may be other coverage options for you and your family. You will be able to buy coverage through the Health Insurance Marketplace during the open enrollment period or if you have a special enrollment opportunity. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Domestic Partners do not have individual rights under federal COBRA law. Enrollment in COBRA continuation coverage is dependent upon Employee enrollment and subsequent termination of benefits under COBRA.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of the medical (including prescription drugs), voluntary dental, voluntary vision, and flexible spending account plan medical spending account benefits coverage when coverage would otherwise end because of a life event known as 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 are an Employee, Spouse, or Dependent, you will become a qualified beneficiary if an Employee loses coverage. An eligible Employee, covered Spouse or covered Dependent are entitled to an additional 18 months of coverage under the Plan because either one of the following qualifying events happens:

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

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage. You are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happens:

- Your Spouse dies;
- 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. They are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced or legally separated; or
- The parent-employee can no longer claim you as a "dependent child" under the Plan.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan's COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the 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 Lafayette College in writing within 60 days after the later of when the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The Employee or family member can provide notice on behalf of themselves, as well as other family members affected by the qualifying event. Written notice of the qualifying event should be sent to Lafayette College and should include the following information:

Date (month/day/year)
Social Security Number / ID Number
Spouse / Dependents Telephone Number
Date of Birth (month/day/year)
Employer's Name
Employee's Social Security Number / ID Number
Loss of Coverage (month/day/year)
Spouse / Dependent's Name
Spouse / Dependent's Address
Gender
Relationship to Employee
Employee's Name
Reason for Loss of Coverage

How is COBRA 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered under the Lafayette College Health and Welfare Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Paying for Continuation Coverage

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. Your employer reserves the right to charge an additional 2% administration fee in addition to the regular premium.

For disability extensions up to 29 months if an individual is determined to be disabled (for Social Security disability purposes) Lafayette College reserves the right to charge an additional 50% of the regular premium. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 18 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under your insurance carrier.

Most coverage under COBRA is paid for with the value of your premiums (plus a 2% administration fee) associated with each insured benefit (i.e. medical (including prescription drugs) voluntary vision and dental). If you have not incurred claims sufficient to spend-down your account balance as of your date of termination, you may continue your participation in the Flexible Spending Account Plan for the remainder of the current Plan Year. Payment for continuation of your Flexible Spending Account Plan benefit is based on the contribution you made to your account while employed. Your premium is the same amount of those contributions withheld from your paycheck during employment.

Termination of Continuation Coverage

The law also provides that your continuation coverage may be terminated for any of the following four reasons:

1. Lafayette College no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to Medicare;
4. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

The Trade Preferences Extension Act of 2015 and COBRA

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals typically include those who have been displaced due to foreign competition). The Trade Preferences Extension Act restored the provisions of the Trade Act of 2002 which expired on January 1, 2014. Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of a portion of premiums paid for qualified health insurance including continuation coverage. The new legislation also added rules for coordinating the health care tax credit with the premium tax credit that is available under health care reform to eligible individuals receiving individual health insurance through an Exchange. A new rule excludes coverage through an Exchange from the list of qualified health insurance for which the health care tax credit may be claimed beginning in 2016. There is also a new requirement to make an election in order for the health care tax credit to apply, and the premium tax credit is not available for the months to which the election applies.

If You Have Questions

Questions concerning your participation in the Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of 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 for return of COBRA Election Forms and Premium Payments:

Discovery Benefits
Participant Services
P.O. Box 2079
Omaha, NE 68103
1-866-451-3399
www.discoverybenefits.com

Written notice is considered to have been made on the date the notice is postmarked or, if notice is delivered by carrier or in person, the date it is signed as being received by that office. All notices must include: the name and address of the employee covered under the Plan, the name(s) and address(es) of the Qualified Beneficiary(ies), the Qualifying Event and the date the event happened.

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- The name of the Plan or Plans under which you lost or are losing coverage;
- The name and address of the Employee covered under the Plan;
- The name(s) and address(es) of the Qualified Beneficiary(ies); and
- The Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Family and Medical Leave

Benefit and Service Continuation during Family and Medical Leave

During the period of your leave under this Plan, the Plan will continue your medical benefits, as required by law. This means Lafayette College will continue your benefits on the same basis as if you were continuing your employment.

If your serious health condition under your approved leave permits you to collect benefits in the short-term disability program, your short-term disability benefits will run concurrently with your approved leave.

Employees on unpaid leave are required to pay required premiums for medical (including prescription drugs), dental, voluntary vision and flexible spending account plan (including medical and dependent care spending accounts) coverage during their leave. Premiums can be paid during your leave with post-tax dollars. The method of payment will be chosen at the discretion of the Plan Administrator.

If you elect to cease participation in the benefits you have elected, expenses incurred while participation has lapsed will not be eligible for reimbursement. If you elect to continue participation in the dependent care spending account, expenses incurred during the leave would not be eligible for reimbursement because you are not working, but contributions could be made during the leave and applied to expenses incurred after you return from leave.

If you elect to cease participation during the leave period, coverage will resume upon your return to work under your prior elections, unless changed by you in accordance with the Change in Election Event rules described above. However, you have two choices regarding the flexible spending health care account:

- You can elect to have your contributions resume at the level in effect prior to the leave, in which case the annual health care account contribution you elected would be reduced to reflect the period of no contributions.
- You can elect to increase your contributions for the remainder of the year following the leave so that your annual contribution to the flexible spending health care account will equal the annual contribution in effect prior to the leave.

For example, suppose you had elected a $1,200 flexible spending health care account (monthly contributions of $100) and were absent on leave for the months of April, May and June. When you return to work in July, you could continue to make contributions of $100 per month, in which case the maximum annual reimbursement from the flexible spending health care account would be $900 ($1,200 minus $300 in missed contributions). Alternatively, you could increase your monthly contribution to $150 for the remainder of the year and have a maximum annual reimbursement from the flexible spending health care account of $1,200 (three months of $100 contributions, three months of $0 contributions and six months of $150 contributions).

Leaves of absence under this policy shall *not* constitute a break in the employee's length of continuous service. You will not lose any employment benefits you have accrued prior to taking leave.

If you terminate your employment during your leave, the date of your qualifying event will be the day of your termination of employment.

Please contact the Human Resources Office regarding procedures and guidelines for the Family Medical Leave Act.

5. SUMMARY OF PLAN BENEFITS AND CONTRIBUTIONS

Benefits and Contributions

The Plan provides you, your Spouse, and eligible Dependents with benefits in the Plan. A summary of each benefit provided under the Plan is set forth in the attached summary plan descriptions, carrier booklets or other governing document behind the applicable Attachments.

The cost of certain benefits provided through the component benefit programs will be funded in part by the College's contributions and in part by pre or post-tax employee contributions. The College will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time. The current cost of participating in the medical (including prescription drugs), voluntary dental, voluntary vision, and supplemental benefits can be found in Attachment # 13.

The College will make its contributions in an amount that (in the College's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The College will pay its contribution and your contributions to the insurance carrier for fully insured benefits. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using College contributions to pay for the cost of such benefits.

Contributions for Coverage

Lafayette College pays the entire premium cost of your coverage under the following plans:

- Basic Life Insurance
- Short Term Disability
- Long Term Disability
- Business Travel Accident

You will pay a portion of the total premium cost of your coverage under the following plans:

- Medical (including prescription drugs) (pre-tax dollars)

You will pay all of the cost of coverage under the following plans:

- Health Savings Account Program (pre-tax Employee Contributions)
- Voluntary Dental (pre-tax dollars)
- Voluntary Vision (post-tax dollars)
- Supplemental Life & AD&D (post-tax dollars)
- Flexible Spending Account Plan (including medical and dependent care spending accounts) (pre-tax dollars)

A summary of the current structure of Participant pre or post-tax contribution requirements can be found in Attachment # 11.

With respect to benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as CARES, CHIPRA, COBRA, USERRA, FFCRA, FMLA, HIPAA, HITECH, GINA, NMHPA, MHPAEA, WHCRA, and PPACA.

Legislative Action Related to the Coronavirus

Families First Coronavirus Response Act ("FFCRA")

The FFCRA was enacted on March 18, 2020. Section 6001 of the FFCRA generally requires group health plans and health insurance insurers offering group health insurance coverage to provide benefits for certain items and services related to diagnostic testing for the detection of SARS-CoV-2 or the diagnosis of COVID-19 when those items or services are furnished on or after March 18, 2020, and during the applicable emergency period. Under the FFCRA, plans and issuers must provide this coverage without imposing any cost-sharing requirements (including deductibles, copayments, and coinsurance) or prior authorization or other medical management requirements.

The Coronavirus Aid, Relief, and Economic Security Act ("CARES Act")

The CARES Act was enacted on March 27, 2020. Section 3201 of the CARES Act amended Section 6001 of the FFCRA to include a broader range of diagnostic items and services that group health plans and insurers must cover without any cost-sharing requirements or prior authorization or other medical management requirements. Additionally, Section 3202 of the CARES Act generally requires plans and insurers providing coverage for these items and services to reimburse any provider of COVID-19 diagnostic testing an amount that equals the negotiated rate or, if the plan or insurer does not have a negotiated rate with the provider, the cash price for such service that is listed by the provider on a public website. (The plan or insurer may negotiate a rate with the provider that is lower than the cash price.)

Nothing in the FFCRA or the CARES Act prevent a state from imposing additional standards or requirements on health insurance insurers with respect to the diagnosis or treatment of COVID-19, to the extent those standards or requirements do not prevent the application of a federal requirement.

Special Rights on Childbirth

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother of newborn child to less than 48 hours following a normal 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 the above periods. In any case, such 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 the above periods.

Special Rights for Women

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 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 states 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.

Genetic Information Nondiscrimination Act ("GINA")

GINA prohibits employer-sponsored group health plans and health insurers providing group insurance from:

- Increasing premium or contribution amounts based on genetic information;
- Requesting or requiring an individual or family member to undergo a genetic test; and
- Requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Genetic information means:

- The individual's genetic tests;
- The genetic tests of family members;

- The manifestation of a disease or disorder in family members; or
- Any request for, or receipt of, genetic services or participation in clinical research that includes genetic services, by the individual or family member.

Genetic information does not include information about the sex or age of any individual, it does include, with respect to a pregnant woman, an individual who is utilizing an assisted reproductive technology, or a family member, genetic information of any fetus carried by the pregnant woman or of any embryo legally held by the individual or family member.

Mental Health Parity and Addiction Equity Act ("MHPAEA")
MHPAEA prohibits financial requirements and treatment limits for mental health and substance use disorder benefits that are more restrictive than the predominant financial requirement or treatment limit that applies to all or substantially all medical and surgical benefits.

Treatment limits include limits on the scope and duration of treatment.

The MHPAEA regulations set out a framework for assessing compliance with respect to financial requirements such as deductibles and coinsurance and quantitative treatment limits (e.g. day and visit limitations).

When the plan provides a mental health or substance use disorder benefit in any of the following six classifications, mental health and substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

The Plan is prohibited from providing a more restrictive financial requirement or treatment limit than the predominant level that applies to all or substantially all medical/surgical benefits on any mental health or substance use disorder benefit within each of the above classifications.

Lifetime and Annual Dollar Limits
In accordance with the Patient Protection and Affordable Care Act (PPACA), any lifetime or annual dollar limits set forth in the medical program shall not apply to "essential health benefits" as defined under Section 1302(b) of the Affordable Care Act (Health Care Reform). The law defines "essential health benefits" to include, at a minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices and laboratory services.

The restrictions regarding lifetime and annual dollar limits under the medical program do not apply to services (even services for essential health benefits) which are limited by the number of visits or other criteria. For example, a medical plan may provide that coverage for a physical therapist is limited to up to 30 visits per year per covered person.

Patient Protection Disclosure
If the medical program in which you are enrolled requires the designation of a primary care provider (PCP), you have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator.

You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you 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 listing of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

Non-Assignment of Benefits
Except as may be required pursuant to a "Qualified Medical Child Support Order" which provides for Plan coverage for an alternate recipient, no participant or beneficiary may transfer, assign or pledge any Plan benefit.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends and if you have exhausted your rights under COBRA. In addition, if any of your health care benefits and life insurance benefits is provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your benefit continuation or conversion rights, please contact the insurance company.

6. HOW THE PLAN IS ADMINISTERED

Plan Administration
The administration of the Plan is under the supervision of the Plan Administrator. The Associate Director of Human Resources/Benefits of Lafayette College has been designated the Plan Administrator.

Discretion of the Plan Administrator
In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

Right to Receive and Release Necessary Information
Each of (i) Lafayette College or (ii) contract administrator (with respect to participants or beneficiaries receiving benefits under the Plan which it administers or provides services with respect to) may, without the consent of or notice to any person, release or obtain any information which such Plan Sponsor or contract administrator reasonably deems necessary in order to perform its duties under the Plan. Any person claiming benefits under the Plan shall furnish such information as may be reasonably required by Lafayette College or contract administrator. Lafayette College or any contract administrator will act in accordance with the rules established under the Health Insurance Portability and Accountability Act's Privacy and Security Rules.

Duties of the Plan Administrator

1) To administer the Plan in accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan;
2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
3) Prescribe applicable procedure, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan;
4) To decide disputes that may arise relative to a Plan participant's rights;
5) To prescribe procedures for filing a claim for benefits and to review claim denials;
6) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;
7) To reject elections or to limit contributions or benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Internal Revenue Code;
8) To provide Employees with reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;
9) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609;
10) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits, if the Plan Administrator determines they should be paid and if the Plan Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Plan Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
11) To appoint a Claims Supervisor to pay self-insured claims, or to appoint agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan; and
12) The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Plan Administrator Compensation
The Plan Administrator serves without compensation however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

The College will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Company
Certain benefits under the Plan are fully insured and provided by contract with an insurance company. Lafayette College has insurance contracts to provide for the following benefits:

Capital Blue Cross	Medical (including prescription drugs)
Highmark Blue Shield	Medical (including prescription drugs)
Capital BlueCross – BlueCross Dental	Voluntary Dental
National Vision Administrators ("NVA")	Voluntary Vision
Mutual of Omaha	Life Insurance (including supplemental / optional coverage for Employee, Spouses and Dependents), and Long-Term Disability
Lloyds of London	Business Travel Accident

The insurance companies are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Power and Authority of the Third-Party Administrator or Insurance Company
The Plan also has benefits that are self-insured with administrative services provided by third party administrators and insurance companies. The Plan Administrator has delegated the following responsibilities to the Third Party Administrator or Insurance Company and they are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Lafayette College has contracted with the following third party administrators to provide the following benefits:

Mutual of Omaha / Lafayette College[3]	Short Term Disability
Discovery Benefits	Flexible Spending Account Program (including medical and dependent care spending accounts)

Questions
If you have questions regarding eligibility for, or the amount of, any benefit payable under the component benefit plans, please contact the appropriate insurance company, the Third-Party Administrator, or the Plan Administrator.

[3] Lafayette College shares the responsibility of administration of their Short-Term Disability Benefits with Mutual of Omaha.

7. CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Denial or Loss of Benefits
An Eligible Employee's benefits (and the benefits of his or her eligible spouses, and dependents) will cease when the Employee's participation in the Plan terminates (that is, when coverage ends). Benefits also cease upon termination of the Plan. In both instances, expenses incurred before coverage ended generally remain payable.

Other Circumstances
Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied based on lack of medical necessity. The group insurance contracts provide additional information.

8. AMENDMENT OR TERMINATION OF THE PLAN

The Plan Administrator shall have the unlimited right to amend, terminate, or merge the Plan at any time without prior written notice to any Participant. Any such amendment, termination, or merger shall be documented in writing by an authorized representative of the Employer and shall become effective as of the date specified in the appropriate documentation. Any such amendment, termination or merger shall be binding upon all Employees and Dependents (including those Participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed without their written consent.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator. No one has the authority to make any oral modification to the Plan. Any change must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator and attached to this Plan Document. An amendment to this Plan may be retroactively effective, but shall not adversely affect the rights of a Participant under this Plan for benefits provided after the effective date of the amendment but before the amendment is adopted.

In the event of termination of the Plan or any benefit program in the Plan, claims or expenses incurred prior to the termination shall be paid in accordance with the terms of the relevant benefit program.

Additionally, the Employer reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

Any provision of the Plan which, on its effective date, is in conflict with the requirement of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Vice President of Human Resources and General Counsel of Lafayette College may sign insurance contracts for this Plan on behalf of the College, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

9. NO CONTRACT OF EMPLOYMENT

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the College to the effect that you will be employed for any specific period of time.

10. CLAIMS PROCEDURES

This Summary Plan Description is intended to provide summary information regarding claims procedures. Always review the attached insurance carrier booklets, summary plan descriptions or governing documents for more information about how to file a claim and for details regarding the insurance company's claim procedures.

FULLY INSURED BENEFITS:

CLAIMS AND APPEALS TIMETABLE

	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
Medical Dental Vision Care Flexible Spending Health Care Spending Account	Urgent Care Claims	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your claim by the Claims Administrator. Note that this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.	As soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of your request for review by the Claims Administrator.
	Pre-Service Claims	Within a reasonable period of time appropriate to the medical circumstances but not later than **15 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time appropriate to the medical circumstances, but not later than **30 days** after receipt of your request for review by the Claims Administrator.
	Post-Service Claims	Within a reasonable period of time, but not later than **30 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **15 days** is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator.
	Concurrent Care Claims	An extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above, but a claim for urgent care continuation submitted **24 hours** before the end of the of the approved course of treatment must be processed within **24 hours** instead of **72 hours**.	An appeal for an extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above
Short or Long Term Disability		Within a reasonable period of time, but not later than **45 days** after receipt of your claim by the Claims Administrator, unless an extension of up to an additional **30 days** is necessary due to matters beyond the control of the Claims Plan Administrator.	A reasonable period of time, but not later than **45 days** after receipt of your request for review by the Claims Administrator. May be extended for an additional **45 days**.*
All Eligibility Determinations and Other Benefits	Includes Life, AD&D, Dependent Care Spending Accounts	Within a reasonable period of time, but not later than **90 days** after receipt of your claim by the Claims Administrator.	A reasonable period of time, but not later than **60 days** after receipt of the request for review by the Claims Administrator. May be extended for an additional **60 days**.*

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or part, you will receive a written notification explaining the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). You have voluntary rights to an external appeal if your internal appeal is denied.

Notice of Decision of Claim – Denied Claims under the Health Plan(s)
If your claim for benefits under the Plan is denied, you will receive a written notice of the decision to deny the claim within 30 days after Highmark, Capital BlueCross, and NVA or any successor thereto (the designated claims processor) receipt of the claim, unless special circumstances require an extension of up to 15 additional days to process the claim. If such an extension of time for processing the claim is required, as determined in the designated claims processor's sole discretion, you will receive written notice of the extension before the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the designated claims processor expects to render a benefit determination. If your claim for benefits under the Plan is denied, the written notice of denial shall include:

- The specific reason or reasons for the denial;
- Reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit the claim for review.

Denied Claims Made Under the Short or Long-Term Disability Plan
If your claim for benefits under the STD or LTD Plan is denied, you will receive a written notice of the decision to deny the claim within 45 days after the receipt of the claim by Mutual of Omaha or any successor thereto ("Disability Claims Processor"), unless the Disability Claims Processor determines that matters beyond the control of the Plan necessitate an extension of up to 30 days to process the claim. If the Disability Claims Processor determines that a decision cannot be rendered during the first 30-day extension period due to matters beyond the control of the Plan, the period for making a determination regarding your claim may be extended for an additional 30 days. If an extension of time for processing the claim is required (as described above), you will be provided with an explanation of the circumstances requiring the extension of time, including the following information:

- The date by which the Disability Claims Processor expects to render a decision on the claim;
- An explanation of the standards on which entitlement to a benefit is based;
- A description of the unresolved issues that prevent a decision on the claim; and
- A description of additional information needed to resolve such issues.

If the extension notice requires you to provide additional information to process your claim, you must provide the information to the Disability Claims Processor within 45 days after the date the notice is sent to you. If an extension notice requests specific information, the extension period will not begin to run until you respond to the Disability Claims Processor's request for information. If you do not respond to the Disability Claims Processor's request for additional information within 45 days, your claim will be decided without such information.

If your claim for benefits under the STD or LTD Plan is denied, the written notice of denial shall be provided in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant and will include the following information:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material and information is necessary;
- A discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security disability determination;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- The specific internal rules, guidelines, protocols, or other similar criterion relied on in making the adverse determination, a statement that a copy of such rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and will be provided to the claimant free of charge upon request or a statement that such internal guidelines or criteria do not exist; and

- If the denial is based on a medical necessity or experimental treatment or other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided to the claimant free of charge upon request.

Review of Claims Made under the Short or Long-Term Disability Plan
The following claims review procedures apply to the review of claims denied under the STD or LTD Plan without regard to any conflicting claims appeal or review procedures described in the attached booklet.

Appeal: If your claim for benefits under the STD or LTD Plan is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim under the STD or LTD Plan or no notification as to an extension of the determination period within 45 days after submission of the claim to the Disability Claims Processor, the claim will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing with the Claims Administrator a written request for review, provided that your request for review of a claim must be submitted within 180 days after (a) your receipt of the written notice of the denial or (b) the date of the deemed denial of the claim.

Review: The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within 45 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the Claims Administrator will render a decision as soon as possible, but not later than 90 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 45-day period; such notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a determination on review. The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim. If you request that the Claims Administrator review your claim, you may submit written comments, documents, records and other information relating to the claim. Additionally, you shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, provided that the Claims Administrator shall determine, in its sole discretion, whether documents, records and information are relevant to your claim, subject to applicable regulations.

In reviewing your claim, the Claims Administrator shall take into account all comments, documents, records, and other information you submit that relates to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additionally, the Claims Administrator's review of your claim shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination regarding your claim nor a subordinate of such individual. In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, provided that such health care professional shall not be the individual who was consulted in connection with the initial adverse benefit determination regarding the claim or a subordinate of such individual.

Disposition on Review: You will receive written notification of the Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a culturally and linguistically appropriate manner and in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:
- The specific reason or reasons for the denial of the claim;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A discussion of the decision, including reasons for disagreeing with views of treating professionals, medical or vocational experts consulted, or Social Security disability determination;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits, provided that the Claims Administrator

shall, in its sole discretion, determine whether documents, records and information are relevant to your claim under applicable regulations;

- The specific internal rules, guidelines, protocols, or similar criterion was relied on in making the adverse determination; a statement that a copy of such rules, guidelines, protocols, or other similar criterion will be provided to you free of charge upon request; or a statement that such internal guidelines or criteria do not exist;
- A statement of your right to bring an action under ERISA;
- A statement describing any voluntary appeal procedures;
- If the denial is based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If you have questions about claims procedures, contact:

> ***Customer Services toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.***

Rights to an External Appeal for Medical (including prescription drugs) Denied Claims
Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if CapitalBlue Cross or Highmark has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

You will lose your right to an external appeal if you do not file an application for an external appeal within a period of time stated in the attached insurance contract.

The external appeal program is a voluntary program. Please refer to the appropriate attachment to this document for more information on requesting an external appeal.

You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination regarding your claim, without regard to whether such expert's advice was relied upon in making a benefit determination on review.

See the certificate of insurance for more information about how to file a claim and for details regarding the claims procedures of the applicable insurance company.

Subrogation/Right of Reimbursement
As a condition to receiving medical, disability or any other benefits under the Plan, covered person(s), including all Dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person received any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefit paid by it (i.e. the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability, or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by

requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

Coordination of Benefits and Right of Recovery

Coordination of Benefits

The benefits that would otherwise be payable under the Plan shall be reduced by the amount, if any, necessary so that the sum of the benefits payable under the Plan and any other plans (whether or not maintained by the Employer) does not exceed the total of the Claimant's allowable expenses. The manner and extent to which the Plan coordinates benefit payments with other coverage shall be governed by the terms of the contract.

Right of Recovery

Whenever benefits have been paid with respect to covered expenses in a total amount at any time in excess of the amount of payment necessary, the Plan Administrator shall have the right to recover such payments to the extent of such excess from among any one or more of the following, as the Plan Administrator shall determine: (i.) any persons (including, without limitation, an Employee, a Covered Dependent, a trust, or an estate) to, for or with respect to whom such payments were made, (ii) any insurance companies, or (iii) any other organizations. The Plan Administrator shall have the right to pay any amount it shall determine to be warranted to satisfy the intent of this Section to any organization making payments under other plans which should have been made under this Plan.

Claim Procedures for Self-Insured Plans – Flexible Spending Account Program

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the College's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-insured arrangement.

The Plan permits participants the use of a debit card for benefit claims under the Plan. In the event you terminate your employment with Lafayette College and do not continue your flexible spending account plan benefits through COBRA, you will no longer be permitted to use your debit card beyond your date of termination. If you have claims that were incurred during your employment, you must submit your claims with claims forms designated for use by Capital BlueCross. Please see the Plan Administrator for questions regarding continuation coverage through COBRA or if you need to file a claim incurred prior to your termination of employment after the date you terminated your employment.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. If you do not appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

The Heroes Earnings Assistance and Relief Tax Act of 2008 (the "HEART Act")

The HEART Act permits employers to allow qualified reservist distributions from medical flexible spending account programs. Distributions of unused medical flexible spending accounts to reservists called to active duty will provide an amount actually contributed to the medical flexible spending account by the employee as of the date of the distribution request, minus reimbursements received to date.

This distribution option applies to a member of a reserve component who is called to active duty for a period of 180 days or more or an indefinite period of time. The period of active duty specified in the order is used by the employer to determine the duration of the order, even if the period of active duty is later changed. However, if subsequent orders increase the total period of active duty to more than 180 days, the employee qualifies for a qualified reservist distribution.

An employee may request a qualified reservist distribution on or after the date of call to active duty and before the last day of the plan year or the applicable grace period for the plan year in which the call to active duty occurred.

Lafayette College must pay the qualified reservist distribution to the employee within a reasonable time, but not more than 60 days after the request is made.

A qualified reservist distribution is included in the gross income of the employee and subject to employment taxes. The employer must report the amount of the distribution as wages on the employee's Form W-2 for the year in which the distribution was paid to the employee.

The employer must receive a copy of the employee's order or call to active duty prior to making the distribution.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

No clerical error made by the Plan Sponsor, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under the Plan and its amount.

Effect on Workers' Compensation
The Plan is not intended to be and is not in lieu of any Workers' Compensation Act insurance and does not affect any requirement for Workers' Compensation Act insurance coverage.

Law of Governing Venue
This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement. Any actions related to this Plan shall be brought in the federal or state courts located in the Commonwealth of Pennsylvania.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under component benefits of the Plan more than 24 months after the final review/appeal decision by the Plan Administrator or Claims Administrator has been rendered (or deemed rendered).

11. HIPAA PROVISIONS FOR HEALTH COMPONENT BENEFITS

This provision shall only apply to benefits that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and its implementing regulations, issued under the Privacy Regulations at 45 C.F.R. Parts 160 and 164.

This section shall be interpreted in a manner that permits the Plan to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state laws regarding protection of Protected Health Information (PHI).

The health component benefits of the Plan will use and disclose protected health information (PHI), as defined in 45 CFR 164.501, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the health component benefits will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the health component benefit HIPAA Privacy Notice (as defined in 45 CFR 164.520) distributed to Participants.

Health i*nformation* means any information, whether oral or recorded in any form or medium, that:

a) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

b) Relates to the past, present, future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual; and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future payment for the provision of health care to an individual; and
    a. Identifies the individual; or
    b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information means individually identifiable health information (defined above):

1. Except as provided in paragraph (2) of this definition; that is:
    a. Transmitted by electronic media;
    b. Maintained in electronic media; or
    c. Transmitted or maintained in any other form or medium.

2. Protected Health Information excludes individually identifiable health information in:
    a. Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g:
    b. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
    c. Employment records held by a covered entity in its role as employer.

The HIPAA Privacy Rules covers protected health information in any medium while the HIPAA Security Rule covers electronic protected health information.

The health component benefits of the Plan will disclose PHI to Lafayette College only upon receipt of a certification from Lafayette College that this Summary Plan Description has been amended to incorporate the provisions below and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the health component benefits and Lafayette College.

Lafayette College's Obligations with Respect to PHI

With respect to PHI, Lafayette College agrees to certain conditions. Lafayette College agrees to:

- not use or disclose PHI other than as permitted or required by this Summary Plan Description or as required by law;
- ensure that any agents (including a subcontractor) to whom Lafayette College provides PHI received from the Plan agree to the same restrictions and conditions that apply to Lafayette College with respect to such PHI;

- not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of Lafayette College unless authorized by an individual;
- report to the Plan any PHI use or disclosures of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA;
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Lafayette College will follow the privacy and security obligations required under the Health Information Technology for Economic and Clinical Health Act (HITECH) enacted February 17, 2009, including notification of a breach involving unsecured PHI within the required 60-day timeframe, securing PHI, and development of procedures for breach identification.

Access to PHI within Employer

Adequate separation will be maintained between the Plan and Lafayette College If the persons described herein or any other employees do not comply with the Summary Plan Description, Lafayette College shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. Lafayette College shall cooperate with the Plan to correct and mitigate any such noncompliance.

Employees who work in the Plan Sponsor's Benefits or Human Resources Office will have access to Protected Health Information:

A. To the extent necessary to assist Plan participants and their family members with getting benefit claims resolved;
B. That is the result of pre-employment physicals requested or required by the Plan Sponsor before hiring prospective employees;
C. To the extent necessary to fulfill any responsibility they may have to review and determine claims and appeals of denied claims under this Plan;
D. To the extent necessary to monitor and enforce the subrogation provisions of the Plan, and work with the Plan Sponsor's subrogation entity to help the Plan obtain reimbursement when appropriate;
E. For activities related to ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care; and
F. To the extent necessary to correspond with other group health plans on coordination of benefits issues.

Employees who work in the Plan Sponsor's Legal Department will have access to Protected Health Information to the extent necessary to: (i) enforce the provisions of the Plan; and (ii) respond to, defend against, and provide necessary information to outside counsel for responding to or defending against, lawsuits against the Plan, Plan Sponsor or Plan fiduciaries, or other lawsuits that require benefits information or Protected Health Information.

Employees who work in the Plan Sponsor's Finance Department will have access to Protected Health Information to the extent necessary to conduct an internal audit of the Plan's expenses and payments of claims.

Privacy Official

The Privacy Official shall be responsible for compliance with Lafayette College and the health component benefits obligations under this section and HIPAA. The Director of Human Resources/Benefits has been named as the Privacy Officer. Specific rules regarding the Privacy Official follow:

1. Appointment, Resignation and Removal of Privacy Official. Lafayette College shall appoint one or more individuals to act as Privacy Official on matters regarding the health component benefits. The individual appointed as Privacy Official may resign by giving 30 day notice in writing to Lafayette College. The Company shall have the power to remove that individual for any or no reason.

2. Policies and Procedures. The Privacy Official shall from time to time formulate and issue to Participants and Lafayette College such policies and procedures as he or she deems necessary for substantive provision of the health component benefits. Additionally, such policies and procedures must be accepted by the Plan Administrator.
3. Privacy Notice. The Privacy Official shall be responsible for arranging with Lafayette College, the Plan Administrator and any third-party administrator for the issuance of, and any changes to the Privacy Notice under the health component benefits.
4. Complaint Contact Person. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this section and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the health component benefits HIPAA Privacy Notice.

   If you believe your privacy rights have been violated, you may file a complaint with the Associate Director of Human Resources/Benefits of Lafayette College or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

   You will not be penalized or retaliated against for filing a complaint.

HIPAA Security Standards

This section explains Lafayette College's obligations with respect to the security of Electronic Protected Health Information under the security standards of HIPAA.

Where Electronic Protected Health Information (e-PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, Lafayette College will reasonably safeguard the e-PHI as follows:

- Lafayette College will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that Lafayette College creates, receives, maintains, or transmits on behalf of the Plan,
- Lafayette College will ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures,
- Lafayette College will ensure that any agent, including a subcontractor, to whom it provides e-PHI agrees to implement reasonable and appropriate security measures to protect such e-PHI, and the Plan Sponsor will report to the Plan any security incidents of which it becomes aware as described below:
  - ✓ Lafayette College will report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any security incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's e-PHI, and
  - ✓ Lafayette College will report to the Plan any other security incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

12. STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as other work-sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan of the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them in 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $147 a day, not exceed $1,473 per request, until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue N. W., Washington, D.C. 20210, 1-866-487-2365, www.dol.gov/ebsa.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication's hotline of the Employee Benefits Security Administration.

SIGNATURE:

IN WITNESS WHEREOF, we have executed this Plan Agreement the date and year first written above.

Employer: _____
Lafayette College

Date: _____

Attest: _____