

# Welfare Benefits Plan

Summary of Material Modification — Effective January 1, 2019

Changes to the Plan and Summary Plan Description (SPD) for Trustees of Hamilton College's Welfare Benefits Plan are described below.

## Welfare Benefits Plan (Plan Number 510)

### A. GENERAL INFORMATION ABOUT THE PLAN

This section contains general information that you may need to know about the Plan.

#### 1. General Plan Information

The name of the Plan is the Trustees of Hamilton College Welfare Benefits Plan.

The Plan Sponsor has assigned Plan Number 510 to the Plan.

The Plan Year is the twelve-month period ending each December 31<sup>st</sup>.

This plan has been renewed.

The Plan includes the following Plan features:

Group Medical Benefits
Group Dental Benefits
Group Vision Benefits
Group Life/ADPL Benefits
Group Supplemental Term Life and ADPL Benefits
Group Long Term Disability Benefits

#### 2. Employer Information

The Plan Sponsor's name, address, and employer identification number are:

Trustees of Hamilton College  
198 College Hill Road  
Clinton, NY 13323  
E.I.N.: 15-0532200

#### 3. Plan Administrator Information

The Plan Administrator's name and telephone number is:

Trustees of Hamilton College  
198 College Hill Road  
Clinton, NY 13323  
Telephone: 315-859-4689

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan.

The Plan Administrator will also answer any questions you may have about the Plan.

### B. ELIGIBILITY AND BENEFITS

#### 1. Employee Eligibility Requirements

In order to be an eligible employee under the **Group Medical, Group Dental, Group Vision, Group Term Life/ADPL, Group Supplemental Term Life/ADPL, and Group Long Term Disability Insurance Plans** you must be a regular Exempt or Non-Exempt employee of the employer scheduled to work at least 17.5 hours per week and you must not be a non-resident alien without any U.S. source income. You will be eligible to enroll in the Group Medical, Group Dental, Group Vision, Group Term Life/ADPL, Group Supplemental Term Life / ADPL and Travel Accident Insurance Plans at date of hire in an eligible position.

You will be eligible to enroll in the **Group Long Term Disability Insurance Plan** the first day of the month following 1 continuous year of service, in an eligible position or on the 1<sup>st</sup> of the month coinciding with or following your date of hire if you had prior coverage with previous employer immediately preceding employment with the Plan Sponsor.

In order to be an eligible **Retiree** under the **Group Medical**, you must have been enrolled in the plan sponsor's health plan immediately prior to retirement and attained a combined age and years of service that equals or exceeds 75. Any Retiree Group Medical participant age 65 or over, including retiree, spouse or domestic partner, must enroll and have coverage in Medicare Part A & B. A surviving spouse of a qualified Retiree may retain coverage until death or remarriage. Once a retiree cancels group medical coverage, it may not be reinstated.

Subject to each Plan feature's eligibility requirements that are set forth in the provider contracts or other plan documents identified in Schedule A, and their respective policies, descriptions, plan materials and participant communications, all regular full-time and part-time employees of the Plan Sponsor are eligible to participate in the Plan except for employees in the following categories:

- employees covered by a collective bargaining agreement to which the Plan Sponsor is a party and which does not provide for participation in the Plan;
- "leased employees" within the meaning of Internal Revenue Code Section 414(n);
- individuals who are classified by the Plan Sponsor as temporary workers, interns, co-ops, independent contractors, or consultants;
- individuals from whom the Plan Sponsor does not withhold federal income and employment taxes from such person's compensation; or
- employees who are not regularly scheduled to work according to the eligibility requirements indicated above.

To the extent that the Plan and/or a Plan feature's provider contracts and/or other plan documents refer to the eligibility of "employees," only individuals classified as "employees" by the Plan Sponsor are eligible to participate in such Plan feature. Independent contractors, freelancers and individuals hired through staffing firms shall not be eligible even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by the Internal Revenue Service, the Department of Labor or any other Federal or state agency, administrative body or court. Any such determination should have a prospective effect only.

**Notwithstanding the foregoing, an employee who is not eligible to participate in the Plan because the employee is not regularly scheduled to work at least [30] hours per week shall become eligible for Plan participation on the date that he or she becomes eligible under the "look-back" eligibility definition set forth in Appendix A.**

## Annual Notices

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### B. ELIGIBILITY AND BENEFITS

#### 3. Special Enrollment Rights

If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child.

You may also enroll yourself and your dependents in a group health plan if your or one of your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for premium assistance under a Medicaid or CHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP.

See the Plan Administrator for details about special enrollment.

### C. NOTICES AND DISCLOSURES

#### 1. Special Rule for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier

than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

2. Special Rule for Women’s Health Coverage

The Women’s Health and Cancer Rights Act of 1998 (“WHCRA”) requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Group Medical Feature. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits.

3. Patient Protection Disclosure

If the Group Medical Feature in which you are enrolled requires the designation of a primary care provider, 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 list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

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This Summary of Material Modification (SMM) describes the changes that affect your benefit plans and updates your plan descriptions. SMM’s together with the plan booklets make up your official plan descriptions; please keep them together and refer to them as necessary. We’ve made every attempt to insure the accuracy of the information in this SMM. However, if there is any discrepancy between this and the insurance contracts, the insurance contracts will always govern.

## **SUMMARY OF BENEFIT AND COVERAGE**

As required under the Affordable Care Act (ACA), the following items are available on the Trustees of Hamilton College Human Resources website:

- ♦ Summary of Benefit and Coverage
- ♦ Glossary of Terms.

Printed copies of these documents are available at no charge through your Plan Sponsor, noted previously.

## **REMINDER OF AVAILABILITY OF PRIVACY NOTICE**

Trustees of Trustees of Hamilton College maintains the HIPAA Notice of Privacy Practices for the Plan, which describes how health information about you may be used and disclosed. You may obtain a copy of our HIPAA Notice of Privacy Practices by contacting the Plan Sponsor or Privacy Office, noted previously.

**TRUSTEES OF HAMILTON COLLEGE  
WELFARE BENEFITS PLAN**

**Schedule A— As of January 1, 2019**

**I. Group Medical and Pharmacy Benefits**

Administrator/Carrier	Contract/Group No.
Excellus BlueCross Blue Shield, Central New York Region	122472
OptumRx, Schaumburg, IL	PURHAMILC

**II. Group Dental Benefits**

Administrator/Carrier	Contract/Group No.
The Guardian	00532833

**III. Group Vision Benefits**

Carrier	Contract/Group No.
The Guardian	00532833

**IV. Group Term Life and ADPL Benefits**

Carrier	Contract/Group No.
The Business Council	2059/AXA 002767

**V. Group Supplemental Term Life and ADPL Benefits**

Carrier	Contract/Group No.
The Business Council	2059/AXA 002767

**VI. Group Long Term Disability Benefits**

Carrier	Contract/Group No.
The Standard	430229