

Welfare Benefits Plan

Summary of Material Modification — Effective *January 1, 2021*

Official Name of Plan: Trustees of Hamilton College Welfare Benefits Plan
Plan Sponsor: Trustees of Hamilton College
198 College Hill Road
Clinton, New York 13323
Employer Identification Number: 15-0532200
Plan Number: 510

This Summary of Material Modifications ("SMM") describes important changes made to the Trustees of Hamilton College Welfare Benefits Plan since the Plan's Summary Plan Description ("SPD") was last distributed. Unless otherwise specified herein, the changes described herein are effective as of January 1, 2021.

The SPD and this SMM will help you to understand the provisions of the Plan. We believe that these two documents accurately describe the provisions of the Plan. However, the Plan document itself, as interpreted by the Plan Administrator, controls the operation of the Plan. Additionally, as set forth in the SPD, the policies, contracts, or booklets for each underlying Plan feature govern the benefits to be provided and include more details on how the Plan features operate. If there is any conflict between this SMM and/or the SPD and such policies, contracts, or booklets, then such other documents will control, unless otherwise specified herein.

Definitions

For purposes of this SMM, the following definitions apply:

"COVID-19" is a disease that is caused by the SARS-CoV-2 coronavirus.

"COVID-19 Public Health Emergency" is the declaration of a public health emergency based on an outbreak of a SARS-CoV-2 or other coronavirus with pandemic potential designated by the Secretary of Health and Human Services pursuant to section 319 of the Public Health Service Act (42 U.S.C. §247d).

"FFCRA" means the Families First Coronavirus Response Act, H.R.6201, Public Law No. 116-127, as amended.

"CARES Act" means the Coronavirus Aid, Relief, and Economic Security Act, H.R.748, Public Law No. 116-136, enacted on March 27, 2020.

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 31st**.

This plan has been renewed.

The Plan includes the following Plan features:

Group Medical Benefits
Group Dental Benefits
Group Vision Benefits
Group Life/AD&D Benefits
Group Supplemental Term Life and AD&D Benefits
Group Long Term Disability Benefits
Travel Accident Insurance Benefits

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/AD&D, Group Supplemental Term Life/AD&D, Group Long Term Disability, and Travel Accident 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/AD&D, Group Supplemental Term Life / AD&D 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 1st 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 sponsors 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.

NOTE: The Plan Administrator reserves the right to terminate your health care coverage prospectively without notice for cause (as determined by the Plan Administrator), or if you or a dependent are otherwise determined to be ineligible for coverage under the Plan. In addition, if you or your dependent commits fraud or intentional misrepresentation of a material fact (including, for example, in an application for health coverage under the Plan, in connection with a benefit claim or appeal, or in response to any request for information by the Plan Sponsor or its delegates (including the Plan Administrator or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30 days' notice. Failure to inform any such persons that you or your dependent is covered under another group health plan (if required by the Plan) or knowingly providing false information in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan. Coverage may also be terminated retroactively and without notice (unless required by law) if the Plan Administrator or its delegee determines that a spouse or dependent is ineligible for coverage under the Plan and such retroactive termination would not be considered a rescission under the Affordable Care Act. If coverage is terminated retroactively, you must reimburse the Plan and/or its delegee for the costs associated with providing coverage to any ineligible persons (including benefit claims, processing fees, administrative charges and all other costs), plus interest and any attorneys' fees incurred by them in order to collect such amounts. Additionally, you may be subject to further disciplinary action from the Plan Sponsor, including, but not limited to, termination of employment.

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.

4. 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.

Changes to Section 6 are effective July 1, 2020

6. Nondiscrimination and Accessibility Requirements

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. The Plan:

- Will take appropriate steps to ensure communications with individuals with disabilities are as effective as communications with other plan participants. This may include providing auxiliary aids and services, including:
 - Interpreters (free of charge) and
 - Information in alternate formats.
- Will take reasonable steps to provide meaningful access under the facts and circumstances and within available resources to Participants whose primary language is not English. This may include free language services, such as:
 - Qualified interpreters; and the use of qualified bilingual or multilingual staff;
 - Information written in other languages.

If you need these services, contact the Plan Administrator. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the Plan Administrator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Plan Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Section 7 is effective July 1, 2020.

7. Effective January 1, 2020, the Plan's health flexible spending account shall reimburse the following qualified expenses:

- (i) Expenses incurred for medicines or drugs that are available over-the-counter-with or without a prescription
- (ii) Expenses incurred for menstrual care products as defined under Section 223(d)(2)(D) of the Internal Revenue Code.

F. LEAVE UNDER FAMILY MEDICAL LEAVE ACT

If you take a leave of absence for any of the below reasons, you may be able to continue your health coverage under the Plan:

- (i) for your own serious health condition;
- (ii) to care for family members with a serious health condition;
- (iii) to care for a newborn or adopted child;
- (iv) to care for an injured or ill covered service member of the Armed Forces;
- (v) due to a qualifying exigency arising out of a covered service member's active duty;
- (vi) if, on or after April 1, 2020, you are unable to work (or telework) because you are caring for your child whose school or place of care is closed, or whose childcare provider is unavailable, due to COVID-19 related reasons; or
- (vii) if, on or after April 1, 2020, you are unable to work (or telework) because:
 - a. you are subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
 - b. you have been advised by a health care provider to self-quarantine related to COVID-19;
 - c. you have been experiencing COVID-19 symptoms and are seeking a medical diagnosis;
 - d. you are caring for an individual subject to an order pursuant to (vii)(a) or (b) above; or
 - e. you are experiencing another substantially similar condition specified by the U.S. Department of Health and Human Services.

Subsections (vi) and (vii) expire on December 31, 2020, unless extended.

If you drop your health coverage during a period of unpaid leave, you can also have your health coverage reinstated on the date you return to work assuming you pay any contributions required for the coverage. See the Plan Administrator for more information about your FMLA rights.

This Summary of Material Modification (SMM) describes the changes that affect your benefit plans and updates your plan descriptions. SMMs 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 ensure 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, 2021

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 AD&D Benefits

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

V. Group Supplemental Term Life and AD&D Benefits

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

VI. Group Long Term Disability Benefits

Carrier	Contract/Group No.
The Standard	430229

VII. Travel Accident Insurance

Carrier	Contract/Group No.
AIG Accident & Health	GTP 0009156848