Summary Plan Description Introduction

NAME OF PLAN: Marlboro College Group Health Plan	**PLAN NUMBER:** 507
COMMON NAME OF PLAN (if different)**:** same	**TYPE OF PLAN:** Employee Health &Welfare Benefit Plan
PLAN SPONSOR: Corporation of Marlboro College	**PLAN ADMINISTRATOR:** Corporation of Marlboro College
ADDRESS OF PLAN SPONSOR: 2582 South Road Marlboro, Vermont 05344	**ADDRESS OF PLAN ADMINISTRATOR:** 2582 South Road Marlboro, Vermont 05344
AGENT FOR SERVICE OF LEGAL PROCESS (service can also be made on a Plan trustee or Plan administrator)**:** Corporation of Marlboro College	**BUSINESS PHONE NUMBER OF PLAN ADMINISTRATOR:** 802-257-4333
ADDRESS FOR SERVICE OF LEGAL PROCESS: Corporation of Marlboro College 2582 South Road Marlboro , VT 05344	**INSURER** (a nonprofit hospital/medical service corp.)**:** Blue Cross Blue Shield of VT **TRUSTEE** (if more than one, please see attached list to this document)**:**
EMPLOYER IDENTIFICATION NUMBER: 03-0179593	☐ If checked, this Plan is maintained pursuant to a collective bargaining agreement. You may obtain and examine a copy of this agreement by writing to the Plan administrator.

CONTRACT NUMBER: 81243	**OPEN ENROLLMENT PERIOD:** To be determined by the employer
YOUR CONTRIBUTION TO THE COST OF THIS PLAN: see attached rate sheet	**ELIGIBILITY (**you are eligible for coverage after complete the following)**:** 30 days from hire date
TYPE OF ADMINISTRATION (the Plan is administered by a nonprofit hospital service corporation on a fully insured basis)**:**	**PLAN YEAR:** 1/1-12/31

Your Benefit Materials

Your benefit materials include this introduction document your Certificate of Coverage, any riders that amend it and your Summary of Benefits and Coverage, which gives you information about your costs when you receive care. You or your dependent may obtain a Summary of Benefits and Coverage at no cost upon request.

You may have received these benefit materials electronically or on paper with this introduction. You may request copies at any time without cost to you.

Open Enrollment

Your employer may have an open enrollment period. If so, you may make changes to your existing Plan during the open enrollment period. The date for your open enrollment, if you have one, appears above. Changes to your enrollment will be effective on the first of the month following BCBSVT's receipt of the change during open enrollment.

At open enrollment, you may only make changes as otherwise described in this section.

When Coverage Ends

In general, your Plan Coverage will end for you and your Dependents:

- the end of the month in which your employment ends;
- when you stop making required contributions to your Plan;
- when you or your Dependents are no longer eligible to participate in your Plan; or
- when your Plan is terminated.

You may be eligible for benefits after termination of Coverage. See the "Membership" section of your Summary Plan Description. You may also be able to continue your Plan Coverage under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or Vermont Statute.

Resuming Participation

If you are rehired or if you return from a leave of absence or furlough, you will become eligible to participate in your Plan on the date you are rehired, recalled or return to work.

If you are rehired, recalled or return to work, and resume participation in your Plan, you must select new benefits for you and your eligible Dependents by re-enrolling in the Plan.

If you are rehired, recalled or return to work during the same Plan Year in which you were terminated, took leave or were furloughed, your prior enrollment election will be reinstated for the balance of the Plan Year. You can make changes within 31 days of the date of your rehire or return to work.

If You Go To Work for another Employer

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines eligibility for medical Coverage and may be limited based on a pre-existing medical condition.

If you leave your employer and go to work for another employer whose medical plan includes a pre-existing condition exclusion from Coverage, the HIPAA "prior creditable Coverage" may help protect you from any such exclusion.

When you leave your employer, you and your Covered Dependents will automatically receive a certificate of creditable Coverage from your employer. This certificate will document that you (and any of your eligible, enrolled Dependents) had medical Coverage under the Plan.

If your new employer's medical plan includes a pre-existing condition clause, you can use your certificate(s) of creditable Coverage to shorten or eliminate any applicable waiting period for full medical benefits under the new employer's plan.

You can request a certificate of creditable Coverage by calling the appropriate medical carrier.

Note: If your new employer benefits has a pre-existing condition clause, a certificate of creditable Coverage will not be effective to shorten or eliminate any applicable waiting period.

Paying for Coverage

You and your employer share in the cost of your medical Coverage. In general, your employer determines your portion of the contribution costs prior to the beginning of each Plan Year. (Your Plan Year appears on your Summary of Benefits and Coverage.) Your current contribution appears on the first page of this introduction. Each year, before the annual enrollment period, your employer will give you information about your Coverage options.

If you are on an unpaid leave of absence or furlough, your payment will be made to Blue Cross and Blue Shield of Vermont on an after-tax basis.

Continuation of Coverage

COBRA Eligibility

If you face losing health insurance Coverage, COBRA may apply. COBRA doesn't apply if you are fired for gross misconduct. COBRA requires your employer to keep you and/or your Dependents on the group plan for a certain period of time. You must pay for your Coverage.

You could lose Coverage under your Plan because:

- you quit your job;
- you are laid off;
- you enter active military service;
- your job status changes;
- you are fired; or
- your company goes bankrupt but does not cancel the group policy.

In the cases above, your employer must allow you to stay on the Plan for 18 months.

Your employer must tell you of your COBRA rights when you become eligible. To continue your Coverage, you must tell your employer you elect COBRA. You must do so within 60 days after one of the events above (or after your employer tells you of your COBRA rights). You must then pay the cost of Coverage, plus up to 2 percent in a service fee.

If you or a Dependent are disabled or become disabled within 60 days of the COBRA event (see event list above), you can keep Coverage longer. You and your Covered Dependents may continue for up to 29 months. You must pay a 50 percent service fee for months 19 to 29.

In other cases (such as divorce or death of the subscriber), you may keep your Coverage for up to 36 months. Please check with your employer or an attorney for more information.

Vermont Continuation of Coverage

Vermont law requires your employer to keep you on your Plan after:

- Loss of employment, including a reduction of hours resulting in ineligibility for employer-sponsored Coverage;
- Divorce, civil union dissolution, or legal separation resulting in a loss of Coverage for a Covered employee's spouse, civil union partner or domestic partner if domestic partners are Covered under your employer's plan;
- A child no longer qualifying as a Dependent child under the plan rules (e.g.—due to the child's age), or
- Death of the Covered employee, which causes Dependents to lose Coverage.

Generally, continuation of Coverage lasts for 18 months.

Continuation of Coverage could end sooner, under the following circumstances:

- You don't pay your premiums on a timely basis.
- Your employer ceases to maintain any group health insurance plan.
- You obtain Coverage with another employer's group health insurance plan that does not contain any exclusion or limitation for pre-existing conditions.
- You become entitled to Medicare benefits.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, eligible employees are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted due to military service, plus additional seniority, rights and benefits that the employee would have attained if he or she had not left employment.

You may continue your medical Coverage for a period of time by paying premiums as stated per company policy or your collectively bargained agreement.

If you choose not to continue your medical Coverage while on military leave, you may reinstate Coverage with no waiting periods or exclusions (exception the exclusion that applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days;
- Return to or re-apply for re-employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days; or
- Return to or re-apply for re-employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage while on a Family and Medical Leave

Under the Family and Medical Leave Act (FMLA), eligible employees may generally take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical Coverage benefits during this time. If you take this unpaid leave and wish to continue your medical Coverage under the Plan, you will be billed directly on a monthly basis, at the same rates applicable before the unpaid leave began.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care;
- To care for a Spouse, child, or parent who has a serious health condition; or
- For your own serious health condition.

The number of weeks of unpaid leave available to you for family and medical reasons may vary based on the applicable state law requirements.

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:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 Benefits Security Administration.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.
- 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 on 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, your union, 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 a 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 within 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 $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If it should happen that 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 Benefits 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your Plan is administered by your Plan administrator, which has the authority to delegate the day-to-day administrative duties to a third party. Here, your Plan administrator has delegated such duties to Blue Cross and Blue Shield of Vermont.

Blue Cross and Blue Shield of Vermont, as delegated by your Plan administrator, shall have complete discretion to interpret and construe the provisions of the Plan options, programs and policies described in this Benefits Booklet, to determine eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations Blue Cross and Blue Shield of Vermont made pursuant to the Plan options, programs and policies described in this Benefits Booklet shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious, or unless found by an independent medical review organization, after external review, to be made in error. Your Plan administrator may delegate this discretionary authority to select service providers.

If you have questions or comments regarding the Plan's administration, contact customer service at Blue Cross and Blue Shield of Vermont.

Qualified Medical Child Support Orders (QMCSO)

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) mandates that group health plans provide benefits according to qualified medical child support order requirements. Contact your plan administrator to obtain, without charge, a copy of the QMCSO procedures.

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.