

# Summary Plan Description of the LVAIC Group Health Plan For Moravian College

## Introduction

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This summary plan description is dated January 1, 2018.

The purpose of this summary plan description is to explain the provisions of the LVAIC Group Health Plan (the "Plan") that apply to employees of Moravian College. LVAIC maintains this Plan for the exclusive benefit of its employees of Moravian College (and employees of other participating colleges which are members of the LVAIC Health Insurance Consortium) along with their spouses and dependents. Participants are urged to read this document carefully.

Generally, the terms and conditions under which an employee may be eligible for and receive the benefits are set forth in the terms of a Summary Benefit Booklet. These benefit programs are managed by a claims administrator (this summary is referred to in this document as the "Booklet"). A copy of this Booklet has been provided to each participating employee (referred to as a "Participant"). Additional copies are available upon request. All available options are listed on Attachment A, which is attached to and incorporated into this Summary Plan Description.

The benefits under the Plan are provided solely through LVAIC Health Care Consortium as Plan Administrator.

Whether and under what circumstances coverage is provided for medical tests, devices and procedures;

Provisions governing the use of network providers (if any). If there is a network, the Booklet will contain a general description of the provider network and Participants will receive a list of providers in the network from the claims administrator. A list of network providers will be included in Attachment A;

Whether and under what circumstances coverage is provided for any out-of-network services;

Any conditions or limits on the selection of primary care physicians or providers of specific specialty medical care;

Any conditions or limits applicable to obtaining emergency medical care;

Any services requiring pre-authorization or utilization review as a condition for obtaining a-3(re) JETB

# General Information about the Plan

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Plan Name: LVAIC Group Health Plan

Employer: Moravian College  
1200 Main Street  
Bethlehem, PA 18018

Type of Plan: Welfare plan providing medical benefits

Plan Year:

Trustee:

## General Information about the Benefits

### Type of Benefits Available

See Attachment A for specific information about the types of benefits available under the Plan.

### Funding of Benefits

The medical benefits are paid in part from the LVAIC Health Plan Trust and in part by pre-tax contributions made by the employees.

If the domestic partner is not a Qualifying Relative under Internal Revenue Code Section 152, the incremental premium for the domestic partner will be paid on a post-tax basis and the value of the incremental premium for the domestic partner will be included in the employee's gross income for the year.

## Eligibility for and Termination of Coverage under the Plan

### Eligibility for Coverage

All employees of the Employer working a minimum of thirty hours per week over the course of time described within his/her position/offer letter.

Upon receipt of a child support order, the plan administrator will promptly send a written notice of receipt of the order to the participant and all alternate recipient children named in the order and their legal representatives. If the plan administrator receives a National Medical Support Notice, it must notify the state agency whether coverage for the child is available under the plan and indicate the effective date of coverage (or any steps necessary to make the coverage effective, including copies of any forms that must be completed). The plan administrator must also send a description of the coverage.

After sending the notice of receipt, the plan administrator has the ultimate authority to determine whether or not the order meets the requirements of a QMCSO. Within 40 days after receiving the order, the plan administrator will notify the participant and the alternate recipients that either the order is a valid QMCSO or that the order is not a valid QMCSO. If an

Benefits for Dependents

To be eligible to enroll as a Dependent, a person must be: a) the lawful spouse of a Participant as defined by the laws of state in which the marriage took place; or b) the same sex or newborn children, step-children, children legally placed for adoption, legally adopted children, handicapped individuals and children required to be covered under a Court Order.

Benefits for Domestic Partners

An eligible domestic partner will be treated as a lawful spouse according to the terms and policies of this Plan. Upon termination, the domestic partner will be afforded the same continuation rights as a lawful spouse under COBRA.

Enrollment

In order to remain eligible for coverage under the Plan, a Participant must remain an eligible employee actively working for the Employer under the terms set forth above and in the Booklet, or in the event the Employer terminates a Participant and/or his/her spouse and dependents may be eligible for continued coverage and/or a conversion policy, as explained in the following sections.

Continued Coverage under the FMLA (if applicable) and USERRA

Notwithstanding any other provision to the contrary, if a Participant goes on a qualifying unpaid leave under the provisions of these laws. Participants will be required to continue to pay their portion of the premium for continued coverage as required by the FMLA and USERRA.

Except as otherwise provided in the FMLA, participation may be terminated by the Plan Administrator when notified that the Participant does

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, enrollment of the Participant in Medicare (Part A, Part B, or both), divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation lasts for up to 36 months. When the qualifying event is the end of employment or reduction in the DUfford hours of employment, COBRA continuation coverage lasts for up to 18 months. There are three ways in which this 18-month period can be extended: (1) if the Participant or dependent covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and the Plan Administrator is notified in a timely fashion,



- (6) The Employee, spouse, or a Dependent is determined to be eligible for group health plan premium assistance under Medicaid or SCHIP plan;
- (7) The Employee takes an FMLA leave of absence;
- (8) The Employee receives a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a Qualified Medical Child Support Order) requiring the Employee to provide coverage for a dependent or requiring another person to provide such coverage;
- (9) There is a signi

## Women's Health & Cancer Rights Act (WHCRA)

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

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurances shown in the Booklet will apply.

No Contract of Employment

Nothing in this Plan shall be construed as a contract of employment between the LVAIC or the Employer and any Employee or Participant, or as a guarantee of any Employee or Participant to be continued in the employment of the Employer or LVAIC, nor as a limitation on the right of the Employer or LVAIC to discharge any of its employees with or without cause.

Privacy and Security

PHI, in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)



## 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 are entitled to:

### Receive Information about the Plan and its Benefits

You are entitled to examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if there are 100 or more participants, 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 Pension and Welfare Benefit Administration.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), any updated summary plan description and, if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

If there are more than 100 participants in the Plan, you are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in 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 Plan 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 medical child support order, you may file suit in federal court. 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 federal court. The court shall 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 Questions

If you have any questions about the 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 (s f)3(ro)4(m t)-11(h)-3(e PI)-3( t)-11(h)-3(e .f2e7.[96.624 486.79 T)-7(ra)-3(t)-9(i)-4(o)4(n)-