Summary Plan Description
of the
Moravian College
Employee Benefit Plan

Introduction

This summary plan description is dated January 1, 2018.

The purpose of this summary plan description is to explain the provisions of the Moravian College (the "Employer") Employee Benefit Plan (the "Plan"). The Employer

The Booklets for this plan are incorporated into this SPD by reference. These Booklets, along with any amendments or attachments, may contain the following information (as applicable):

Additional procedures for enrolling in the Plan;

A summary of benefits, though this may be provided as a separate document;

A description of any premiums, deductibles, coinsurance or copayment amounts. The schedule of contributions, if any, to the premium payment will be provided by the Employer as a separate document;

A description of any annual or lifetime caps or other limits on benefits;

Whether and under what circumstances preventive services are covered;

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 insurance companies. A list of network providers can also be found on the insurance company's website, which is listed on 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 preauthorization or utilization review as a condition to obtaining a benefit service;

Provisions relating to termination of coverage;

A summary of the claim procedures. However, if the claims procedures are not included in the Booklet, a copy will be provided without charge from the insurance company;

Provisions describing the coordination of benefits under this Plan with the benefits provided under another similar plan in which the Participant or his/her spouse are enrolled;

Any subrogation or reimbursement rights of the insurance company that prevent duplicate payments for health care; and

Any other benefit limitations and exclusions.

General Information about the Plan

Plan Name:	Moravian College Employee Benefit Plan
Type of Plan:	Welfare plan providing medical, dental, vision, disability, and life benefits; The medical expense reimbursement plan and health flexible spending account plans are each described in separate plan documents and summary plan descriptions.
Plan Year:	January 1st through December 31st
Plan Number:	502
Effective Date:	January 1, 2010; This Plan has been amended and restated as of January 1, 2018
Plan Sponsor:	Moravian College 1200 Main Street Bethlehem, PA 18018
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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

Insurance premiums for employees and their families are paid by the Employer out of its general assets. Employees are required to contribute toward the premium on a pre-tax basis.

If the domestic partner is not a Qualifying Relative under Internal Revenue Code Section 152 requirements, then the portion of the employee's payroll contribution attributable to the domestic partner's coverage will be paid on a post-

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 order is found to be invalid, the parties may "cure" the deficiencies with a subsequent order.

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 Employee was married; or b) the same sex or opposite sex domestic partner of a Participant; or c) the Participant's or Participant's lawful spouse's or Participant's domestic partner's child(ren), including: 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

Eligible employees must enroll for coverage by filling out, signing and returning an enrollment form and/or salary reduction agreement. New employees must enroll within 30 days of eligibility or they will not be permitted to enroll until an annual enrollment period, if applicable, that is held each year, except as otherwise provided in the "Election Change" section below. Please read the Enrollment provisions of the applicable Booklet for more information about enrollment for each Component Benefit.

Except as otherwise provided in the FMLA, participation may be terminated by the Plan Administrator when notified that the Participant does not intend to return to work after the FMLA leave or at the end of the leave if the Participant does not return to work. However, coverage may be continued to comply with the Employer's leave of absence policies or if required by the American's with Disabilities Act.

Coverage will be reinstated following a military leave as required by USERRA.

COBRA Continuation

If a Participant's dental or vision coverage (and/or the coverage of any dependent) terminates because of a life event known as a "qualifying event," then the Participant and eligible family members may have the right to purchase continued coverage for a temporary period of time. Qualifying events include termination of employment (other than for gross misconduct), reduction in hours, divorce, death, a child ceasing to meet the definition of dependent, or the Participant's or spouse's eligibility for Medicare (Part A, Part B or both).

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has received timely notification 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 enrollment of the Participant in Medicare, the Employer musTBToymived

For additional information about COBRA continuation rights and for any questions about COBRA, please read the initial COBRA notice, a copy of which has been provided to each Participant and his/her covered spor6B/ re.

(10) There is a significant curtailment of coverage or an addition or significant improvement in a Component Benefits. The Employer in its sole discretion and applied on a consistent basis will determine whether there has been a significant curtailment (with or without loss of coverage) or an addition or significant improvement in a Component Benefit that entitles a Participant to make a corresponding election change. In the case of curtailment that results in a loss of coverage under any Component Benefit, the Employer may permit the Participant to withdraw from the Plan;

(11) There is a change made under another employer plan and the other plan allows an election change or the other employer plan has a different period of coverage.

An Employee/Participant may make a new election within 30 or 60 days of the occurrence of an event described in this section, as applicable (election changes for events listed under 4, 5, and 6 must be requested within 60 days and all others 30), but only if the election is made on account of and is consistent with the event and if the election is made within the specified time period.

Plan Notices

Benefits after Childbirth (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 requires group health plans, insurance companies, and HMO's that cover hospital stays following childbirth to provide coverage for a minimum period of time. In general, hospital coverage for the mother and newborn must be provided for a minimum of 48 hours following normal delivery, or 96 hours following a cesarean section. Group health plans may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-

Special Enrollment Rights

If an Employee declines enrollment for him/herself or his/her dependents (including spouse) because of other health insurance coverage, the Employee may in the future be able to enroll and enroll his/her dependents in this plan, provided that enrollment is requested within 30 days after the other coverage ends. In addition, if a Participant has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the Participant may be able to enroll and enroll his/her dependents, provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

Additional Information

Administration

The Employer is also the Plan Administrator. The Plan Administrator is charged with the administration of the Plan and has certain discretionary authority with respect to the administration of the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing certain procedures, such as those for Qualified Medical Child Support Orders and COBRA notice requirements, preparing and distributing information explaining the Plan to Participants and Dependents, furnishing annual reports with respect to the administration of the Plan, keeping reports of claims and disbursements for claims under the Plan, modifying elections under the Plan, promulgating election and claim forms, and preparing and filing reports to applicable governmental agencies.

However, for benefits under the Plan that are fully insured, the insurer has the ultimate discretion and authority to determine all questions of eligibility for participation and eligibility for payment of benefits, to determine the amount and manner of the payment of benefits and to otherwise construe and interpret the terms of the policy.

Claims Procedures

Each insurance company or claims administrator will decide claims and make claim payments in accordance with its reasonable claims procedures, as required by federal and any applicable state laws. A complete description of the insurance company's or claims administrator's claims procedures can be found in the Booklet or can be obtained from the company.

Amendment and Termination of the Plan

The Employer, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The insurance companies that provide benefits under the Plan may make changes to the Plan either as required by law, as requested by the Employer, or in their own discretion. However, no amendment or termination can retroactively diminish a participant's right to obtain Plan benefits.

No Contract of Employment

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

Privacy and Security

The Plan will use a Participant's or Dependent's PHI, in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), only to make required disclosures or for purposes related to treatment, Payment for healthcare, and the Healthcare Operations of the Plan or to make any other disclosures that are required by Law. However, if a Participant or Dependent requests to see the information or provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the request or the authorization.

With respect to PHI, the Employer will:

- Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
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Only specified employees of the Employer may be given access to PHI, and they may use and disclose PHI only for plan administration functions (which includes both Payment and Health Care Operations) that the Employer performs for the Plan. If any of these persons do not comply with the HIPAA provisions of this Plan Document, the Employer will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Definitions.

"Breach" means the unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by HIPAA privacy rules that compromises the security or privacy of the PHI.

"DHHS" means the federal Department of Health and Human Services.

"Electronic PHI" is health information about a plan participant that is in an electronic format. Health information includes information about the individual's past, present, or future physical or mental condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.

"Health Care Operations" means activities of the Plan related to its health care functions, including quality assessment, case management, care coordination, reviewing competence of health care professionals, evaluating provider performance, health plan performance, cost management, resolution of grievances, or any other related activities.

"Payment" includes all activities regarding the provision of benefits under the Plan.

"Protected Health Information" or "PHI" shall mean any individually identifiable health information in electronic, oral or written form that pertains to the past, present or future mental or physical condition of an individual. Protected Health Information is limited to the information created or received by the Covered Entity or its business associate on behalf of the Health Plans. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.

"Unsecured PHI" means PHI that is not secured through the use of a technology or methodology described in regulations to the HITECH Act or otherwise approved by the Secretary of the DHHS.

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.