Summary Plan Description of the Elizabethtown College Cafeteria Benefit Plan

General Information

WHAT IS THE PURPOSE OF THE PLAN?
The purpose of the Plan is to allow eligible employees to select the benefits that they want and to pay for their share of these benefits with pre-tax salary reductions.

WHAT BENEFITS ARE PROVIDED BY THE PLAN?
The plan includes a Health Care Flexible Spending Plan (also referred to as a Health FSA), a Dependent Care Assistance Plan (also referred to as the DCAP), and a premium payment component that allows you to pay your premium contributions for participation in the group medical, prescription, dental, vision, group term life plans as well as the health savings account (HSA) on a pre-tax basis.

WHAT IS THE HEALTH FSA?
The Health FSA allows employees to pay for eligible health care expenses on a pre-tax basis. The program is established under Internal Revenue Code § 105.

WHAT IS THE DCAP?
The DCAP permits an employee to pay for his or her qualifying Dependent Care Expenses with pre-tax dollars.

WHO CAN PARTICIPATE IN THE PLAN?
All regular employees of the Employer hired on or before January 1, 2015 and working an average of twenty (20) hours per week over the course of the academic year are eligible for coverage. Adjunct staff employees are not eligible for coverage.

All regular employees of the Employer hired after January 1, 2015 and working an average of thirty (30) hours per week over the course of the academic year are eligible for coverage. Adjunct staff employees are eligible for coverage.

Employees enrolled in an HSA cannot participate in the Health FSA.

HOW LONG MUST I WORK FOR ELIZABETHTOWN COLLEGE BEFORE I BECOME ELIGIBLE TO PARTICIPATE IN THE PLAN?
Employees of Elizabethtown College will be eligible to participate in the Plan upon date of hire.

HOW DO I ENROLL IN THIS PLAN?
To enroll in this Plan, you must first satisfy the eligibility requirements. Then, you must complete an enrollment form. Every year you will be asked to complete a new enrollment form in order to continue to participate in any of the benefits of the Plan.

You must complete and return your enrollment form to the Employer either within 30 days of becoming eligible to participate in the Plan or during an open enrollment period. If you become an employee after the effective date of this Plan, you are eligible to participate in this Plan as of the first day after you meet the eligibility requirements.

On the enrollment form, you will indicate the amount that you want to contribute to your Health FSA, DCAP, and HSA for the year, if any. The amount that you elect to contribute to your Health FSA, DCAP, and HSA, if any, along with your contributions for the group health plans will be deducted from your paycheck in equal installments on a pre-tax basis.

If you do not submit a new enrollment form during any open enrollment period, your enrollment in all of the benefits for the next Plan Year will be terminated.

WHEN DOES MY COVERAGE BECOME EFFECTIVE IN THE PLAN?
Coverage will become effective on the date that you meet all of the eligibility requirements and have completed an enrollment form, through which you elect to participate in any portion of the Plan.

IF I DO NOT ENROLL INITIALLY CAN I ENROLL LATER?
Yes. Each year the Elizabethtown College will sponsor one or more open enrollment periods during which you can elect to participate in the Health FSA, the DCAP, the HSA and/or any other plans offered by the Employer, for which you are required to contribute. Other than during an open enrollment period, you can only enroll in the Plan or make changes to the amount that you are contributing if you experience a qualifying life event.

Qualifying life events include:

- Marriage or divorce
- Death of a spouse or dependent
- Birth or adoption (or placement for adoption) of a child
- Change in dependent child's custody
- Any other event that changes the number of your dependents
- Change in employment status that causes a gain or loss of Plan eligibility
- Eligibility for Medicare, Medicaid or CHIP
- Loss of eligibility for Medicaid or CHIP coverage
- Determination of eligibility for Medicaid or CHIP premium assistance
- For the DCAP, employees may revoke or change their salary reduction elections if the employee experiences a change in dependent care provider or in dependent care provider cost for services.

Changes to participation and/or to contribution amounts during the plan year must be made on account of and consistent with the qualifying life event and must be made within 60 days of the event for changes due to loss of eligibility for Medicaid or CHIP or determination of eligibility for premium assistance under Medicaid or CHIP. For all other changes, enrollment must be made within 30 days.

Any deadlines for HIPAA special enrollment rights that would have taken place within the outbreak period (March 1, 2020 through sixty (60) days after the government lifts the national state of emergency) are tolled. Employees have thirty (30) or sixty (60) days to request a HIPAA special enrollment right starting sixty (60) days after the national state of emergency is lifted.

The Health FSA and/or DCAP may be revoked, decreased, made, or increased without experiencing an exception to irrevocability as described within the Plan Document and this Plan Summary.

WHAT IS THE MAXIMUM AMOUNT THAT I MAY CONTRIBUTE TO THIS PLAN?

The *Maximum Contribution* for the Health FSA is $2,850 per plan year. If both you and your spouse are employees of Elizabethtown College you can both contribute up to $2,850. The *Maximum Contribution* for the DCAP is $10,500 per plan year. However, if you are married and reside with your spouse, but you file a separate income tax return, then the maximum that you may elect is $5,250. (This maximum includes any amount contributed by both you and your spouse). Also, your contribution to the DCAP cannot exceed your or your spouse's earned income for the year.

IS THERE A MINIMUM CONTRIBUTION AMOUNT?

No. You may contribute as little as you wish to either the Health FSA or the DCAP to participate in that portion of the Plan.

WHAT HAPPENS WHEN AN EMPLOYEE'S HEALTH FSA FUNDS ARE NOT USED DURING THE PLAN YEAR?

Any unused funds remaining in an Employee's Health FSA at the end of the Plan Year and the claims submission period will be carried over to a maximum of $570.

HOW WILL CARRY OVER AMOUNT WORK?

All claims will be paid out of any balance remaining in your account from the prior Plan Year until that balance is used. This means that if you have an expense that was incurred during the prior year (but have not yet submitted it), and you submit a claim incurred during the current Plan Year, this claim will be paid out of last year's account balance. If you wait to submit a claim from the prior year, you may find that last year's Account balance has been spent and the claim is not eligible for payment using this year's funds.

WHAT HAPPENS TO ANY MONEY IN MY ACCOUNTS THAT I DON'T USE?

The IRS requires that you forfeit any unclaimed money in your Health FSA and DCAP at the end of each Plan Year or after termination of participation in the Plan. In addition, you may carry over up to $570 under the Health FSA for use in the next Plan Year. You can submit claims for up to 90 days after the end of the Plan Year or after your participation terminates.

Details of Health Care Flexible Spending Account

HOW DOES THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT WORK?

The Health FSA works like this:

- During enrollment, you specify how much you want to set aside from your paycheck each month up to the Maximum Contribution;
- This amount is deposited in your Health Care Account, though the account exists only as a paper record;
- When you have an eligible expense, you will submit a claim form or use your debit card and submit, when applicable, either an Explanation or Benefits from the insurance company or a detailed receipt from the provider to the Claims Administrator as verification of the expense;
- If the claim is eligible for reimbursement, the Claims Administrator will send you or the provider of services a check and subtract that amount from your balance (if submitting a paper claim) or, if using the debit card, the amount will be subtracted directly from your balance once the expense has been substantiated.

HOW DOES THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT SAVE ME MONEY?

You save money on your taxes. Your Health FSA contributions are deducted from your paycheck on a pre-tax basis. This means that you do not have to pay taxes on the money deducted from your pay.

The tax savings are reflected in your paycheck each month, all year.

The savings depend on your particular tax situation. You can look at Internal Revenue Service Publication 502 (www.IRS.gov) or consult your tax advisor for additional information.

WHOSE HEALTH CARE EXPENSES CAN BE REIMBURSED WITH THE MONEY IN MY HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

The health care expenses of the following individuals are eligible for reimbursement:

- An eligible employee of Elizabethtown College who participates in the Plan (once enrolled, an employee will be considered a "Participant");
- A Participant's spouse; and/or
- Any child (as defined in Internal Revenue Code §152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27 and any other individual who is a dependent as defined as in Code §152 , determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof and related IRS publications.

You may be asked to list each eligible dependent on the enrollment form.

WHAT EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER MY HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

To be eligible for reimbursement, health care expenses must meet the statutory requirements of IRC § 213d and be included on the list below.

However, Elizabethtown College is not providing tax advice. You are responsible for making sure that all expenses submitted for reimbursement are eligible.

Here are some of the requirements for expenses to be considered eligible:

- The expense must be incurred during the Plan Year, which is January 1st through December 31st. An expense is incurred when the care is provided rather than when you are billed or when you pay for the service. However, for orthodontia expenses, the Claims Administrator will determine the amount that can be reimbursed in any one Plan Year by taking the total charges billed and dividing this amount by the total time over which the services will be rendered. If a fee is paid at the start of orthodontic treatment to cover initial services performed, this can be reimbursed up front, with the remaining treatment cost pro-rated over the total length of treatment.
- The expense must be primarily for medical care.
- If you enroll in the Plan in the middle of a Plan Year, expenses incurred before your effective date are not eligible (This is also true for any dependents who are enrolled during a Plan Year).
- Any expenses incurred after your participation in the Plan ends are not eligible, though you will have 90 days after termination of your coverage to submit any expenses incurred during your participation. See the section on COBRA continuation for a discussion of extended coverage.

- The health care expense must not be eligible for reimbursement under any other health care plan.

Some expenses currently considered reimbursable by the IRS include:

- Prescription drugs, over-the-counter drugs, vaccines, doctor prescribed birth control pills;
- Services performed by medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, dermatologists, psychologists and physical therapists;
- Medical treatment including alcohol and substance abuse, hospital services, lab fees, legal abortion, organ transplants, in-vitro fertilization, x-rays for medical reasons, sterilization, vasectomy, insulin treatment and well-baby care;
- Medical equipment such as hearing aids, eyeglasses, contact lenses, braces, crutches, artificial limb, abdominal supports, back supports and orthopedic shoes;
- Menstrual products (tampons, pads, liners, cups, sponges, etc.); and
- Ambulance service, transportation costs essential to medical care.

Items not covered under this plan include:

- Expenses reimbursed through any other insurance plan;
- Health care premiums; and
- Treatments or drugs for cosmetic purposes.

Details of the DCAP

HOW DOES THE DCAP WORK?

The DCAP works like this:

- During enrollment, you may specify how much you want to set aside from each paycheck up to the Maximum Contribution;
- This amount is withheld from your pay in equal installments;
- When you have an eligible expense, you will submit a claim form to the Claims Administrator, along with paperwork to substantiate the expense;
- The Claims Administrator will send you a reimbursement check to the extent that the claim has been substantiated and funds are available. The amount of funds available will be based on how much has been withheld from your pay and how much has been previously reimbursed.

HOW DOES THE DCAP SAVE ME MONEY?

You save money on both federal income tax and FICA (Social Security) taxes by participating in the Plan. Your contributions to your DCAP are made on a pre-tax basis.

WHOSE DEPENDENT CARE EXPENSES CAN BE REIMBURSED WITH THE MONEY IN MY DCAP?

Each dependent, considered a qualifying dependent, for whom you incur reimbursable expenses must be:

- A person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child is your dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
- Your spouse or a person who is your dependent under federal tax law (whether or not you are entitled to claim the dependency), but only if he or she is physically or mentally incapable of self-care.

WHAT EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT UNDER MY DCAP?

Dependent Care Expenses mean employment-related expenses incurred on behalf of any dependent under federal tax law who meets the requirements to be a qualifying dependent as described in this Summary Plan Description.

Dependent Care Expenses must also meet the following requirements:

- The expenses must be incurred after the date of election to receive Dependent Care benefits and during the Plan Year to which the election applies. A Dependent Care Expense is incurred when the service that gives rise to the expenses is provided, regardless of when the expenses is billed or paid. A childcare expense is not incurred until the end of the period for which you have paid.
- The expenses must have been incurred to enable you (and your spouse, if you are married) to be gainfully employed, which generally means working or looking for work. (Exception – if your spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care).
- You (or you and your spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a qualifying dependent.

- The expenses are incurred for the care of a qualifying dependent or for household services attributable in part to the care of a qualifying dependent.
- If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13 who is your dependent under federal tax law; or (2) your spouse or a person who is your dependent under federal tax law and who is physically or mentally incapable or self-care, and regularly spends at least eight hours per day in your household. You must provide over 50% of the dependent's financial support.
- If the expenses are incurred for services provided by a dependent care facility, the center complies with all applicable state and local laws and regulations and is licensed to care for more than 6 children at a time.
- The person who provided care was not your spouse or a person for whom you are entitled to a personal exemption under Code § 151(c). If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The care cannot be provided at a nursing home facility.
- The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

You can get more information about what items are and are not deductible Dependent Care Expenses in IRS Publication 503.

Reimbursement Information

HOW DO I FILE CLAIMS FOR REIMBURSEMENT?
You can get a copy of the claim forms from the Employer or Claims Administrator. The Claims Administrator may have additional rules that you will be required to follow when submitting a claim. You have until 90 days after the end of any Plan Year or within 90 days after termination of your participation to submit a claim.

For the Health FSA you must include a copy of the health plan Explanation of Benefits with your claim. If you did not submit the claim for reimbursement, you are permitted to submit a copy of a detailed bill or receipt. You will have access to the total amount that you elected for the Plan Year as soon as any eligible expenses are incurred.

For the DCAP, you must include written statements and/or bills from independent third parties stating that the dependent care expenses have been incurred, and the amount of such dependent care expenses, along with your claim form. You will be reimbursed for dependent care expenses only to the extent that you have the money available in your dependent care account.

Claims for both Accounts can be submitted up to 90 days after the end of the Plan Year – for expenses incurred during that Plan Year. Claims following termination of your participation in the Plan must be submitted within 90 days of termination.

You must certify on the claim form that your expenses are eligible under the Plan.

WHEN CAN I EXPECT MY REIMBURSEMENT?
All claims will be processed and paid (if eligible under the Plan) within 30 days of receipt of a completed reimbursement form. However, the Claims Administrator may request a 15-day extension for matters beyond its control.

WHAT HAPPENS IF MY CLAIM IS DENIED?
If your claim is denied because it is incomplete, the Claims Administrator will provide you with a description of any additional material or information necessary and an explanation of why this material or information is necessary. This notice will be provided within 5 days of receipt of the claim.

After receipt of all the information needed to review a claim, if any claim for benefits under the Plan is wholly or partially denied, the Claims Administrator will give notice in writing of the denial within 30 days after the claim is filed. This notice will include the following information:
- The specific reason or reasons for the denial;
- Specific reference to the Plan provision, internal rule, guideline, protocol or similar criteria on which the denial is based;
- An explanation that a full and fair review by a claim review committee of the decision denying the claim may be requested within 180 days after the notice of denial has been received.

If you request a review of the claim denial, you may review pertinent documents and submit issues and comments in writing. The decision of the Claims Administrator on review will be made promptly, but not later than 30 days after receipt of the request for review, unless special circumstances require an extension of time for processing. The decision on review will be made in writing and will include specific reasons for the denial, written in a manner that you can understand and will include references to the Plan provisions on which the denial is based.

For the calendar year 2020, appeals are paused beginning March 1, 2020 and will continue starting sixty (60) days after the national emergency status is lifted.

IF THE CLAIMS ADMINISTRATOR APPROVES AND PAYS MY CLAIM DOES THIS MEAN THAT THE AMOUNT OF THE CLAIM IS NOT SUBJECT TO TAXATION?
No. It is your responsibility to make sure that expenses you submit for reimbursement are eligible under the IRS regulations. You are responsible for taxes and penalties associated with any ineligible expenses if the IRS audits you.

Other Information

WHAT HAPPENS TO MY ACCOUNT BALANCES IF I LOSE COVERAGE UNDER THE PLAN?
If you lose coverage under the Plan, you will lose any amount remaining in your Health FSA and DCAP, except for any money that is reimbursed for a claim that is submitted within 90 days of termination, but which was incurred while you were still covered by the Plan. If you resume employment with Elizabethtown College within 30 days, your Plan elections will be automatically reinstated.

WHAT HAPPENS TO MY ACCOUNT BALANCES IF I AM DISABLED AND/OR ON A LEAVE OF ABSENCE?
If you are not working for a period of time, your account will remain in force, but you will need to continue to pay your contributions, either on a post tax basis or on a pre-tax basis prior to or after the leave. You will need to determine how you will make these payments prior to the leave.

If you take a paid leave of absence, your contributions will continue to be made to the plan.

WHAT HAPPENS TO MY ACCOUNT BALANCES IF I DIE?
If you die while you are actively employed, your spouse or estate can file claims for eligible expenses incurred while you were still alive. Your spouse and dependents will also have the opportunity to elect COBRA for the Health FSA as described below. Claims can be submitted until 90 days after the end of the Plan Year in which you die.

CAN I ELECT COBRA IF I LOSE COVERAGE UNDER THIS PLAN?
You may elect to continue your coverage under the Health FSA up until the end of the current Plan Year after you are no longer employed by Elizabethtown College or otherwise lose coverage because of a "qualifying event". You will need to follow the procedures set forth in the Notice that you will receive when your participation ends. Coverage will continue only if you make direct, after-tax payments to your Health FSA through the end of the Plan Year.

Qualifying events include termination of employment, reduction in hours, divorce, death, or a child ceasing to meet the definition of dependent. A Participant or dependent who is covered under the Plan must notify the Administrator of any divorce, legal separation, or a child ceasing to be considered a Dependent under the Plan within 60 days after the event. This notice must be in writing and addressed to the Administrator. In addition, if a second qualifying event occurs during COBRA continuation coverage or if the former Employee becomes entitled to Medicare or dies during the COBRA coverage, the Participant or Dependent must notify the Administrator. Finally, a Participant must notify the Administrator of the start or end of any disability that is determined under the Social Security Act to be a covered disability.
The Administrator will provide Participants and Dependents with the forms needed to make the required notifications.

Any notice described in the above paragraph must be provided in writing to the Administrator within 60 days of the occurrence of the applicable event (except that if there is a change in the Participant's disability status, notice must be given within 30 days). If the Participant or dependent fails to provide notice within the required time period, he or she may no longer be eligible for COBRA continuation coverage. In this event, the Administrator may send Notice of Unavailability of COBRA Coverage upon receipt of the late notice.

If you have any questions about your COBRA rights, please read the COBRA notice, which has been provided to you and your spouse (if covered) at the time of your enrollment in the Plan. You can contact the Administrator if you need another copy.

HOW LONG WILL THE PLAN REMAIN IN EFFECT?
Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax law may require that the Plan be amended accordingly.

WHAT IF I HAVE A PROBLEM OR QUESTION?
If you have a question or problem, please call the Employer at (717) 361-1406. You can also request a copy of the Plan Document which contains more information about the Plan.

Supplemental Plan Information:

Plan Name:		Elizabethtown College Benefit Welfare Plan
Type of Plan:		Cafeteria benefit plan
Plan Year:		January 1st – December 31st
Grace Period:		None
Carry-forward Amount:		$570 for Health FSA only
Plan Number:		501
Effective Date:		January 1, 1992; The Plan has been amended and restated as of January 1, 2022
Plan Sponsor:		Elizabethtown College One Alpha Drive Elizabethtown, PA 17022 (717) 361-1406
Name and Address of Other Participating Related Employers:		None
Plan Sponsor's Employer Identification number:		23-1352632
Plan Administrator:		Elizabethtown College One Alpha Drive Elizabethtown, PA 17022 (717) 361-1406
Claims Administrator		Benecon CDH Services P.O. Box 5406 Lancaster, PA 17606-5406 (833) 738-6729
Named Fiduciary:		Elizabethtown College One Alpha Drive Elizabethtown, PA 17022 Attention: Richelyn Penn Mekile (717) 361-1406
Agent for Service of Legal Process:		Elizabethtown College One Alpha Drive Elizabethtown, PA 17022 Attention: Richelyn Penn Mekile (717) 361-1406

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 Employee Benefits Security 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 with a copy of this summary annual report.

Continue Group Health Plan Coverage
During any plan year in which the Employer is subject to COBRA, you are entitled to 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. You are also entitled to review this summary plan description and the documents 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union (if any), 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 Participant's 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 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 that 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 Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.