Summary Plan Description

For the

Sarah Lawrence College Wrap Welfare Benefits Plan

Effective as of January 1, 2011

This document together with the Certificates of Coverage or the Component Benefit Plans and other documents identified in this document constitutes the Summary Plan Description.

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SARAH LAWRENCE COLLEGE WRAP WELFARE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION

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Introduction

Sarah Lawrence College (the "Employer") has established the Sarah Lawrence College Wrap Welfare Benefits Plan (the "Plan"). The Plan's purpose is to consolidate in one plan document certain provisions of welfare benefit plans (the "Component Benefit Plans") sponsored by the Employer and its affiliated employers, and to provide uniform administration of such welfare benefits. The Component Benefit Plans are listed in **Appendix A** to this Summary Plan Description. This Summary Plan Description ("SPD") is effective January 1, 2011. Presently, there are no controlled group entities of the Employer that have employees participating in the Plan. Participating controlled group entities may be added or changed from time to time.

The insurance contracts, summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are not affected by the adoption of the Plan and the terms of the Component Benefit Plans will continue to control for purposes of determining your benefits. (References in this document to insurance contracts, insurance policies and insurance generally will include any HMO contract or similar arrangement.) The terms of each Component Benefit Plan are incorporated into this Summary Plan Description by reference and will continue to act as the primary source of information for each Component Benefit Plan. Where a conflict of language exists between the Component Benefit Plan and this SPD, the Component Benefit Plan will control to the extent such Component Benefit Plan is not inconsistent with Federal law and regulations.

Note: This material summarizes the legal document that governs the Plan. Every effort has been made to accurately describe the Plan in this Summary. However, if there should be a discrepancy between this Summary and the Plan document -- or if the Plan is required to operate in a different manner to comply with Federal laws and regulations -- the Plan document or the appropriate Federal laws and regulations will control.

General Information Pertaining to the Plan

Plan Name, Sponsor and Employer EIN

The name of the Plan is Sarah Lawrence College Wrap Welfare Benefits Plan. Sarah Lawrence College is the Plan Sponsor. The Employer's address is 1 Mead Way, Bronxville, New York, 10708. The Employer's telephone number is (914) 337-0700. You may wish to ask for a representative in the Human Resources department. The Employer's Federal employer identification number (EIN) is 23-7223216.

Plan Year

For recordkeeping purposes, the Plan Year for the Plan is the 12 month period beginning on January 1 and ending December 31. For this purpose, the Plan Year identified herein overrides any Plan Year reference in any other documents inconsistent herewith.

Plan Number

Each ERISA plan maintained by the Employer is issued a plan number for reporting purposes. The number of this Plan is 521.

Type of Welfare Benefit Plan(s)

The Plan may provide various welfare benefits under the Component Benefit Plan(s) listed in **Appendix A** to this Summary Plan Description.

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Funding

Benefits under the Plan are funded by one or more of the following methods selected by the Employer for a Component Benefit Plan: insured benefits, self-funded benefits (these are benefits funded by general assets of the Employer) or through a trust, or a combination of insured benefits, self-funded benefits and trust benefits. For specifics on the funding status of Component Benefit Plans, see **Appendix A.** Funding for the Plan shall consist of the sum of the funding for all Component Benefit Plans and may include funding through a cafeteria plan which, if available, is identified in **Appendix A.**

The Employer has the right to pay benefits from its general assets, insure any benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as the Employer deems advisable. In addition, the Employer has the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance company. To the extent funds are transferred to or accumulated in a trust to provide any benefit, that benefit will be payable from the assets of such trust.

Insurance Company Refund

With respect to any insurance company refund received by the Employer, such amount will be refunded to current employees in the same ratio that their contributions bear to the total cost of the applicable Component Benefit Plan at the time of distribution ("Contribution Ratio") with the balance being retained by the Employer. If such refund is not practicable such refund shall be used to reduce future employee contributions (if any) on a prorata basis consistent with the Contribution Ratio (which distribution shall not exceed 90 days of the refund).

Plan Administrator

The Plan Administrator is Sarah Lawrence College, 1 Mead Way, Bronxville, New York, 10708, telephone number (914) 337-0700, which, with respect to insured benefits offered through the Plan, shares the responsibility for administering the Component Benefit Plans with the insurance companies providing benefits under the Component Benefit Plans as named fiduciaries. The insurance companies shown in **Appendix A** to this document are responsible for considering, accepting or denying, and paying claims with respect to the insured benefits. The applicable insurance company is responsible for considering any appeals with respect to the insured benefits made pursuant to a Component Benefit Plan's claim procedures and, to the extent applicable, the claim procedures set forth in this Plan. Any third-party administrator responsible for administering a Component Benefit Plan not funded through insurance is listed separately in **Appendix A**. In addition, if a party has accepted named fiduciary status in considering, accepting or denying, and paying claims (including any appeals relating to such claims, such party is identified in **Appendix A**.)

Agent for Service of Legal Process

The agent for service of legal process is Sarah Lawrence College, 1 Mead Way, Bronxville, New York, 10708. Service may also be made on the Plan Administrator and on a Trustee (if any) serving with respect to a Component Benefit Plan. The name, title and business address of each Plan Trustee of any Trustee funded Plan are listed in **Appendix A**.

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Named Fiduciary

The Plan Administrator is the named fiduciary of the Plan and has the exclusive and express discretionary authority to interpret the terms of the Plan and the terms of all the Component Benefit Plans to the extent not delegated to another named fiduciary. With respect to the determination of the amount of, and entitlement to, insured benefits under any Component Benefit Plan, however, the respective insurance company is also a named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance policy.

Plan Document

The Plan and those documents incorporated by reference constitute a written employee benefit welfare plan as defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Coverage for Spouses and Dependents

One or more Component Benefit Plans provide coverage for spouses and dependents. The provisions relating to such coverage should be detailed in the Certificates (Evidences) of Coverage or other Component Benefit Plan documents.

Coverage for Domestic Partners

One or more Component Benefit Plans also provide coverage for domestic partners under certain circumstances. The provisions relating to such coverage should be detailed in the Certificates (Evidences) of Coverage or other Component Benefit Plan documents. A Participant should inquire at the time of enrollment elections as to information necessary to apply for such coverage, including any affidavit and/or other documentation required by the Employer. Contact the Plan Administrator if you have questions.

No Guarantee of Non-Taxability

The Plan provides benefits intended to be non-taxable; however, the Plan Administrator or any fiduciary or party associated with the Plan shall not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

Eligibility, Participation and Benefits

Eligibility and Participation

Eligibility for participation and benefits under the Plan is determined under the written terms of each Component Benefit Plan. See a summary of more information regarding eligibility and participation in **Appendix A**.

Contributions

The cost of the benefits provided through the Component Benefit Plans may be funded in part by Employer contributions and in part by employee contributions. In some instances, a Component Benefit Plan may require only the Employer or the employee to contribute. If specified in **Appendix A,** the cost of benefits provided through a Component Benefit Plan may be funded pre-tax through a cafeteria plan under Section 125 of the Internal Revenue Code. The sources of Plan contributions are listed in **Appendix A**. The Employer will determine and periodically communicate the employee's share of the cost of the benefits provided through each Component Benefit Plan, and it may change that determination at any time. The Employer will make its contributions in an amount that in the Employer's sole discretion is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee

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contributions. The Employer will pay its contribution and employee contributions to an insurance company or, with respect to benefits that are self-funded, will use these contributions to pay benefits directly to or on behalf of employees or their eligible family members from the Employer's general assets. Employee contributions will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit. Where relevant to a Component Benefit Plan, an employee will receive, during the open enrollment period, notice of the amount for which the employee is responsible adjusted, if necessary, during the Plan Year for the applicable Component Benefit Plan.

The Plan Administrator will have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment.

Benefits Available

The benefits available under the Plan consist of the benefits available under the Component Benefit Plans, including all limitations and exclusions with respect to each Component Benefit Plan's benefits. The benefits available under each Component Benefit Plan are set forth in the Component Benefit Plan documents. The availability of benefits is subject to payment by the Participant of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Component Benefit Plan. Any flexible spending account ("FSA") under the cafeteria plan will be subject to this Plan and the requirements of ERISA. Nonetheless, such cafeteria plan (and any dependent care assistance plan offered under the plan) will not be subject to the requirements of ERISA, even though the cafeteria plan (and any dependent care assistance plan) may be considered part the Plan.

Loss of Benefits

Your benefits (and the benefits of your eligible family members) generally will cease when your participation in the Plan terminates. Benefits will also cease upon termination of the Plan. Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied under the medical or dental benefit programs if you have a preexisting condition and incur costs within the exclusionary period under each Component Benefit Plan. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable Attachments identified in **Appendix A** provide additional information.

Benefit Elections

Electing Your Benefits for the Plan Year under a Component Benefit Plan

Some of the Component Benefit Plans require that you make an annual election to enroll for coverage for the next Plan Year prior to the beginning of that year. The Plan Year for each Component Benefit Plan should be set forth in such plan and may be different than the Plan Year for this Plan.

If you first become eligible to participate in the Plan during a Plan Year in progress, your initial elections pertain to the remaining part of that Plan Year. Then, before each new Plan Year begins, you will have an opportunity to change or cancel your elections during the annual election period. The annual election period is described below.

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Making Your Elections

In making your elections, you may elect and enroll for some or all of the benefits available under a Component Benefit Plan. You may also elect not to participate in a Component Benefit Plan for which annual elections are then being made.

Benefits are elected by completing and submitting an election form before the end of the annual election period. When you make your elections, you also authorize the necessary salary reductions for paying your part of the cost of the benefits you elect.

Once you are a Participant in the Plan, if you become eligible for additional benefits during a Plan Year, you will be given an opportunity to elect and enroll for the benefits for which you are newly eligible. Also, if the cost of the benefits changes during the Plan Year, the amount of your salary reduction contributions will be automatically adjusted.

Annual Election Period

Before the beginning of each Plan Year, the Employer will hold an annual election period. The Employer will notify you when the dates for the annual election period will occur each year. During this time, you may make new elections for the upcoming Plan Year.

Changing Your Elections during a Plan Year

Where a Component Benefit Plan is funded through a cafeteria plan, once you have made your elections for a Plan Year, it pertains to the entire Plan Year as it applies to that Component Benefit Plan and cannot be changed or cancelled during that time except in certain limited situations, which are described in the cafeteria plan. Other election restrictions may apply to component benefit plans. For example, if you elect not to participate in the health plan when first eligible, you may need to wait until an open enrollment period as specified in the Component Benefit Plan.

Claims Procedures

Benefits Administered by Insurers and TPAs

Claims for benefits that are insured or administered by a third party administrator shall be filed in accordance with the specific procedures contained in the insurance policies, Component Benefit Plans or the third party administrative services agreement. These procedures will be followed unless inconsistent with the requirements of ERISA as specified in more detail below. The address of the individual insurance company providing benefits and/or third party administrator (if any) that reviews claims made under a Component Benefit Plan is set forth in **Appendix A**. All other general claims or requests should be directed to the Plan Administrator.

General Claims Procedure

The Plan's claims procedures are described below. (These claims procedures do not apply to any cafeteria plan (which is a premium-only plan ("POP")) or any dependent care assistance plan offered thereunder.)

The following procedures will be followed for denied claims under a Component Benefit Plan that is not a group health plan or long-term disability plan.

(a) If your claim is denied, you or your beneficiary will receive written notification within 90 days after your claim was submitted. The notification will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Plan on which the denial was based, a description of any additional information needed to process the claim, and an

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explanation of the claims review procedure. If you do not receive a response within 90 days, your claim is treated as denied.

(b) Within 60 days after notification of a claim denial, you may appeal the denial by submitting a written request for reconsideration of the claim to the Plan Administrator. Documents or records in support of your appeal should accompany any such request. The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator. The Plan Administrator's response will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based. The Plan Administrator (or the applicable insurance company that has accepted its fiduciary responsibility to make claim determinations with respect to the applicable insured plan) has the exclusive and discretionary right to interpret the appropriate plan provisions. Decisions of the Plan Administrator (or insurance company or other party accepting claims responsibility) are conclusive and binding.

Special Rules for Group Health Plan Claims

For purposes of ERISA, there are three categories of claims under a Component Benefit Plan that is a group health plan and each one has a specific timetable for approval, payment, request for additional information, or denial of the claim. The three categories of claims are:

Urgent Care Claim is a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition may determine if a claim is an Urgent Care claim.

Pre-Service Claim is a claim for which you are required to get advance approval or pre-certification before obtaining service or treatment for the medical services.

Post-Service Claim is a request for payment for covered services you have already received.

(a) Time for Decision on a Claim. The time deadline for making decisions on claims under the Plan depends on the urgency of the claim. You will be notified of any determination on your claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, you will be notified orally and written notice will be provided to you within three days. The deadlines shown on the "Timeline for Group Health Care Claims" chart below are maximum time limits.

(b) Notification of Denial. Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, you will receive written notice if your claim is denied. The notice will contain the following information:

(i) the specific reason or reasons for the adverse determination;

(ii) reference to the specific Plan provisions on which the determination was made;

(iii) a description of any additional material or information necessary to perfect your claim and an explanation of why such material or information is necessary;

(iv) a description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of your right to bring a civil action under ERISA section 502 if your claim is denied on review;

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(v) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim;

(vi) if an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided to you free of charge upon request;

(vii) if the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such decision is based, or a statement that such explanation will be provided free of charge upon request of such person or persons) who conducted the initial claim determination. The Plan fiduciary will provide an independent full and fair review of your claim and shall not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

(c) How to Appeal a Denied Group Health Plan Claim. If your claim is denied, you (or your attorney or other person authorized by you act on your behalf) will have 180 days following the date you receive written notice of the denial in which to appeal your claim. A failure to timely file an appeal request will constitute a waiver of your right to request a review of the denial of your claim. Unless you are appealing the denial of an Urgent Care Claim, your request for review should be made in writing. If you are requesting review of an Urgent Care Claim, you may request review orally or by facsimile. A request for review should contain your name and address, the date you received notice your claim was denied, and your reason(s) for disputing the denial. You may submit written comments, documents, records, and other information relating to your claim. If you request, you will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Plan to review your appeal request and to notify you of its decision depends on the type of claim as follows:

Urgent Care Claim – 72 hours; you will be notified orally and written notice will be provided within three days.

Pre-Service Claim – 15 days.

Post-Service Claim – 30 days.

The review will take into account all comments, documents, records, and other information you submit relating to your claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. The Plan fiduciary will provide an independent full and fair review of your claim and shall not give any deference or weight to the initial adverse determination. You will receive a written notice of the decision on review.

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Timetable for Group Health Plan Claims

Time Limit	Urgent Care	Pre-Service	Post-Service
To make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days
For claimant to request extension of course of treatment	24 hours*	15 days*	N/A

*before expiration of previously approved course of treatment

Special Rules for Disability Claims

A disability claim is a claim that requires the Plan to determine if you are disabled for purposes of eligibility for disability benefits under a Component Benefit Plans. The Plan will notify you of its determination within 45 days after its receipt of your claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. You may appeal the Plan's determination within 180 days following receipt of an adverse determination. The Plan will notify you of its determination on review within 45 days and in accordance with the procedures set forth in paragraph (b) under the heading "General Claims Procedure."

Coverage While on Leave of Absence

Family and Medical Leave Act Coverage

The Family and Medical Leave Act ("FMLA") of 1993 generally applies to employers with 50 or more employees. Where applicable it provides certain rights and options relating to your health plan coverage. Generally, this law requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. Such family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's spouse, child or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform the employee's job.

In 2008 the FMLA was expanded regarding an eligible employee's parents or immediate family members being called to active military duty status or in active military duty: first, the events for triggering family leave now include "qualifying exigencies" of covered service members. (See your Employer for details.) Second, with respect to care for covered service members with a serious injury or illness, eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period.

If you are eligible and chose to take FMLA leave, your employer must maintain your health coverage under any "group health plan" on the same terms as if you had continued to work. Any changes to the

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group health plan during the time you are on FMLA leave apply to you. Your employer must also provide you with notice of any opportunity to change plans or benefits during your FMLA leave period.

Depending on your payment of plan premiums, you may be required to continue to pay premiums during FMLA leave. If you are 30 or more days late in making payment and your employer has given you written notice at least 15 days in advance advising that coverage will cease if payment is not received, you are no longer covered, but upon your return to employment, the employer is required to restore your coverage. However, if you take FMLA leave and do not return to work after leave for a reason other than medical necessity, then you may required to reimburse your employer for the payments made for your coverage during your leave.

You have the right to choose not to retain health coverage during FMLA leave. Upon return from FMLA leave, most employees must still be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of your leave. In addition, your employer cannot require you to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

If you drop health coverage during your FMLA leave, any days without health coverage while on leave will not count toward a 63-day break in coverage relating to another health plan. In addition, if you do not return from leave, the 30-day period to request special enrollment in another plan will not start before your FMLA leave ends. Therefore, if you apply for other health coverage, you should tell your plan administrator or health insurer about any prior FMLA leave.

Coverage provided under FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an Employer's obligation to maintain health benefits under FMLA ceases, such as if you notify the Employer of your intent not to return to work.

Military Service Leave (USERRA Coverage)

Any Participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), shall continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations.

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service begins, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

1) You fail to make a premium payment within the required time;

2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or

3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision

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run concurrently with coverage described below under the section entitled "Other Continuation/Conversion Privilege."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, you coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

Federal Rights of Individuals under Health Plans

Benefits for Adopted Children

If the group health plan provides coverage for dependent children, the Employer group health plan will extend benefits to dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of Participants.

Children's Health Insurance Program Reconciliation Act

The Children's Health Insurance Program ("CHIP") was created in 1997 to provide affordable health coverage to certain individuals and their dependents who are not eligible for Medicaid yet cannot get private coverage. In 2009, CHIP was renewed through the end of 2013 and its scope was expanded. In the case of group health plans, an amendment to CHIP designated "CHIPRA" allows states to subsidize premiums for employer-provided group health coverage for eligible employees and their dependents. It also allows for a special enrollment period under group health plans in case of termination of Medicaid or CHIP coverage. Each state in which an employee resides will choose whether it will implement this optional subsidy.

Generally, if you are eligible, you may be able to enroll in the employer's group health plan within 60 days of losing coverage under the Medicaid or CHIP plan or within 60 days of becoming eligible for premium assistance under the Medicaid or CHIP plan. Find out if your state has CHIP and/or Medicaid available, and speak with your Plan Administrator for further details. Attached, as **Appendix B,** is a chart with more contact information.

COBRA Rights

Employers who employ 20 or more employees are subject to the group health plan continuation provisions of Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Generally, where COBRA applies, if you or your eligible family members' group health plan coverage ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then you or your eligible family members may have the right to purchase continuation coverage for a temporary period of time.

Genetic Information Nondiscrimination Act

In 2009, the Genetic Information Nondiscrimination Act ("GINA") was passed by the Congress. It states that health benefit plans may not discriminate on the basis of genetic information with respect to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by an employer, health plan, or "business associate" of the employer. One exception to this rule is that

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a minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

You should be aware that where GINA applies genetic information is treated as protected health information ("PHI") under another federal law called "HIPAA". The plan must provide that an employer cannot request or require that you reveal whether you have had genetic testing. Neither can your employer require you to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums.

HIPAA Privacy Rule

Information you provide for purposes of a health plan sponsored by the Employer may be PHI under Privacy Standards established under the Health Insurance Portability and Accountability Act ("HIPAA"). Where HIPAA applies, such plan will be operated in accordance with such law and laws that affect this law such as GINA, which makes it clear that genetic information is also PHI. Your HIPAA privacy rights are described in a notice set forth in **Appendix C**. If you have questions about this law, you should contact the Plan Administrator.

Mental Health Parity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") generally applies to employers that employ 50 or more employees and its health plan provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.) These group health plans must cover mental health and substance abuse services in a manner equal to their coverage of predominant medical and surgical services.

Financial and treatment limits for mental health/substance abuse, such as deductibles, co-payments, co-insurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars, scope, or duration of treatment may not be substantially more limited than for medical/surgical benefits provided. For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

Michelle's Law

Many health plans extend health benefits of an employee where they have dependent full-time college students under a certain age. In such a case, a certification of student status may be required by your employer for continued coverage under the heath plan. Due to a recent law known as Michelle's Law, group health plans must provide extended coverage to dependents of any Participant who as full-time students in postsecondary educational institutions would otherwise lose coverage because of taking medically necessary leave due to a serious illness or injury.

If you have a dependent who is a full-time student with a serious illness or injury, that dependent may be eligible for protection until Michelle's Law. Your employer may require you to provide written certification of the condition from the child's treating physician in order for your child to be eligible.

If your child is deemed eligible under Michelle's Law, extension of coverage is required for up to 12 months or, if earlier, the date the coverage would otherwise end under the Component Benefit Plan.

Newborns' and Mothers' Health Protection Act

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child

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to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such 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 the above periods.

Qualified Medical Child Support Orders

The Employer's group health plans will provide benefits as required by any qualified medical child support order ("QMCSO"), in accordance with ERISA. The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage in a manner determined in consultation with the attending physician and the patient for (a) all stages of reconstruction of the breast on which the mastectomy was performed; (b) surgery and reconstruction of the other breast to provide symmetrical appearance; (c) prostheses; and (d) treatment of physical complications of the mastectomy, including lymphedema. Where this law applies, these benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the applicable Component Benefit Plan identified in **Appendix A.** Call your Plan Administrator for more information.

Employer's Rights under the Plan

Employer's Right to Change or End the Plan

The Employer reserves the right to terminate, suspend, withdraw, amend or modify the Plan, or any Component Benefit Plan, in whole or in part at any time.

Employer's Right to Interpret the Plan

The Employer has the right to appoint the Plan Administrator of the Plan. The Plan Administrator has discretion to interpret the provisions of the Plan and any Component Benefit Plan. The Plan Administrator's interpretations and decisions are conclusive and binding on all Plan Participants.

Other Continuation / Conversion Privilege

You may be eligible for continuation of coverage under a COBRA-type continuation of coverage arrangement mandated in the state to which your coverage applies (for example, California, New York, etc.). The availability of this continuation coverage and the rules concerning eligibility should be set forth in the policy of the insurance company allowing the continuation of coverage. Since the time period for exercising your right to elect continuation of coverage may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under this plan.

Also, when you are no longer eligible under the Plan, (either as an active Participant or as a qualified beneficiary receiving continuation coverage) you may be eligible to obtain an individual conversion policy for

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one or more of your insured benefits. The availability of this conversion coverage and the rules concerning your eligibility should be set forth in the policy of the insurance company allowing the conversion privilege. Since the time period for exercising your conversion privileges may be limited, you should inquire with your applicable insurance company as soon as possible once you are no longer eligible for a component benefit under this plan.

ERISA Rights

You are entitled to certain rights and protections under ERISA. ERISA provides that Plan Participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including any applicable insurance contracts 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 any applicable insurance contracts, 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 (Form 5500), if any is required by ERISA to be prepared. Where the annual financial report must be prepared, 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 or your 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 the Summary Plan Description and the documents governing the group health plans for the rules governing your COBRA continuation coverage rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plans, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under a plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 or any other person, may fire you or otherwise discriminate against you in any way to

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prevent you from obtaining health benefits or exercising your rights under ERISA.

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 (Form 5500), if any is required to be prepared, 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 you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed under the heading Claims Procedure), 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 qualified domestic relations order or 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 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.

If you have any questions about your benefits or the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 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.

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Appendix A: Component Benefit Plans

The information below is effective January 1, 2011, unless otherwise indicated below.

Component Benefit Plans Offered Under the Plan

Below is a list of each Component Benefit Plan and the eligibility and participation requirements of those plans. Also listed is the name of the Insurance Company or Administrator that processes claims, the address for filing claims and the telephone number to call for questions regarding claims procedures and forms.

Generally, unless otherwise indicated below, an eligible Employee with respect to the Plan is any regular common-law employee of the Employer who is not a leased employee or a temporary employee and is eligible to participate in and receive benefits under one or more of the Component Benefit Plans. Student employees are excluded from all Component Benefit Plans. To determine whether an Employee is eligible to participate in a Component Benefit Plan, please read the eligibility information below for the applicable Component Benefit Plan.

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Health (EPO) (Aetna) **(Attachment 1)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employer and Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Health (PPO) (Aetna) **(Attachment 2)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employer and Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Dental (Freedom of Choice - DMO) (Aetna) **(Attachment 3A)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Dental (Freedom of Choice – PPO) (Aetna) **(Attachment 3B)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Dental (Freedom of Choice – Comprehensive) (Aetna) **(Attachment 3C)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Dental (PPO) (Aetna) **(Attachment 3D)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Dental (Freedom of Choice – DMO New Jersey) (Aetna) **(Attachment 3E)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Vision (VSP) **(Attachment 4)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employee	1st day of the month coinciding with or following date of hire Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Life (with AD&D) (Hartford) **(Attachment 5)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year Phased Retirement employees: tenured faculty member age 62 or older with 10 or more years of service with Sarah Lawrence College	Employer	1st day of the month coinciding with or following 3 months of employment Phased Retirement employees: when Phased Retirement begins	End of month following date employment with eligible status ends
Long-term Disability (Hartford) **(Attachment 6)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year	Employer	1st day of the month coinciding with or following 3 months of employment	End of month following date employment with eligible status ends

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Component Benefit Plans Funded Through Insurance

Plan / Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per insurance documents attached.**	
Cancer (Aflac) **(Attachment 7)**	Any faculty member who teaches at least half-time (two courses) for a full academic year, and staff employees who work 21 or more hours per week for at least 9 months of the academic year	Employee	1st day of the month coinciding with or following date of hire	Coverage is portable; otherwise, end of month following date employment with eligible status ends

Self-Funded Component Benefit Plans

Plan/ Plan Type	Who Is Eligible	Contribution Source	When Participation Begins*	When Participation Terminates*
			***Note: Additional rules may apply per documents attached.**	
Health Flexible Spending Account **(Attachment 8)**	All employees	Employee	Can elect within 30 days of date of hire or January 1	End of month following date employment with eligible status ends
Employee Assistance Program **(Attachment 9)**	All employees	Employer	Date of hire	Date employment with eligible status ends

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Funding Arrangements

Insurance Company	Component Benefit Plan
Aetna Life Insurance Company 151 Farmington Avenue Hartford, Connecticut 06156 (860) 273-0123	Health (EPO) Health (PPO) Dental
Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	Vision
The Hartford Group Benefits Division, Customer Service P.O. Box 2999 Hartford, CT 06104-2999 (800) 523-2233	Life (with AD&D) Long-term Disability
Aflac, Inc. 1932 Wynnton Road Columbus, Georgia 31999 (800) 992-3522	Cancer

Trustee

Trustee	Component Benefit Plan
NONE	

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Cafeteria Plan

Cafeteria Plan	Component Benefit Plans Funded Through Cafeteria Plan
Administered By: Sarah Lawrence College 1 Mead Way Bronxville, New York 10708 (914) 337-0700 Aflac, Inc. 1932 Wynnton Road Columbus, Georgia 31999 (800) 992-3522	Health (EPO) Health (PPO) Dental Vision Cancer Health Flexible Spending Account

Named Fiduciary Other than the Employer (For Self-Funded Only)

Named Fiduciary Other than the Employer	Component Benefit Plan
NONE	

Other Third-Party Administrators

Company	Component Benefit Plan
The Wellness Corporation 512 West Main Street Shrewsbury, MA 01545 (800) 828-6025	Employee Assistance Program

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Appendix B: CHIPRA Notice

Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of November 3, 2010. You should contact your State for further information on eligibility -

ALABAMA – Medicaid Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504
ALASKA – Medicaid Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529
ARIZONA – CHIP Website: http://www.azahcccs.gov/applicants/default.aspx Phone (In state): 1-877-764-5437
ARKANSAS – CHIP Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275
CALIFORNIA – Medicaid Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
COLORADO – Medicaid and CHIP Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243

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FLORIDA – Medicaid
Website:
http://www.fdhc.state.fl.us/Medicaid/index.shtml
Phone: 1-866-762-2237

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP
Medicaid Website:
www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov.
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid
Website:
http://www.in.gov/fssa/2408.htm
Phone: 1-877-438-4479

IOWA – Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.khpa.ks.gov
Phone: 800-766-9012

KENTUCKY – Medicaid
Website:
http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website:
http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-342-6207

MAINE – Medicaid
Website:
http://www.maine.gov/dhhs/oms/
Phone: 1-800-321-5557

MASSACHUSETTS – Medicaid and CHIP
Medicaid & CHIP Website:
http://www.mass.gov/MassHealth
Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone (Outside of Twin City area): 800-657-3739
Phone (Twin City area): 651-431-2670

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/index.htm
Phone: 573-751-6944

MONTANA – Medicaid
Website:
http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084

NEBRASKA – Medicaid
Website:
http://www.dhhs.ne.gov/med/medindex.htm
Phone: 1-877-255-3092

NEVADA – Medicaid and CHIP
Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900
CHIP Website:
http://www.nevadacheckup.nv.org/
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid
Website:
www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-4238

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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NEW MEXICO – Medicaid and CHIP
Medicaid Website:
http://www.hsd.state.nm.us/mad/index.html
Medicaid Phone: 1-888-997-2583
CHIP Website:
http://www.hsd.state.nm.us/mad/index.html
Click on Insure New Mexico
CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid
Website:
http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: http://www.nc.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid
Website:
http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Medicaid & CHIP Website:
http://www.oregonhealthykids.gov
Medicaid & CHIP Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid
Website:
http://www.dpw.state.pa.us/partnerproviders/medicalassistance/doingbusiness/003670053.htm
Phone: 1-800-644-7730

RHODE ISLAND – Medicaid
Website: www.dhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS – Medicaid
Website:
https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid
Website:
http://health.utah.gov/medicaid/
Phone: 1-866-435-7414

VERMONT– Medicaid
Website: http://ovha.vermont.gov/
Telephone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid
Website:
http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website:
http://www.wvrecovery.com/hipp.htm
Phone: 304-342-1604

WISCONSIN – Medicaid
Website:
http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
http://www.health.wyo.gov/healthcarefin/index.html
Telephone: 307-777-7531

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To see if any more States have added a premium assistance program since November 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

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Appendix C: HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

To persons enrolled in a health benefits component of the Sarah Lawrence College Wrap Welfare Benefits Plan (the "Plan"):

The Plan is required by law to maintain the privacy of protected medical information and to provide covered individuals with notice of its legal duties and privacy practices with respect to protected medical information. However, the Plan is permitted to use and disclose this information under the circumstances described in this notice.

The Plan is required to abide by the terms of this notice until it is amended. The Plan reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

In order for the Plan to pay for your covered medical expenses, the Plan and those administering the Plan must create or receive certain medical information about you. This information may involve:

- Payment activities such as billing and collection activities, eligibility determinations, adjudication of claims, precertification and utilization review, and coordination of benefits, or
- Health care operation activities such as quality assessment, case management, subrogation or business management and general administrative activities, or
- Treatment activities by your health care provider, such as providing information about other treatments you have received.

By your enrolling in the Plan, you have agreed to allow the Plan and its administrators to create or use your medical information in order to perform these duties without your express authorization. The Plan may also disclose medical information about you without your authorization to business associates of the plan, such as the claims administrator who pays the claims or other professionals who perform services on behalf of the Plan. All disclosures made by the Plan of medical information for purposes of payment or health care operation activities shall be the minimum necessary to accomplish the intended purpose of the disclosure, and any business associate who receives the information must agree to keep it confidential.

The Plan may be required to make available to the Department of Health and Human Services all books and records regarding the health information of covered persons if this information is requested for audit purposes. You will not have to authorize this disclosure.

The Plan may disclose information about your medical records to a medical professional treating you. No authorization is necessary for this disclosure. The law requires the Plan to make certain disclosures. These include disclosures:

- As necessary to comply with workers compensation or other similar programs.
- As necessary for courts and law enforcement agencies. Disclosures to a

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law enforcement agency may occur if required by law (such as the occurrence of certain types of wounds) or if required by a court order or other legal process. The Plan may also disclose medical information: for the purpose of identifying or locating a suspect, witness, fugitive or missing person; about a crime victim, if the victim agrees or emergency circumstances require disclosure without consent; about a person who has died if the nature of the death suggests that it may be the result of criminal conduct; or if there is evidence to suggest that a crime occurred on the premises.

- As necessary for public health research and disclosure, including reporting of communicable diseases to the applicable authorities (who may contact exposed individuals) and workforce medical investigations.

- As necessary to a health oversight agency for oversight activities authorized by law. However, this will generally not include an investigation of a particular individual unless it involves receipt of health care, public health benefits or public benefits contingent on the individual's health.

- As necessary if disclosure is required by another law.

The Plan may also be permitted or required to disclose medical information without your authorization under the following circumstances:

- If authorized by law, to the proper authorities for purposes of reporting child abuse or domestic violence. Subject to certain restrictions, the Plan may also report this information to social services, but must generally inform the victim of the abuse that it is making the disclosure.

- To people working for or with the Food and Drug Administration. These disclosures may be necessary: to report adverse events with respect to food or dietary supplements, product defects (including use or labeling defects), or biological product deviations; for product tracking; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance.

- Upon your death, to a coroner, funeral director or to tissue or organ services, as necessary to permit them to perform their functions.

- Under certain circumstances, for research purposes.

- To prevent or lessen a serious threat to the health or safety of a person or the public.

- If authorized by law, in connection with military matters or matters of national security and intelligence.

In addition, the Plan may disclose medical information to the Plan Sponsor, Sarah Lawrence College (the "Employer") under the following conditions:

- The Employer may not use any such information for employment-related decisions.

- The Employer may receive such information as the Plan documents allow.

- You have the right to inspect the Plan documents allowing disclosures.

Other uses and disclosures of your medical information will be made only with your written authorization and you may revoke

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the authorization at any time, upon request.

You have the right:

- To request restrictions on certain uses and disclosures of your medical information. The Plan does not have to agree with a requested restriction, but if the Plan does agree, then the Plan will abide by that restriction.
- To receive your own confidential health information by alternative means or at alternative locations, if receipt of the information in the usual manner could endanger you. You should contact the Employer's Privacy Officer to request the alternative delivery. You must include a statement that disclosure of the information in the usual manner could endanger you.
- To inspect and copy your own health information, but exceptions apply to certain types of information. If you request to see or copy your own health information from the Employer's Privacy Officer and one of these exceptions apply, you will be given more information at that time, including the circumstances under which you may challenge the exception.
- To amend your own health information when that information is incorrect.
- To obtain an accounting of any disclosure of your confidential health information, other than disclosures for purposes of payment, health care operations or treatment, or disclosures made in accordance with your written authorization.

In each case, you must make your request to the Privacy Officer, in writing. Depending upon the nature of the request, you will be given more information at that time, including any exceptions to the rules that may apply to your case.

Individuals may complain to the Employer and/or to the Secretary of Health and Human Services if they believe their privacy rights have been violated. If you wish to file such a complaint, please contact the Employer's Privacy Officer and you will be given information on how to proceed. You may not be retaliated against by the Plan or the Employer for the complaint. The Department of Health and Human Services may be contacted in Washington, D.C. or listings may be found in local telephone directories.

For further information contact Sarah Lawrence College, 1 Mead Way, Bronxville, New York, 10708.

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