

GETTYSBURG COLLEGE
FLEXIBLE BENEFITS PLAN
SUMMARY PLAN DESCRIPTION
EFFECTIVE JANUARY 1, 2019

TABLE OF CONTENTS

<u>Questions</u>	<u>Page</u>
I GENERAL INFORMATION ABOUT THE PLAN.....	1
I-1 What is the purpose of the Plan?	1
I-2 Who may participate in the Plan?.....	1
I-3 What benefits are offered through the Plan?	2
I-4 How do I become a participant in the Plan?.....	3
I-5 What if I fail to timely enroll in the Plan?.....	3
I-6 May I change my election during the Plan Year?	3
I-7 What are my individual benefit accounts?	9
I-8 How are my accounts funded?	9
I-9 Who holds the funds I have set aside under the Plan?	9
I-10 How do I receive my benefits under the Plan?.....	9
I-11 How do I submit my claims for benefits?	9
I-12 Who determines my benefits?	11
I-13 How will I know what action has been taken on my claim?	11
I-14 What do I do if my claim is denied?	11
I-15 Will unused Plan Year-end account balances under my spending accounts be carried over to the next Plan Year?	18
I-16 May I withdraw cash from any of my spending accounts?	18
I-17 May I shift amounts from one spending account to another?	18
I-18 May I stay in the Plan if I am absent on a family medical leave?.....	18
I-19 What if I am absent from work for duty in the uniformed services?	19
I-20 What if I terminate my employment during the Plan Year?	19
I-21 What if I am reemployed?	19
I-22 Will I have any administrative costs under the Plan?.....	19
I-23 How long will the Plan remain in effect?.....	20
I-24 Are my benefits taxable?.....	20
I-25 What is "Continuation Coverage"?	20
I-26 Who is a "Qualified Beneficiary"?	20
I-27 When can I elect Continuation Coverage?	20
I-28 What is a "Qualifying Event"?	21
I-29 Must I notify the Plan Administrator of the occurrence of a Qualifying Event?	21
I-30 How much does Continuation Coverage cost?.....	22
I-31 When does the Continuation Coverage end?	22
I-32 What are my Continuation Coverage rights if I am absent for duty in the uniformed services?	23
I-33 May benefits under the Plan be assigned or alienated?.....	23
I-34 How are Domestic Partners treated under the Plan?	23
II HEALTH CARE REIMBURSEMENT BENEFITS.....	24
II-1 Who may participate in the Health Care Spending Account Plan?.....	24
II-2 How do I become a participant?.....	24
II-3 What is my Health Care Spending Account?	25
II-4 How much may I contribute to my Health Care Spending Account?	25
II-5 What benefit amounts will be available for reimbursement during the Plan Year?	25

II-6	Who is an "Eligible Dependent" for whom I may claim a reimbursement under the Health Care Spending Account Plan?	25
II-7	How do I receive my benefits under the Health Care Spending Account Plan?	26
II-8	What are "Eligible Health Care Expenses"?	26
II-9	When must an Eligible Health Care Expense be incurred to be reimbursed?	26
II-10	What if the Eligible Health Care Expenses I incur during the Plan Year are less than the annual benefit I have elected?	26
II-11	What is an "Electronic Payment Card"?	27
III	DEPENDENT CARE REIMBURSEMENT BENEFITS	28
III-1	Who may participate in the Dependent Care Spending Account Plan?	28
III-2	How do I become a participant?	28
III-3	What is my Dependent Care Spending Account?	28
III-4	How much may I contribute to my Dependent Care Spending Account?	28
III-5	What benefit amounts will be available for reimbursement during the Plan Year?	29
III-6	Who is a "Qualifying Individual" for whom I may claim a reimbursement under the Dependent Care Spending Account ?	29
III-7	How do I receive my benefits under the Dependent Care Spending Account Plan?	29
III-8	What are "Eligible Dependent Care Expenses"?	30
III-9	Will I be taxed on the Dependent Care reimbursement benefits I receive?	31
III-10	When must an Eligible Dependent Care Expense be incurred to be reimbursed?	31
III-11	What if the Eligible Dependent Care Expenses I incur during the Plan Year are less than the annual benefit I have elected?	31
IV	EMPLOYEE WELFARE BENEFITS	31
IV-1	What are the types of employee welfare benefits offered by the College?	31
IV-2	What expenses relating to pregnancy and birthing are covered under the Medical Insurance Plan?	32
IV-3	Are expenses relating to mastectomies covered under the Medical Insurance Plan?	32
IV-4	What other recently enacted Federal laws apply to the Medical Insurance Plan?	33
IV-5	What is "Coordination of Benefits"?	33
V	HSA BENEFITS	34
V-1	What are "HSA Benefits"?	34
V-2	What is my "HSA"?	35
V-3	What are the maximum HSA Benefits that I may elect under the Plan?	35
V-4	How are my HSA Benefits paid for under the Plan?	36
V-5	Will I be taxed on the HSA Benefits that I receive?	36
V-6	Who can contribute to an HSA under the Plan?	37
V-7	Can I change my HSA contribution under the Plan?	37
V-8	Where can I get more information on my HSA and its related tax consequences?	37
VI	USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION	37
VI-1	Use and Disclosure of Protected Health Information	37
VI-2	Disclosure as Required by Law and as Permitted By Authorization of the Participant or Beneficiary	39
VI-3	Disclosure to the College	39

VI-4	With respect to PHI, the College Agrees to Certain Conditions	39
VI-5	Adequate Separation Between the Applicable Underlying Plans and the College Must Be Maintained	40
VI-6	Limitations of PHI Access and Disclosure.....	40
VI-7	Noncompliance Issues	41
VI-8	Permitted Uses and Disclosures of Summary Health Information.....	41
VII	ERISA RIGHTS	41
VIII	ADMINISTRATIVE INFORMATION	43

Gettysburg College (the "College") is pleased to sponsor the Gettysburg College Flexible Benefits Plan (the "Plan") to provide eligible employees of the College and its affiliates, as applicable (collectively the "Employer"), with the opportunity to choose certain types and levels of benefits that best meets your individual needs. The Plan is known as a "cafeteria plan" within the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended (the "Code") because it lets you pay for benefits on a pre-tax basis and in some cases on an after-tax basis.

This Summary Plan Description ("SPD") describes the basic features of the Plan as well as certain other employee welfare benefit plans sponsored by the College that are operated through the Plan. The SPD is only a summary of the key features of the Plan and your rights as a participant. If there is a conflict between the Plan or Underlying Plan(s) and the SPD, the Plan or Underlying Plan(s) will govern. Wherever any words are used herein in the masculine, feminine or neuter gender, they will be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they will be construed as though they were also used in the other form in all cases where they would so apply. This SPD is reflective of the terms of the Plan and the law as in effect on January 1, 2019, unless otherwise specifically stated.

PART I GENERAL INFORMATION ABOUT THE PLAN

I-1. What is the purpose of the Plan?

The purpose of the Plan is to allow eligible employees of the College and its affiliates, as applicable, to choose and pay for certain benefits offered through the Plan.

The Plan must comply with certain consumer protections under the Patient Protection and Affordable Care Act, such as the elimination of lifetime limits on benefits and the prohibition on rescissions of medical coverage except in the case of nonpayment of contributions, fraud or intentional misrepresentations.

I-2. Who may participate in the Plan?

If you are an "Eligible Employee," you may participate in the Plan.

2.1 "Eligible Employee" means, for purposes of participation in the Underlying Plans, a "Full-time Faculty", "Adjunct Faculty", "Full-Time Administrator/Staff", "Adjunct (part-time) Faculty" and "Part-time Administrator/Staff." "Full-time Faculty" means an Employee regularly scheduled to teach 5 courses each Academic Year. "Adjunct Faculty" means an Employee scheduled to teach 4 courses each Academic Year. "Full-time Administrator and Staff" means an Employee regularly scheduled to work at least 34 hours per week. "Part-time Administrator and Staff" means an Employee scheduled to work less than 34 hours per week. "Adjunct (part-time) Faculty" means an Employee scheduled to teach 3 courses or less. "Academic Year" means the period beginning with the start of each Fall semester and ending on the last day of the Spring semester.

The following conditions apply to certain Employees:

- (a) an Adjunct Faculty Employee is not eligible for dental coverage;

(b) an Adjunct (part-time) Faculty Employee is responsible to bear the entire cost of insurance premium benefits (i.e., medical, prescription drug, vision and dental); and

(c) a Part-time Administrator/Staff is not eligible for dental coverage and is only eligible for the other insurance premium benefits provided they work at least 30 hours per week.

An individual who performs services for the College as a leased employee, within the meaning of Code Section 414(n), may be excluded from participation in the Plan.

"Full-Time Administrator and Staff Employee" means an Employee who is regularly scheduled to work at least 30 hours per week.

"Full-Time Adjunct Faculty Employee" means an Employee who teaches or is scheduled to teach four (4) courses during a relevant Academic Year.

An individual who performs services for the Employer as a leased employee, within the meaning of Code Section 414(n), may be excluded from participation in the Plan.

You will cease to be a participant in the Plan upon your date of death. For the reasons described below, you will also cease to be a participant in the Plan on the last day of the month of:

- (a) your resignation or termination of employment with the Employer;
- (b) your cessation of participation in the Plan by failing to make the required contributions with respect to any Underlying Plan following your termination of employment with the Employer;
- (c) you ceasing to be an Eligible Employee;
- (d) the modification of the Plan so as to exclude you;
- (e) the termination of the Plan; or
- (f) the revocation of your benefit election as a result of a change in status event (for details, see Answer I-6, below).

I-3. What benefits are offered through the Plan?

The Plan provides the following types of benefits: (a) health care reimbursement through the Gettysburg College Health Care Spending Account Plan ("Health Care Spending Account Plan"), for details, see Part II, below; (b) Dependent care reimbursement through the Gettysburg College Dependent Care Spending Account Plan ("Dependent Care Spending Account Plan"), for details, see Part III, below; (c) fully-insured medical, prescription drug and vision coverage through the Gettysburg College Medical Insurance Plan ("Medical Insurance Plan"), for details, see Part IV, below; fully-insured dental coverage through the Gettysburg College Dental Insurance Plan ("Dental Insurance Plan"); cancer, specified health and accidental coverage under the Gettysburg College Supplemental Health Plan ("Supplemental Health Plan"); health reimbursement established and

maintained outside the Plan through a Health Savings Account ("HSA"); and limited purpose health care reimbursement through the Health Care Spending Account Plan.

I-4. How do I become a participant in the Plan?

Before you enroll in the Plan, you may choose to complete the Enrollment Form provided to you by the Plan Administrator. The Enrollment Form lists the benefits available through the Plan, the amount of compensation reduction to pay for the benefits you have elected and a detailed description of the benefit enrollment process. You must enroll in the Plan by the date specified in the Enrollment Form. There will be credited to your accounts, as described under Answer I-8, the amount of your compensation reduction on a pre-tax basis and in some cases on an after-tax basis. Thereafter, you will be provided with the opportunity during the annual "Open Enrollment Period" preceding the beginning of each Plan Year (January 1 – December 31) to modify, amend or revoke your election of benefits to the extent provided by the College. "Open Enrollment Period" means the period specified in the Enrollment Form preceding the beginning of each Plan Year during which you may elect or change benefit coverage options under the Plan.

I-5. What if I fail to timely enroll in the Plan?

If you are a newly Eligible Employee who fails to timely enroll in the Plan, you will be deemed to have elected certain benefit default coverage levels as determined by the College, in a uniform and nondiscriminatory manner, excluding participation in the Health Care Spending Account Plan and/or the Dependent Care Spending Account Plan. If you are a Participant who elected benefits for the previous Plan Year and wish to continue with the same benefit coverage, you will be deemed to have elected certain employee welfare benefits (i.e., fully-insured medical benefits under the Medical Insurance Plan), excluding further participation in the Health Care Spending Account Plan and/or the Dependent Care Spending Account Plan. If you wish to change your benefit coverage but fail to make the required timely elections, you will have to wait until the next Open Enrollment Period to participate in those other optional benefits, unless you experience a change in Election Event (for details, see Answer I-6, below).

I-6. May I change my election during the Plan Year?

Generally, you may not change your election whether or not to participate in the Plan or vary the benefits you have elected during the Plan Year, except that your election will terminate if you are no longer working for the College or you do not pay the required premiums for the benefits you have elected. Otherwise, you may change your elections only during the annual Open Enrollment Period, but only for the ensuing Plan Year.

There are several important exceptions to this general rule, known as "Change in Election Events". "Change in Election Events" include the following events, as more fully described below: FMLA leave (for details, see Answer I-18, below), Change in Status, Certain Judgments, Decrees and Orders, Medicare and Medicaid, Change in Cost, and Change in Coverage. The permissible Change in Election Events provided under (g) and (h), below, are not applicable to health care reimbursement coverage under the Health Care Spending Account Plan. Also, all of the permissible Change in Election Events are not applicable to medical reimbursement coverage under the HSA.

An election to make an employee contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis.

If a Change in Election Event (including a Change in Status) occurs, you must complete and return to the Plan Administrator a Benefit Change Form within 30 days (60 days for an event described in items (d)(iii) and (iv), below) of the occurrence of the event.

(a) FMLA Leave. You may change an election under the applicable Underlying Plan if you take a FMLA leave.

(b) Change in Status. If one or more of the following changes in status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

(i) a change in your legal marital status which includes marriage, death of a Spouse (as defined in Answer II-6 of Part II, below), divorce or annulment or commencement or termination of a Domestic Partner relationship (as defined in Answer I-34 of Part I, below);

(ii) a change in the number of your Dependents or your Domestic Partner's Dependents (as defined in Answer II-6 of Part II, below) (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);

(iii) any of the following events that change the employment status of you, your Spouse, your Domestic Partner or your other Dependent(s) and that affects benefit eligibility under a cafeteria plan (including the Plan) or other plan of you, your Spouse, your Domestic Partner or your other Dependent(s). Such events include any of the following changes in employment status: (1) termination or commencement of employment, a commencement of or return from an unpaid leave of absence; (2) incurring a reduction or increase in hours of employment; (3) or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

(iv) an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as attaining a specified age, student status, or similar circumstance); and

(v) a change in your, your Spouse's, your Domestic Partner's or your other Dependent's place of residence. An election change is permissible where the change in residence affects your eligibility for coverage. For example, you may not revoke medical coverage under the applicable Underlying Plan merely because you moved, unless as a result of the move you no longer are eligible for such medical coverage.

(c) **Change in Status – Other Requirements.** If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects eligibility (for Dependent care reimbursement benefits, the event may also affect eligibility of Dependent care expenses (see Answer III-8, below) for the Dependent care tax exclusion). In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

(i) **Loss of Spouse or Dependent Eligibility; Special Rules under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").** For accident and health benefits, a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, if applicable by state, termination of Domestic Partner relationship, the death of your Spouse, Domestic Partner or your other Dependent(s), or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse, Domestic Partner or other Dependent(s). A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, if applicable by state, your Domestic Partner in a termination of relationship, your deceased Spouse, Domestic Partner or other Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

However, if you, your Spouse, or a Dependent elect COBRA continuation coverage (see Answers I-25 through 32, below) under the applicable Underlying Plan, you may elect to increase your contribution to pay for such coverage.

(ii) **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which you, your Spouse, your Domestic Partner or your other Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, your Domestic Partner's or your other Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.

(iii) **Dependent Care Reimbursement Benefits.** With respect to the Dependent care reimbursement benefit under the applicable Underlying Plan, you may change or terminate your election with respect to a Change in Status event only if: (1) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage; or (2) your election change is on account of and conforms with a change in status that affects the eligibility of Dependent care expenses for the available tax exclusion.

(iv) Health Care Reimbursement Benefits. If you terminate employment with a balance with respect to a health care spending account, you may not reduce your coverage under the applicable Underlying Plan for the remainder of the Plan Year.

(v) Termination of Employment. If you terminate employment for more than 30 days during a Plan Year, your termination will be deemed to be a bona fide termination that would permit you to cancel coverage for the remainder of the Plan Year, reinstate your prior elections, or make a new election without regard to your previous elections.

(d) Special Enrollment Rights. If you, your Spouse, your Domestic Partner or your other Dependent(s) is entitled to special enrollment rights permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you may change your election under the applicable Underlying Plan to correspond with the special enrollment right. As required by HIPAA, a special enrollment right will arise if:

(i) you, your Spouse, your Domestic Partner or your other Dependent(s) declined to enroll in group health plan coverage because of other coverage and eligibility for such other coverage is subsequently lost due to legal separation, if applicable by state, divorce, death, termination of employment, reduction in hours, exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated;

(ii) a new Dependent is acquired as a result of marriage or your Domestic Partner relationship, birth, adoption or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse, new Domestic Partner or new Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days);

(iii) you, your Spouse, your Domestic Partner or your other Dependent(s) who is not enrolled in group health coverage under this Plan loses Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage; or

(iv) you, your Spouse, your Domestic Partner or your other Dependent(s) becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

(e) Certain Judgments, Decrees and Orders. If a judgment, decree or order from a divorce, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under an applicable Underlying Plan, you may change your election to provide coverage for the Dependent child. If the order requires that

another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.

(f) Medicare or Medicaid. If you, your Spouse, your Domestic Partner or your other Dependent(s) becomes entitled to Medicare or Medicaid, you may cancel that person's coverage completely under the applicable Underlying Plan but not reduce such coverage. Similarly, if you, your Spouse, your Domestic Partner or your other Dependent(s) who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the applicable Underlying Plan, elect to begin or increase that person's accident or health coverage, and/or begin or increase health care reimbursement benefit.

(g) Change in Cost. If the Plan Administrator notifies you that the cost of your coverage under the applicable Underlying Plan significantly increases during the Plan Year, the Plan Administrator may permit you to: (i) make a corresponding prospective increase in your pre-tax (and in some cases after-tax) contributions; (ii) revoke your election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another benefit option that provides similar coverage; or (iii) drop your coverage prospectively, but only if there is no other benefit option available under the applicable Underlying Plan that provides similar coverage. If the Plan Administrator notifies you that the cost of your coverage under the applicable Underlying Plan significantly decreases during the Plan Year, the Plan Administrator may permit you to: (i) change your election on a prospective basis to elect the benefit option that has decreased in cost provided you were receiving coverage under a benefit option other than the benefit option that had decreased in cost; or (ii) elect the benefit option that had decreased in cost on a prospective basis provided you were an eligible employee who had not previously elected coverage under the applicable Underlying Plan. For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically make a prospective adjustment to your election contributions to reflect the minor change in cost. The change in cost provision relating to Dependent care applies to benefits only if the cost change is imposed by a Dependent care provider who is not your relative.

(h) Change in Coverage. You may also change your election for the Plan if one of the following events occurs:

(i) Significant Curtailment of Coverage. If the Plan Administrator notifies you that your coverage under the applicable Underlying Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another option that provides similar coverage. If the Plan Administrator notifies you that your coverage under the applicable Underlying Plan is significantly curtailed with a loss of coverage, then you may either revoke your election and elect coverage under another option that provides similar coverage, elect similar coverage under the plan of your Spouse's or your Domestic Partner's employer, or drop coverage but only if there is no option available that provides similar coverage.

(ii) Addition or Significant Improvement of Plan Option. If the Plan adds a new option or significantly improves an existing option, the Plan Administrator

may permit you to revoke your election under the Plan and, instead, make an election on a prospective basis for coverage under the new or improved benefit package option.

(iii) **Loss of Other Group Medical Coverage.** You may change your election to add group medical coverage for you, your Spouse, your Domestic Partner or your other Dependent(s), if any of you loses coverage under any group medical coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

(iv) **Change in Election Under Another Employer Plan.** You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the College or a plan of your Spouse's, your Domestic Partner's or other Dependent's employer), so long as: (1) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (2) the Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during their employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.

(v) **Dependent Care Reimbursement Benefits Coverage Changes.** You may make a prospective election change under the applicable Underlying Plan that is on account of and corresponds with a change by your Dependent care service provider. For example: (1) if you terminate one Dependent care service provider and hire a new Dependent care service provider, you may change coverage to reflect the cost of the new service provider; and (2) if you terminate a Dependent care service provider because a relative becomes available to take care of the child at no charge, you may cancel coverage.

(vi) **Reduction in Hours or Enrollment in an Exchange Plan.** You may revoke your coverage under the applicable Underlying Plan outside of the Open Enrollment Period, if your employment status changes from working at least 30 hours per week to less than 30 hours. This is regardless of whether the reduction in hours has resulted in loss of eligibility. You must show intent to enroll in another health plan. You may also revoke your coverage under the applicable Underlying Plan if you are eligible to obtain coverage through the health exchanges.

Additionally, the Plan Administrator may modify your election(s) downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

I-7. What are my individual benefit accounts?

If you elect benefits under the Plan, one or more individual benefit accounts will be set up in your name to keep a record of the benefits you are entitled to receive. The number of accounts that are established depends on what benefits you have elected. For example, if you have chosen to participate in the Health Care Spending Account Plan and the Dependent Care Spending Account Plan, two accounts will be maintained in your name.

I-8. How are my accounts funded?

When you enroll in the Plan, you specify which benefits you wish to pay for through salary reduction. Thereafter, your accounts will be credited with that portion of your gross income you have elected to forego through salary reduction.

The amount that is available in any one of your accounts at any particular time will depend on the benefits you have elected. Insurance benefit accounts are current in nature, and the College will pay out amounts you have set aside for insurance benefits as they become due to the insurance company or companies. If you elect health care reimbursement benefits, your corresponding account will be credited to reflect the amount you set aside from each paycheck, although the full, annual amount of the benefit will at all times be available to you (less previous benefits). If you elect Dependent care reimbursement benefits, your corresponding account will be credited with the amount you set aside from each paycheck and will accumulate until you submit a documented claim for reimbursement of eligible expenses. If you elect to establish an HSA, HSA contributions may consist of both non-elective employer contributions and employee pre-tax contributions that will be set aside from each pay period and accumulate under the account established with the HSA custodian or trustee until you submit a documented claim for reimbursement of eligible medical expenses.

I-9. Who holds the funds I have set aside under the Plan?

The money you set aside as payment for reimbursement of your benefit expenses will be segregated by the College as soon as administratively possible after an amount has been deducted from your paycheck. Payroll deductions for insurance premiums will be currently forwarded to respective insurance companies (where appropriate) as the premiums become payable.

I-10. How do I receive my benefits under the Plan?

If you have elected to participate in the Plan, you will have to take certain steps to be reimbursed for your eligible benefit expenses. When you incur an expense that is eligible for reimbursement, you submit a claim on a claim form that will be supplied to you by the Plan Administrator.

I-11. How do I submit my claims for benefits?

All claims for benefits provided through the Plan are processed for the College by a TPA or the insurance provider (collectively, the "Claims Administrator"). How you file a claim for benefits depends on the type of claim. There are several categories of benefits:

(a) **Concurrent Care Claim.** A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously approved benefit claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

(b) **Pre-Service Care Claim.** A pre-service claim is a claim for a benefit under the applicable Underlying Plan with respect to which the terms of the applicable Underlying Plan require approval (usually referred to as precertification) of the benefit in advance of obtaining medical care.

(c) **Post-Service Care Claim.** A post-service claim is a claim for a benefit under the applicable Underlying Plan that does not require approval of the benefit in advance of obtaining medical care. Dependent care reimbursement claims and health care reimbursement claims are considered post-service claims.

(d) **Urgent Care Claim.** An urgent care claim is any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured Dependent or subject you or your Dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

You may file any claim for benefits, including ones for concurrent care, pre-service care, or post-service care, yourself, by your authorized representative, or by your health care service provider. Any of these types of claims must be filed using a written form supplied by the Claims Administrator and may be submitted by U.S. Mail, by hand delivery or by facsimile (FAX).

If your claim involves urgent care, you may initiate a claim for urgent care benefits yourself if you are able, or your treating physician may file the claim for you. The claim may be made by telephone or by U.S. Mail, by hand delivery or by facsimile (FAX). If your claim is filed by telephone, you will be responsible for completing any follow-up paperwork the applicable Underlying Plan may require in support of your claim.

You may file any claim yourself, or you may designate another person as your "authorized representative" by notifying the Claims Administrator in writing of that person's designation. In that case, all subsequent notices and decisions concerning a claim will be provided to you through your authorized representative.

The Claims Administrator provides forms for filing those claims and authorized representative designations under the Plan that must be filed in writing. Each Underlying Plan has established deadlines after the close of the Plan Year by which claims must be submitted. You should contact the Plan Administrator for further details regarding these deadlines.

I-12. Who determines my benefits?

In making benefit determinations, the Claims Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claim. In any case, you will receive only those benefits under the applicable Underlying Plan that the Claims Administrator, in its sole discretion, determines you are entitled to receive.

I-13. How will I know what action has been taken on my claim?

If your claim involves urgent care, you or your authorized representative will be notified of the Claims Administrator's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Claims Administrator to make a decision, you or your authorized representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; the Claims Administrator then must inform you of its decision within 48 hours of receiving the additional information.

If your claim is one involving concurrent care, the Claims Administrator will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim. You will be given time to provide any additional information required to reach a decision.

If your claim is for a pre-service authorization, the Claims Administrator will notify you of its initial determination, whether adverse or not, as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Claims Administrator for an additional 15 days if the extension is required due to matters beyond the Claims Administrator's control. You will have at least 45 days to provide any additional information requested of you by the Claims Administrator.

If you have filed a post-service claim for reimbursement of medical care services that already have been rendered, you will be notified of the Claims Administrator's decision on your claim only if it is denied in whole or in part. This notification will be issued no more than 30 days after the Claims Administrator receives the claim; the Claims Administrator may extend this 30-day period once for up to 15 days if the extension is required due to matters beyond the Claims Administrator's control. You will have at least 45 days to provide any additional information requested of you by the Claims Administrator, if the need for the extension is due to the Claims Administrator's additional information from you or your health care providers.

I-14. What do I do if my claim is denied?

The Claims Administrator will provide you with written notice or electronic notice (or orally as described under DOL Reg. Section 2560.503-1(g)(2)) within 90 days, of the denial of your claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 90-day period.

In no event will such extension exceed a period of 90 days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Underlying Plan expects to render the benefit determination. If the Underlying Plan provides disability benefits, the Claims Administrator will notify you of the denial within a reasonable period of time, but not later than 45 days after receipt of the claim by the Underlying Plan. This period may be extended by the Underlying Plan for up to 30 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Underlying Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Underlying Plan expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Underlying Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Underlying Plan expects to render a decision. The notice will contain the following information:

- (a) the specific reason(s) for a denial;
- (b) the specific applicable Underlying Plan provisions upon which a denial is based;
- (c) a description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- (d) a description of the Underlying Plan's internal review procedures and the time limits applicable to the procedures available external review procedures, including a statement of your right to bring a civil action under Section 502 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") following an adverse benefit determination on final review;
- (e) any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided you, free of charge, upon request); and if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- (f) in the case involving urgent care, a description of the expedited review process applicable to such claim;
- (g) in the case of denials based upon a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Underlying Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge, upon request; and
- (h) in the case of denials with respect to disability benefits -

(i) discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- (A) the views presented by you to the Underlying Plan of health care professionals treating you and vocational professionals who evaluated you;
- (B) the views of medical or vocational experts whose advice was obtained on behalf of the Underlying Plan in connection with your denial, without regard to whether the advice was relied upon in making the benefit determination; and
- (C) a disability determination regarding you presented by you to the Underlying Plan made by the Social Security Administration.

(ii) if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Underlying Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon your request;

(iii) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist;

(iv) 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 the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits as determined under DOL Reg. Section 2560.503-1(m)(8); and

(v) in the case of a denial with respect to disability benefits, the notification will be provided in a culturally and linguistically appropriate manner.

The claims procedures of the Underlying Plan will not be deemed to provide you with a reasonable opportunity for a full and fair review of a claim and the denial unless the claims procedures provide:

- (a) you at least 60 days following receipt of a notification of the denial within which to appeal the determination;
- (b) you the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- (c) that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

(d) for a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The claims procedures will not be deemed to provide you with a reasonable opportunity for a full and fair review of a claim and denial unless the claims procedures further provide:

(a) you at least 180 days following receipt of a notification of denial within which to appeal the determination;

(b) for a review that does not afford deference to the initial denial benefit determination and that is conducted by an appropriate named fiduciary of the Underlying Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of such individual;

(c) that, in deciding an appeal of any denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

(d) for the identification of medical or vocational experts whose advice was obtained on behalf of the Underlying Plan in connection with your denial, without regard to whether the advice was relied upon in making the benefit determination;

(e) that the health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the denial that is the subject of the appeal, nor the subordinate of any such individual; and

(f) in the case of a claim involving urgent care, for an expedited review process pursuant to which:

(i) a request for an expedited appeal of denial may be submitted orally or in writing by the claimant; and

(ii) all necessary information, including the Underlying Plan's benefit determination on review, will be transmitted between the Underlying Plan and you by telephone, facsimile, or other available similarly expeditious method.

If the Underlying Plan provides disability benefits, with respect to claims for such benefits, it will be deemed to provide you with a reasonable opportunity for a full and fair review of a claim and denial provided the claims procedures provide:

(a) that before the Underlying Plan can issue a denial on review of a disability benefit claim, the Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Underlying Plan, insurer, or other person making the benefit determination (or at the direction of the Underlying Plan, insurer, or such other

person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on review is required to be provided to give you a reasonable opportunity to respond prior to that date; and

(b) that, before the Underlying Plan can issue a denial on review on a disability benefit claim based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of denial on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

The Claims Administrator must issue a review decision on your appeal according to the following timetable:

- (a) no later than 72 hours after receiving your request for an urgent care claim review;
- (b) no later than 30 days after receiving your request for a pre-service claim review; and
- (c) no later than 60 days after receiving your request for a post-service claim review.

The Claims Administrator has 60 days to act on your request for review. Under special circumstances an extension of time may be needed. If an extension is needed, the Claims Administrator must inform you of the extension and must make a decision within 120 days from the receipt of your review request. If the Underlying Plan provides disability benefits, a period of 45 days will apply instead of 60 days.

The Claims Administrator will provide you or your authorized representative with written or electronic notice of the benefit determination on review in accordance with the applicable time frames. In the case of an adverse benefit determination, the notice shall set forth, in a manner calculated to be understood by you:

- (a) the specific reason or reasons for the adverse benefit determination;
- (b) reference to the specific applicable Underlying Plan provisions on which the benefit determination is based;
- (c) a statement that you are entitled to receive without charge reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- (d) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge upon your request;
- (e) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying

the terms of the applicable Underlying Plan to your medical condition, or a statement that this will be provided without charge on request; and

(f) a statement describing voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures and a statement of your right to bring action under Section 502(a) of ERISA. If disability benefits are provided under the Underlying Plan, the statement of your rights to bring action under 502(a) of ERISA will also describe any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim; and

(g) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If the Underlying Plan provides disability benefits:

(a) a discussion of the adverse decision, including an explanation of the basis for disagreeing with or not following:

(i) the views presented by you to the Underlying Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

(ii) the views of medical or vocational experts whose advice was obtained on behalf of the Underlying Plan in connection with your adverse decision, without regard to whether the advice was relied upon in making the benefit determination; and

(iii) a disability determination regarding you presented by you to the Underlying Plan made by the Social Security Administration.

(b) If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(c) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

In the case of an adverse decision on review with respect to a claim for disability benefits, the notification will be provided in a culturally and linguistically appropriate manner.

In the case of the failure of the Underlying Plan to establish or follow claims procedures consistent with the requirements of this Section, you will be deemed to have exhausted the administrative remedies available under the Underlying Plan and will be entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the Underlying Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

If the Underlying Plan provides disability benefits and if the Underlying Plan fails to strictly adhere to all the requirements of this Section with respect to a claim, you will be deemed to have exhausted the administrative remedies available under the Underlying Plan, except as provided below. Accordingly, you are entitled to pursue any available remedies under section 502(a) of ERISA on the basis that the Underlying Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim. If you choose to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding the foregoing, the administrative remedies available under the Underlying Plan with respect to claims for disability benefits will not be deemed exhausted based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the Underlying Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Underlying Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Underlying Plan and you. This exception is not available if the violation is part of a pattern or practice of violations by the Underlying Plan. You may request a written explanation of the violation from the Underlying Plan, and the Underlying Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Underlying Plan to be deemed exhausted. If a court rejects your request for immediate review on the basis that the Underlying Plan met the standards for the exception, the claim will be considered as re-filed on appeal upon the Underlying Plan's receipt of the decision of the court. Within a reasonable time after the receipt of the decision, the Underlying Plan will provide you with notice of the resubmission.

Except as provided through the external review process, the Claims Administrator has the final authority to determine the amount of benefits that shall be paid on a particular benefit claim. In making determinations, the Claims Administrator has the complete discretion and authority to make factual findings regarding a claim and to interpret the terms of the applicable Underlying Plan as it applies to the claim. In any case, you shall receive only those benefits under the applicable Underlying Plan that the Claims Administrator, in its sole discretion, determines you are entitled to receive.

A new external appeal option will be available for adverse benefit determinations that do not relate to a failure to meet the eligibility requirements under the applicable Underlying Plan. If a claim for benefits is denied, the denial letter will contain information relative to the external review.

The Claimant or their Authorized Representative may initiate an external appeal within four (4) months of the date they are served with the Claim Administrator's final internal adverse benefit determination on appeal. Under the external appeal process, the Claims Administrator shall assign an independent review of the Claim from an accredited independent review organization ("IRO"). The determination of the IRO is generally binding on all parties; however, it does not prevent the Claimant from initiating litigation under Section 502 of ERISA if the IRO confirms the benefit denial.

These procedures are intended to comply with the interim safe harbor contained in DOL Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-01,

and 76 Federal Regulation 37208-37234. At such time as guidance is revised or replaced by the DOL, the new guidance shall be incorporated by reference herein and these procedures shall be suspended by such new guidance to the extent necessary to comply with the Patient Protection and Affordable Care Act.

I-15. Will unused Plan Year-end account balances under my spending accounts be carried over to the next Plan Year?

No. By law, any unused amounts credited to your account(s) as of the end of the Plan Year plus the "Grace Period" will be forfeited if you have not submitted a claim for Eligible Health Care Expenses and/or Eligible Dependent Care Expenses incurred by April 30th following the end of the Grace Period. This 2 ½ month period is referred to as the "Grace Period." Eligible Health Care Expenses and/or Eligible Dependent Care Expenses incurred during the Grace Period may be paid or reimbursed from the remaining unused account balance(s) at the end of the immediately preceding Plan Year.

I-16. May I withdraw cash from any of my spending accounts?

No. Your spending account balances may be used only to provide reimbursement of Eligible Health Care Expenses and/or Eligible Dependent Care Expenses.

I-17. May I shift amounts from one spending account to another?

You may not transfer credits from one spending account to another. Thus, for example, credits to your health care spending account may only be used for that type of expense; no amount would be available for any other purpose.

I-18. May I stay in the Plan if I am absent on a family medical leave?

If you are absent from work on a leave of absence covered by the Family and Medical Leave Act ("FMLA") for periods totaling up to 12 weeks during the Plan Year, you are entitled to maintain the coverage you have under the Plan during your absence. You are responsible for the cost of coverage during your absence using one of the following methods:

(a) Prepayment. Under the prepayment option, you may increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave;

(b) Pay-As-You-Go. Under the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you continue to receive your salary while you are gone, the premiums will be paid with pre-tax money as if you had not taken the leave. On the other hand, if your FMLA leave is unpaid and you choose this option, you will have to reimburse the College at regular intervals from your after-tax funds for the premiums that come due during the leave; or

(c) Catch-Up. Under the catch-up option, you remit catch-up amounts upon your return to employment to the College.

If you are absent from work on a qualifying exigency leave or a service member care leave that is covered under the National Defense Authorization Act of 2008, you are entitled to maintain benefit coverage under the Medical Insurance Plan (including the Health Care Spending Account Plan) during your absence. Under the qualifying exigency leave, you are entitled to take up to 12 weeks during any 12-month period for a qualifying exigency (as defined under the DOL regulations) as a result of your Spouse, son, daughter or parent being on (or notified of) active duty in the Armed Forces in support of a specified military operation. Under the service member care leave, if you are a Spouse, son or daughter, parent or next of kin of a disabled covered service member (as defined under the DOL regulations), you are entitled to take up to 26 weeks during a 12-month period to care for the service member.

I-19. What if I am absent from work for duty in the uniformed services?

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994. Accordingly, if you are absent from work due to a period of active duty in the military for more than 31 days in duration, you and your covered Dependents will have the opportunity to elect COBRA Continuation Coverage for the 24-month period that begins on the first day of your leave of absence. You must pay the premiums for COBRA Continuation Coverage with after-tax funds.

I-20. What if I terminate my employment during the Plan Year?

If you terminated your employment with the Employer during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan, other than as may be permitted under the COBRA Continuation Coverage provisions that apply to medical benefits and health care reimbursement, but only if an Eligible Employee of the Employer, elected under the applicable Underlying Plans. You will have until the deadline established by the Underlying Plan to submit a claim for expenses incurred by you during the time you were covered under the Plan. Reimbursements for pretermination expenses will be limited to the balance of the annual benefit you elected, reduced by any reimbursements you have already received during the Plan Year.

I-21. What if I am reemployed by the College?

If your employment terminates and you are subsequently re-employed with the Employer within 30 days of your separation of service and within the same Plan Year, you will immediately rejoin the Plan with the same elected benefits you had before termination. If you return to employment within 30 days of your separation of service during the following Plan Year, you will be allowed to change elected benefits during the applicable Open Enrollment Period.

If your employment terminates and you are subsequently re-employed with the Employer more than 30 days separation of service, you will need to re-satisfy Plan eligibility requirements and make new benefit elections.

I-22. Will I have any administrative costs under the Plan?

No. The College is bearing the entire cost of administering the Plan.

I-23. How long will the Plan remain in effect?

Although the College expects to maintain the Plan indefinitely, the College has retained the right to modify or terminate the Plan at any time. The Plan may be amended by a written instrument executed by an authorized officer of the College. If the Plan is terminated, credits to your reimbursement accounts will be used to provide benefits through the end of the Plan Year in which the termination occurs. Termination of the Plan will be effective, by action of the Board of Trustees of the College, as of the date specified by a written instrument executed by an authorized officer of the College or such later date as is the earliest date established under any applicable statute or regulations governing such matters.

I-24. Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, certain benefits you receive under the Plan are not currently taxable to you. The tax treatment of benefits provided to Domestic Partners are described more fully in Answer I-34, below. However, neither the College, the Plan Administrator, nor the Claim Administrator can guarantee the tax treatment to any given participant, as individual circumstances may produce differing results. If you have any questions regarding tax issues, you should consult your own tax adviser.

I-25. What is "Continuation Coverage"?

"Continuation Coverage" is the extension of coverage under the Medical Insurance Plan and/or Health Care Spending Account Plan for a certain period of time provided under COBRA.

I-26. Who is a "Qualified Beneficiary"?

A Qualified Beneficiary is either you, your Spouse, your Domestic Partner (for COBRA – like rights for certain Qualifying Events) or any Dependent child covered under the Medical Insurance Plan (as described in Part IV, below) and/or the Health Care Spending Account Plan (as described in Part II).

I-27. When can I elect Continuation Coverage?

You may elect Continuation Coverage once your regular coverage ends due to a Qualifying Event (as described in Answer I-28, below). You must elect the coverage during the "Election Period". The Election Period must begin no later than the date you would lose coverage on account of the Qualifying Event. The Election Period must not end before the date that is 60 days after the later of:

- (a) the date you would lose coverage on account of the Qualifying Event; or
- (b) the date notice is provided to you or your rights to elect COBRA Continuation Coverage.

Generally, each Qualified Beneficiary may make their own election for Continuation Coverage whether you elect it or not.

EXAMPLE: Employee A terminates employment with the College and decides not to elect Continuation Coverage under the applicable Medical Insurance Plan for themselves. However, Employee A's Spouse may elect COBRA Continuation Coverage for themselves if they were covered under the Medical Insurance Plan that Employee A had in effect before terminating employment.

I-28. What is a "Qualifying Event"?

A "Qualifying Event" occurs when:

- (a) you die;
- (b) your employment is terminated (other than for gross misconduct) or your employment status is less than that of a Full-Time Faculty, Full-Time Non-Faculty, Full-Time Adjunct Faculty, or Part-Time Faculty Employee, including a Part-Time Non-Faculty Employee for health care reimbursement purposes. (If you take an FMLA leave of absence and do not return to active employment, the Qualifying Event of termination of employment occurs at the end of the leave);
- (c) you divorce or legally separate, if applicable by state, from your Spouse;
- (d) you become entitled to receive Medicare benefits under Social Security. You are not "entitled" to Medicare until you have actually completed the Medicare enrollment and you have been notified your Medicare coverage is in effect;
- (e) the College becomes bankrupt; or
- (f) for Dependent coverage for your children covered under the applicable Underlying Plan, a qualifying event occurs when the Dependent child ceases to qualify as a Dependent.

I-29. Must I notify the Plan Administrator of the occurrence of a Qualifying Event?

You must notify, by either written or oral communication, the Plan Administrator of the occurrence of certain Qualifying Events. The Plan Administrator will then provide you with a Qualifying Event Form ("Form") to complete and return to the Plan Administrator in order to continue your medical insurance coverage and/or health care reimbursement coverage under the Underlying Plan(s). The Qualifying Events that require notification are as follows:

- (a) divorce;
- (b) loss of Dependent status;
- (c) occurrence of a second Qualifying Event during an 18 (or 29)-month period of Continuation Coverage;

- (d) entitlement to Social Security disability income; or
- (e) termination of Social Security disability income.

You must return to the Plan Administrator the completed Form within 60 days of the Qualifying Event. However, the 60-day period does not begin until you have received the Form with instructions.

I-30. How much does Continuation Coverage cost?

If you elect COBRA Continuation Coverage under the applicable Medical Insurance Plan (including dental and/or vision) sponsored by the College, you must pay 102% of the applicable premium for the period of coverage. You may pay the premium on a monthly basis and your first premium is due and payable 45 days after you make the initial election for coverage. As for Continuation Coverage under the Health Care Spending Account Plan, the applicable amount of payment due under such Underlying Plan is based on the Plan Year coverage you elect.

I-31. When does the Continuation Coverage end?

You will be able to continue coverage for up to 18 months after the date of your termination of employment or reduction in hours. If during this 18-month period, the Social Security Administration determines you were disabled at the time of your Qualifying Event, you may extend your coverage up to 29 months from the date of the Qualifying Event. Under certain circumstances, if you were entitled to Medicare benefits at the date of your Qualifying Event, then you and/or each of your Dependents may be entitled to extended Continuation Coverage of up to 36 months. In addition, if a second Qualifying Event occurs during the period of Continuation Coverage, you may be eligible for an extended period of Continuation Coverage (up to a maximum of 36 months in total) depending upon the nature of the second Qualifying Event. Continuation Coverage is available for up to 36 months for the following:

- (a) if you and your Spouse are divorced or legally separated, if applicable by state, and your Spouse is no longer covered under the Plan;
- (b) if your child loses coverage because the child is no longer your Dependent;
- (c) if you die;
- (d) if you become entitled to Medicare; or
- (e) if the College becomes bankrupt.

Continuation Coverage automatically ends after the following:

- (a) the date the College terminates all of its group medical plans;
- (b) 30 days after the due date of your premium and the premium was not paid;

- (c) the date the Qualified Beneficiary becomes covered under another group health plan that does not contain a preexisting condition clause;
- (d) the date the Qualified Beneficiary becomes entitled to Medicare; or
- (e) for disabled Qualified Beneficiaries, the date the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

I-32. What are my Continuation Coverage rights if I am absent for duty in the uniformed services?

If you fail to work at least 30 hours per week for more than 31 days because of duty in the uniformed services, you and your covered Dependents will be entitled to elect Continuation Coverage the same as if you had experienced one of the Qualifying Events described above. There may, however, be restrictions on the duration of this coverage. Contact the Plan Administrator for details. However, this extended coverage will last no more than 24 months and cannot be extended regardless of the occurrence of any other subsequent event.

I-33. May benefits under the Plan be assigned or alienated?

Generally, benefits under the Plan may not be assigned or alienated. However, an exception applies in the case of a Qualified Medical Child Support Order ("QMCSO"). Basically, a QMCSO is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (a) creates or extends the rights of an "Alternate Recipient" to participate in a group medical plan, including this Plan, or (b) enforces certain laws relating to medical child support. An "Alternate Recipient" is any child of a participant who is recognized by a medical child support order as having a right to enrollment under a participant's group medical plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the College if it receives a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

I-34. How are Domestic Partners treated under the Plan?

A Domestic Partner means an individual who is the same-sex or opposite-sex companion of a Participant with respect to whom the Participant has completed and filed with the Plan Administrator an affidavit or any such other documentation required by the Plan Administrator to confirm the status of such individual. A Domestic Partner may, but is not required to be, a Dependent of the Participant. To the extent a Domestic Partner is otherwise defined in one of the plans referenced in Answer I-3, or if such plan imposes additional qualifications or coverage restrictions on an individual intending to qualify for Domestic Partner status, such definitions, qualifications and/or coverage restrictions will be controlling.

With respect to a Domestic Partner who qualifies as a Dependent, a Participant may elect to pay for the Participant's share of the cost of the Domestic Partner's coverage on a pre-tax basis and such benefits will not constitute taxable income to the Participant. With respect to a Domestic

Partner who does not qualify as a Dependent, the cost attributable to such benefits for such individual may only be paid on an after-tax basis and the value of such coverage will be treated as taxable income to the Participant. In addition, a Participant may not be reimbursed under the Health Care Spending Account Plan for any health care expenses incurred by a Domestic Partner who is not a Dependent.

PART II HEALTH CARE REIMBURSEMENT BENEFITS

One of the important features of the Plan is your opportunity each Plan Year to elect to receive income tax-free (for federal and certain state income tax purposes) reimbursement for some or all of your uninsured Eligible Health Care Expenses under the Health Care Spending Account Plan. Under the Health Care Spending Account Plan, you elect to contribute funds to an account on a pre-tax basis (and in some cases on an after-tax basis) to be used to reimburse you for certain Eligible Health Care Expenses.

II-1. Who may participate in the Health Care Spending Account Plan?

Each Employee of the College who is a Full-Time Faculty, a Full-Time Non-Faculty, a Part-Time Faculty or a "Part-Time Non-Faculty" (as defined in Answer I-2, above) is eligible to participate in the Plan.

II-2. How do I become a participant?

You become a participant in the Health Care Spending Account Plan by completing and filing an Enrollment Form with the Plan Administrator by the date specified on the form initially provided to you or during subsequent annual Open Enrollment Period(s).

Note: If you elect health care flexible spending account benefits, you cannot also elect HSA benefits or otherwise make contributions to an HSA unless you elect the limited (vision/dental/preventive care) health care flexible spending account coverage option. If you are married and elect the general purpose health care flexible spending account coverage option, your Spouse will also be ineligible to make HSA contributions. In addition, because the health care flexible spending account includes a Grace Period, if you have an election for health care flexible spending account benefits (other than the limited (vision/dental/ preventive care) health care flexible spending account coverage option) that is in effect on the last day of a Plan Year, you cannot elect HSA benefits or otherwise make contributions to an HSA for any of the first three calendar months following the close of that Plan Year, unless the balance in your health care flexible spending account is \$0 as of the last day of that Plan Year. Unless you have elected employee-only or employee-plus-children health care flexible spending account coverage, your Spouse will also be unable to make HSA contributions during this period, unless the balance in your health care flexible spending account is \$0 as of the last day of that Plan Year. For this purpose, your health care flexible spending account balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

II-3. What is my Health Care Spending Account?

If you elect to participate in the Health Care Spending Account Plan, a medical spending account will be set up in your name to receive your contributions. Reimbursement of Eligible Health Care Expenses (as defined in Answer II-8, below) will be paid from this account. No interest or earnings will be credited to your account at any time.

II-4. How much may I contribute to my Health Care Spending Account?

You may set aside up to \$2,700 for payments or reimbursements of Eligible Health Care Expenses effective for 2019 Plan Year.

The Plan Administrator may adjust your contributions and reimburse funds in your health care spending account, during a Plan Year if you are a key employee or highly compensated individual (as defined by the Code), if necessary to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

II-5. What benefit amounts will be available for reimbursement during the Plan Year?

Provided that you have continued to make the periodic contributions to your health care spending account, the full amount of coverage you have elected will be available as a benefit at any time during the Plan Year plus the Grace Period, reduced by the amount of prior reimbursements received during the Plan Year.

II-6. Who is an "Eligible Dependent" for whom I may claim a reimbursement under the Health Care Spending Account Plan?

"Dependent" means, unless otherwise provided in the Compensation Reduction Agreement, (a) a Participant's "Spouse"; (b) a "Child" through the end of the Plan Year in which they turn age 26, regardless of student status, employment status or marital status, and regardless of whether they live with you and/or is financially dependent upon you for support; or (c) of any age, provided they are "Totally Disabled." A Domestic Partner (as defined in Answer I-34 above) may also qualify as a Dependent. For purposes of defining Dependent, "Spouse", "Child" and "Totally Disabled" are defined as follows:

(i) "Spouse" means an individual who is legally married to the Participant;

(ii) "Child" means, an individual who: (1) is the natural child, legally adopted child, child legally placed for adoption, foster child, or a stepchild of the Participant; (2) is under permanent legal guardianship of the Participant; or (3) is awarded coverage pursuant to an Order of the Court; and

(iii) "Totally Disabled" means an individual that suffers from the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from injury or illness which can be expected to result in death

or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months, and that such persistent inability commenced prior to the last day of the month of their 26th birthday.

II-7. How do I receive my benefits under the Health Care Spending Account Plan?

If you elect to participate in the Health Care Spending Account Plan, you will have to take certain steps to be reimbursed for your Eligible Health Care Expenses. When you incur an expense that is eligible for payment, you may submit a claim in writing to the Claims Administrator. Alternatively, you may be able to use an electronic payment card to pay for Eligible Health Care Expenses. In order to be eligible for the electronic payment card, you must abide by the terms and conditions of the electronic payment card program as described under Answer II-11, below.

You may not be reimbursed for any Eligible Health Care Expenses above the annual amount of benefit you have elected. You may not be reimbursed for any Eligible Health Care Expenses that arise before your Enrollment Form becomes effective, or for any expense incurred after the close of the Plan Year plus the Grace Period.

Please note that it is not necessary that you have actually paid an amount due for an Eligible Health Care Expense only that you have incurred such an expense, and that it is not being paid for or reimbursed from any other source.

II-8. What are "Eligible Health Care Expenses"?

"Eligible Health Care Expenses" mean deductibles, co-payments, co-insurance and expenses incurred during the Plan Year by you, your Spouse, your Domestic Partner or your Dependent(s), for medical care as defined in Section 213(d) of the Code (i.e., amounts paid for hospital bills, doctor bills, dental bills, vision bills, hearing bills and well baby bills), but only to the extent that you or another person incurring the expense is not reimbursed for the expense through insurance or otherwise (other than under the Health Care Spending Account Plan). Notwithstanding the foregoing, Eligible Health Care Expenses will not include premiums for health coverage, or (b) an expenditure for a drug other than (i) one that is prescribed by a physician, (ii) insulin, or (iii) an expenditure for nonprescription drugs (only prescribed over-the-counter drugs that are purchased will be eligible for reimbursement) provided the expense is for medical care as defined in Section 213(d) of the Code. The Plan Administrator will determine whether any other amounts constitute Eligible Health Care Expenses. Eligible Health Care Expenses are incurred, under most circumstances, when the medical care is provided, not when you are formally billed, charged for, or pay the expense.

II-9. When must an Eligible Health Care Expense be incurred to be reimbursed?

Eligible Health Care Expenses must have been incurred during the Plan Year plus the Grace Period immediately following the Plan Year. You may not be reimbursed for any expenses arising before your benefits enrollment becomes effective, or for any expenses incurred after the close of the Plan Year plus the Grace Period immediately following the Plan Year.

II-10. What if the Eligible Health Care Expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any unused amounts credited to your health care spending account as of the end of the Plan Year plus the Grace Period immediately following the Plan Year will be forfeited and retained by the College.

II-11. What is an "Electronic Payment Card"?

An Electronic Payment Card (the "Card") allows you to pay for certain benefits in which you participate at the time that you incur the expense. In order to be eligible for the Card, you must agree, in writing, to abide by the terms and conditions of the Card Program (the "Program") and the Electronic Payment Cardholder Agreement (the "Agreement"), including any fees applicable to the Program, limitations as to Card usage, the Plan's right to withhold and offset for ineligible claims, etc. You must agree to abide by the terms of the Program during the initial election period and during each annual election period. The Agreement will be provided to you when you receive the Card from the Claims Administrator. The Card will be effective the first day of the Plan Year unless you affirmatively opt-out of the Program.

You must abide by the following rules when activating the Card:

- (a) the Card will automatically be cancelled upon your termination of employment or coverage under the Plan. You may not use the Card during any applicable coverage continuation period under COBRA;
- (b) as specified in the Agreement, you must certify during the applicable election period that (i) the amounts in the Plan will only be used for eligible expenses (*i.e.*, health care expenses incurred by you, your Spouse and/or your Dependent(s)), (ii) you have not been reimbursed for the expense, (iii) you will not seek reimbursement for the expense from any other source and (iv) you will acquire and retain sufficient documentation (including invoices and receipts for any expense paid with the Card);
- (c) use of the Card for expenses under the Health Care Spending Account Plan will be limited to merchants who are healthcare providers (doctors, pharmacies, etc.). As set forth in the Agreement, you will not be able to use the Card at a regular retail store. Use of the Card for expenses under the Dependent Care Spending Account Plan will be limited to merchants who are child care providers. Use of the Card for other Plan expenses will be limited to merchants of qualified classifications;
- (d) the amount available through the Card will equal the amount elected by you for reimbursement under the applicable spending account plan (reduced by amounts paid or reimbursed during the Plan Year);
- (e) the Card and/or Program will include a statement providing that the Agreement applies each time you use the Card; and
- (f) if you do not provide adequate or timely substantiation as requested by the Plan service provider, you will repay the Plan for the unsubstantiated expense. The deadline for repaying the Plan will be determined by the Claims Administrator. If you fail to repay the

Plan within the applicable time period, the Card will be turned off and an amount equal to the unsubstantiated expense will be offset against future eligible claims under the Plan. If claims fail to be submitted prior to the date your coverage terminates in the Plan, or claims fail to be sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay or the remaining unpaid amount will be included in your gross income as taxable wages.

PART III DEPENDENT CARE REIMBURSEMENT BENEFITS

Another major feature of the Plan is your opportunity each Plan Year to elect to receive tax-free (for federal income tax purposes) reimbursement for some or all of your Eligible Dependent Care Expenses under the Dependent Care Spending Account Plan. Under the Dependent Care Spending Account Plan, you elect to contribute funds to an account on a pre-tax basis to be used to reimburse you for certain Eligible Dependent Care Expenses.

III-1. Who may participate in the Dependent Care Spending Account Plan?

Each employee of the College who is eligible to participate in the Health Care Spending Account Plan as described in Answer II-1, above.

III-2. How do I become a participant?

You become a participant in the Dependent Care Spending Account Plan by completing and filing an Enrollment Form with the Plan Administrator by the date specified on the form initially provided to you or during subsequent annual Open Enrollment Period(s).

III-3. What is my Dependent Care Spending Account?

If you elect to participate in the Dependent Care Spending Account Plan, a Dependent Care Spending Account will be set up in your name to receive your contributions. Reimbursement of Eligible Dependent Care Expenses (as defined in Answer III-8, below) will be paid from this Dependent Care Spending Account. No interest or earnings will be credited to your Dependent Care Spending Account at any time.

III-4. How much may I contribute to my Dependent Care spending Account?

The maximum amount of Eligible Dependent Care Expenses which will be reimbursed under the Dependent Care Spending Account Plan is the least of:

- (a) \$5,000 per calendar year (or \$2,500 in the case where a separate federal income tax return is filed by you, as married);
- (b) your earned income for the Plan Year; or
- (c) your Spouse's earned income for the Plan Year. If your Spouse is a student or is physically or mentally incapable of caring for themselves, your Spouse will be deemed to

have earned income (for each month that your Spouse is a student or incapacitated) of \$250 per month if you have one Qualifying Individual (as defined in Answer III-6, below) for whom care is provided and of \$500 per month if you have two or more Qualifying Individuals for whom care is provided.

The College may require that you and/or your Spouse certify to the College the amount of your Spouse's expected earned income for the Plan Year in question and may require that you provide documentary evidence of the amount certified in the form of an employment contract, paycheck stub, medical records (if your Spouse is incapacitated) or a school enrollment form (if your Spouse is a student).

III-5. What benefit amounts will be available for reimbursement during the Plan Year?

Provided that you have continued to make periodic contributions to your Dependent Care Spending Account, the amount of coverage that is available for reimbursement of Eligible Dependent Care Expenses at any particular time during the Plan Year plus the Grace Period immediately following the Plan Year will be equal to the amount credited to your account at the time your claim is paid, reduced by the amount of prior reimbursements received during the Plan Year plus the Grace Period.

III-6. Who is a "Qualifying Individual" for whom I may claim a reimbursement under the Dependent Care Spending Account Plan?

You may be reimbursed for expenses incurred on behalf of any individual who is:

(a) 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 dependence exemption); or

(b) your Spouse or a person who is your Dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), but only if they are physically or mentally incapable of self-care.

III-7. How do I receive my benefits under the Dependent Care Spending Account Plan?

If you elect to participate in the Dependent Care Spending Account Plan, you will have to take certain steps to be reimbursed for your Eligible Dependent Care Expenses. When you incur an expense that is eligible for payment, you must submit a claim on a claim form that will be supplied to you by the Claims Administrator to pay for Eligible Dependent Care Expenses incurred during the Plan Year plus the Grace Period. If there are enough credits to the account, you will be reimbursed for your Eligible Dependent Care Expenses, as soon as administratively feasible, following the date of your submitted claim. Alternatively, you may be able to use an electronic payment card to pay for Eligible Dependent Care Expenses. In order to be eligible for the electronic payment card, you must abide by the terms and conditions of the electronic payment card program described under Answer II-11, above.

If your claim was for an amount that was more than your current account balance, the excess part of the claim will be carried over, to be paid out as your balance becomes adequate. Remember though, that you cannot be reimbursed for any total Eligible Dependent Care Expenses above your available, annual credits to your account. You may not be reimbursed for any Eligible Dependent Care Expenses that arise before your Compensation Reduction Agreement form becomes effective, or for any expense incurred after the close of the Plan Year plus the Grace Period.

Please note that it is not necessary that you have actually paid an amount due for an Eligible Dependent care Expense only that you have incurred such an expense, and that it is not being paid or reimbursed from any other source.

III-8. What are "Eligible Dependent Care Expenses"?

Eligible Dependent Care Expenses are expenses incurred during the Plan Year by you to enable you to be gainfully employed and which is paid for the care of a Qualifying Individual in your home or at a dependent care facility or for related household services.

The following items will not be considered Eligible Dependent Care Expenses:

- (a) amounts paid to a person with respect to whom you or your Spouse is entitled to claim an exemption for federal income tax purposes;
- (b) amounts paid to your child who is 18 years of age or younger;
- (c) amounts paid to your Spouse;
- (d) amounts paid for or reimbursed under another plan of the College or to which the College contributed on your behalf, under any federal, state or local program of dependent care assistance, or by the employer of your Spouse or by an educational institution where your Spouse is an enrolled student;
- (e) expenses incurred for food or clothing for your Qualifying Individual(s);
- (f) expenses incurred for housekeeping not related to dependent care;
- (g) expenses incurred for day care that is not provided by an approved, certified or licensed provider under applicable state or local law;
- (h) expenses incurred for music lessons, dance lessons or other educational activities for your Qualifying Individual in kindergarten or higher-grade level;
- (i) expenses incurred for overnight camp;
- (j) expenses incurred for transporting your Qualifying Individual(s) between your home and a dependent care facility; or
- (k) expenses incurred for medical care of your Qualifying Individual(s).

III-9. Will I be taxed on the Dependent Care reimbursement benefits I receive?

You will not normally be taxed for federal income tax purposes on your Dependent care reimbursement benefits, up to the limits described in Answer III-4, above. However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with Dependent care services during the calendar year for which you have claimed a tax-free reimbursement.

III-10. When must an Eligible Dependent Care Expense be incurred to be reimbursed?

Eligible Dependent Care Expenses must have been incurred during the Plan Year plus the Grace Period immediately following the Plan Year. You may not be reimbursed for any expenses arising before your Enrollment Form becomes effective or for any expenses incurred after the close of the Plan Year plus the Grace Period immediately following the Plan Year.

Qualifying Dependent Care Expenses incurred after the date you cease participation in the Plan (for example, after termination of employment) and through the last day of that Plan Year (including the Grace Period immediately following that Plan Year) may be reimbursed provided all of the requirements of Code Section 129 are satisfied.

III-11. What if the Eligible Dependent Care Expenses I incur during the Plan Year are less than the annual benefit I have elected?

Any unused amounts credited to your Dependent Care Spending Account as of the end of the Plan Year plus the Grace Period will be forfeited and retained by the College.

**PART IV
EMPLOYEE WELFARE BENEFITS**

IV-1. What are the types of employee welfare benefits offered by the College?

In addition to the reimbursement-type benefits described in Parts II and III, above, the College sponsors the Medical Insurance Plan, the Dental Insurance Plan and the Supplemental Health Plan. For example, you become a participant in the Medical Insurance Plan by completing and filing an Enrollment Form with the Plan Administrator by the date specified on the form initially provided to you or during subsequent annual Open Enrollment Period(s).

You will be provided, at no charge, a detailed description of benefits and the various conditions relating to eligibility for those benefits as well as a detailed schedule of benefits under separate employee welfare benefit plan communications. Some of the items addressed in the communications that are not covered in the SPD include the following:

- (a) a description of any cost-sharing provisions, including premiums, deductibles, coinsurance, and co-payment amounts for which you will be responsible and any annual or lifetime caps or other limits on benefits under the Medical Insurance Plan;

- (b) the extent to which preventive services are covered under the Medical Insurance Plan;
- (c) whether and under what circumstances existing and new drugs are covered under the Medical Insurance Plan;
- (d) whether and under what circumstances coverage is provided for medical tests, devices and procedures;
- (e) any conditions or limits on selection of primary care providers or providers of specialty medical care;
- (f) any conditions or limits applicable to obtaining emergency medical care; and
- (g) any provisions requiring preauthorization or utilization review as a condition of obtaining a benefit on service under the Medical Insurance Plan.

IV-2. What expenses relating to pregnancy and birthing are covered under the Medical Insurance Plan?

Expenses related to pregnancy and birthing are covered under the Medical Insurance Plan according to the following schedule:

- (a) Prenatal care of the mother and/or fetus is treated as any other illness or injury covered under the Medical Insurance Plan.
- (b) Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending health care provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- (c) No authorization from the Medical Insurance Plan need be sought by the attending provider for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, as the case may be). In any case, the 48- or 96-hour limit may be exceeded with authorization of the College in cases of medical necessity.

IV-3. Are expenses relating to mastectomies covered under the Medical Insurance Plan?

Since the Medical Insurance Plan provides medical and surgical benefits for mastectomies, the Plan is subject to the requirements of the Women's Health and Cancer Rights Act of 1998. If you are receiving benefits in connection with a mastectomy, coverage will be provided in a manner determined in consultation with the attending physician and you, for:

- (a) all stages of reconstruction of the breast on which the mastectomy was performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

IV-4. What other recently enacted Federal laws apply to the Medical Insurance Plan?

Each Plan Year, a notice will be provided, as part of the annual Benefit enrollment materials, to all individuals who are eligible to enroll in the prescription drug program under Medicare Part D stating whether the prescription drug program maintained by the College constitutes "creditable" or "non-creditable" prescription drug coverage so as to afford these individuals with the information necessary to help them decide whether to enroll in Medicare Part D.

Under the Mental Health Parity and Addiction Equity Act of 2008, co-pays, deductibles and annual and lifetime health treatment benefits will be required to be treated in the same way as all other medical and surgical procedures covered by the Medical Insurance Plan.

The Genetic Information Nondiscrimination Act of 2008 ("GINA"), added new provisions regarding genetic information. Generally, these provisions include prohibitions against: (a) requesting or requiring individuals or their family members to undergo genetic testing; (b) using genetic information to determine eligibility for coverage or to impose preexisting condition exclusions; (c) collecting genetic information for underwriting purposes or with respect to any individual prior to enrollment or coverage; and (d) adjusting group premium or contribution amounts on the basis of genetic information.

IV-5. What is "Coordination of Benefits"?

"Coordination of Benefits" means the order of payment when benefits are payable under two (2) or more plans. If you are covered under the Medical Insurance Plan and also covered under one or more "Other Plans" and the sum of the benefits payable under all the plans exceed your "Eligible Charges" during any "Claim Determination Period," then the benefits payable under all the plans involved will not exceed the Eligible Charges for such period as determined under the Medical Insurance Plan. Benefits payable under another plan are included, whether or not a claim has been made. For this purpose, "Other Plan," "Claim Determination Period" and "Eligible Charge" are defined as follows:

(a) "Other Plan" means the following plans providing benefits or services for medical or dental care or treatment: (i) group insurance or any other arrangement for coverage for individuals in a group, whether on an insured or uninsured basis; (ii) any individual insurance arrangement, (iii) Medicare or Medicaid; or (iv) No-Fault or uninsured motorist automobile coverage.

(b) "Claim Determination Period" means a calendar year.

(c) "Eligible Charge" means any necessary, reasonable and customary item of which at least a portion is covered under the Medical Insurance Plan, but does not include charges specifically excluded from benefits under the Medical Insurance Plan that also may be eligible under any other plans covering the individual for whom the claim is made.

If an individual is covered under two or more plans, the plans will coordinate benefits and share the responsibility for payment of Eligible Charges. The order in which benefits will be determined is as follows:

(a) if the Other Plan does not have a coordinating provision, the Other Plan will be the primary plan and will pay first; and

(b) if the Other Plan has a coordinating provision, reimbursement will be primarily payable under the Medical Insurance Plan if you incurred the Eligible Charge as an Eligible Employee.

PART V HSA BENEFITS

V-1. What are "HSA Benefits"?

An HSA permits Eligible Employees to make pre-tax contributions to an HSA established and maintained outside the Plan with the Eligible Employee's HSA trustee/custodian. For purposes of the Plan, HSA Benefits consist solely of the ability to make such pre-tax contributions under the Plan.

If you elect HSA Benefits, then you will be able to provide a source of pre-tax contributions by entering into agreement with the College. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes.

To participate in the HSA Benefits, you must be an "HSA-Eligible Individual." This means that you are eligible to contribute to an HSA under the requirements of Code Section 223 and that you have elected qualifying High Deductible Health Plan coverage offered by the College and have not elected any disqualifying non-High Deductible Health Plan coverage offered by the College. "High Deductible Health Plan" means the high deductible health plan offered by the College that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials that will be provided separately to you by the College. If you elect HSA Benefits, you will be required to certify that you meet all of the requirements under Code Section 223 to be eligible to contribute to an HSA. These requirements include such things as not having any disqualifying coverage – and you should be aware that coverage under a Spouse's or Domestic Partner's plan could make you ineligible to contribute to an HSA. To find out more about HSA eligibility requirements and the consequences of making contributions to an HSA when you are not eligible (including possible excise taxes and other penalties), see IRS Publication 969 ("Health Savings Accounts and other Tax-Favored Health Plans"). In order to elect HSA Benefits under the Plan, you must establish and maintain an HSA outside of the Plan with an HSA trustee/custodian and you must provide sufficient identifying information about your HSA to facilitate the forwarding of your contributions through the College's payroll system to your designated HSA trustee/custodian.

If you elect to participate in the Health Care Flexible Spending Account Plan, you cannot also elect HSA Benefits (or otherwise make contributions to an HSA) unless you elect the limited (vision/dental/preventive care) health care flexible spending account coverage option. In addition, because the health care flexible spending account includes a Grace Period, if you have an election for health care flexible spending account reimbursement (other than the limited (vision/dental/preventive care) health care flexible spending account coverage option) that is in effect on the last day of a Plan Year, you cannot elect HSA Benefits (or otherwise make contributions to an HSA) for any of the first three calendar months following the close of that Plan Year, unless the balance in your health care flexible spending account is \$0 as of the last day of that Plan Year. For this purpose, your health care flexible spending account balance is determined on a cash basis – that is, without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

In the event that an expense is eligible for reimbursement under both the Health Care Flexible Spending Account Plan and the HSA, you may seek reimbursement from either the Health Care Flexible Spending Account Plan or the HSA, but not both. (If the College ever adds an HRA, then in the event that an expense is eligible for reimbursement under both the Health Care Flexible Spending Account Plan and the HRA, the Health Care Flexible Spending Account Plan must pay first.)

V-2. What is my "HSA"?

The HSA is not an employer-sponsored employee benefit plan. The HSA is an individual trust or custodial account that you open with an HSA trustee/custodian to be used primarily for reimbursement of "eligible medical expenses" as set forth in Code Section 223 incurred by you, your Spouse, your Domestic Partner and your other Dependent(s). Consequently, an HSA trustee/custodian, not the College, will establish and maintain your HSA. The HSA trustee/custodian will be chosen by you, as the participant, and not by the College. The College may, however, limit the number of HSA providers to whom it will forward pre-tax contributions, a list of whom will be provided upon request. Any such list of HSA trustees/custodians, however, shall be maintained for administrative simplification and shall not be an endorsement of any particular HSA trustee/custodian. Your HSA is administered by your HSA trustee/custodian. The College's role is limited to allowing you to contribute to your HSA on a pre-tax contribution basis. The College has no authority or control over the funds deposited in your HSA. As such, the HSA identified above is not subject to ERISA.

The Plan Administrator will maintain records to keep track of HSA pre-tax contributions that you make, but it will not create a separate fund or otherwise segregate assets for this purpose.

V-3. What are the maximum HSA Benefits that I may elect under the Plan?

Your annual contribution for HSA Benefits is equal to the annual benefit amount that you elect (for example, if the maximum \$7,000 annual benefit amount is elected for 2019, then the annual contribution amount is also \$7,000). The amount you elect must not exceed the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. (Note: \$3,500 for single and \$7,000 for family are the statutory maximum amounts for 2019). An additional catch-up

contribution of \$1,000 may be made if you are age 55 or older (you must certify your age to the College).

In addition, the maximum annual contribution shall be:

- (a) reduced by any matching (or other) College contribution made on your behalf (there are currently no such College contributions, other than pre-tax contributions, made under the Plan); and
- (b) pro-rated for the number of months in which you are an HSA-Eligible Individual.

Note: if you are an HSA-Eligible Individual for only part of the year but you meet all of the requirements under Code Section 223 to be eligible to contribute to an HSA on December 1, you may be able to contribute up to the full statutory maximum amount for HSA contributions applicable to your coverage option (i.e., single or family). However, any contributions in excess of your annual contribution under the Plan for HSA Benefits (as described above), but not in excess of the applicable full statutory maximum amount, must be made outside the Plan. In addition, if you do not remain eligible to contribute to an HSA under the requirements of Code Section 223 during the following year, the portion of HSA contributions attributable to months that you were not actually eligible to contribute to an HSA will be includible in your gross income and subject to a 10% penalty (exceptions apply in the event of death or disability).

V-4. How are my HSA Benefits paid for under the Plan?

To participate in HSA Benefits, you specify the amount of HSA Benefits that you wish to pay for with your salary reduction contributions. From then on, you make a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator). For example, suppose that you have elected to contribute up to \$1,000 per year for HSA Benefits and that you have chosen no other benefits under the Plan. If you pay all of your contributions, then our records would reflect that you have contributed a total of \$1,000 during the Plan Year. If you are paid bi-weekly, then our records would reflect that you have paid \$41.66 (\$1,000 divided by 24) each pay period in contributions for the HSA Benefits that you have elected. Such contributions will be forwarded to the HSA trustee/custodian (or its designee) within a reasonable time after being withheld.

The College makes no contribution to your HSA, nor does the College have authority or control over the funds deposited in your HSA.

V-5. Will I be taxed on the HSA Benefits that I receive?

You may save both federal income taxes and FICA (Social Security) taxes by participating in the Plan. However, very different rules apply with respect to taxability of HSA Benefits than for other benefits offered under this Plan. For more information regarding the tax ramifications of participating in HSA benefits with an HSA trustee/custodian and see IRS Publication 969 ("Health Savings Accounts and Other Tax-Favored Health Plans").

The College cannot guarantee that specific tax consequences will flow from your participation in the Plan. Ultimately, it is your responsibility to determine the tax treatment of HSA Benefits. Remember that the Plan Administrator is not providing legal advice. If you need an answer upon which you can rely, you may wish to consult a tax advisor.

V-6. Who can contribute to an HSA under the Plan?

Only Eligible Employees who are HSA-Eligible Individuals can participate in the HSA Benefits.

V-7. Can I change my HSA contribution under the Plan?

You may increase, decrease, or revoke your HSA contribution election at any time during the Plan Year for any reason by submitting an election change form to the Plan Administrator (or to its designee). Your election change will be prospectively effective on the first day of the month following the month in which you properly submitted your election change. Your ability to make pre-tax contributions under this Plan to the HSA identified above ends on the date that you cease to meet the eligibility requirement.

V-8. Where can I get more information on my HSA and its related tax consequences?

For details regarding your rights and responsibilities with respect to your HSA (including information regarding the terms of eligibility, what constitutes a qualifying High Deductible Health Plan, contributions to the HSA, and distributions from the HSA), please refer to your HSA trust or custodial agreement and other documentation associated with your HSA and provided to you by your HSA trustee/custodian. You may also want to review IRS Publication 969 ("Health Savings Accounts and Other Tax Favored Health Plans").

**PART VI
USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

VI-1. Use and Disclosure of Protected Health Information.

The applicable Underlying Plans shall use protected health information ("PHI") to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the applicable Underlying Plans shall use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the applicable Underlying Plans to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- (a) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

- (b) coordination of benefits;
- (c) adjudication of health benefit claims (including appeals and other payment disputes);
- (d) subrogation of health benefit claims;
- (e) establishing employee contributions;
- (f) risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (g) billing, collection activities and related health care data processing;
- (h) claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- (i) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- (j) medical necessity reviews or reviews of appropriateness of care or justification of charges;
- (k) utilization review, including precertification, preauthorization, concurrent review and retrospective review, and;
- (l) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

Health Care Operations include, but are not limited to, the following activities:

- (a) quality assessment;
- (b) population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- (c) rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- (d) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

- (e) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- (f) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the applicable Underlying Plans, including formulary development and administration, development or improvement of payment methods or coverage policies;
- (g) business management and general administrative activities of the applicable Underlying Plans, including, but not limited to:
 - (i) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (ii) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- (h) resolution of internal grievances; and
- (i) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, shall become a covered entity.

VI-2. Disclosure as Required by Law and as Permitted By Authorization of the Participant or Beneficiary.

The applicable Underlying Plans will use and disclose PHI as required by law and as permitted by authorization of the Participant or Beneficiary.

VI-3. Disclosure to the College.

The applicable Underlying Plans shall disclose PHI to the College only upon receipt of a certification from the College that the applicable Underlying Plan documents have been amended to incorporate the following provisions set forth in Section VI-4.

VI-4. With respect to PHI, the College Agrees to Certain Conditions.

The College agrees to:

- (a) not use or further disclose PHI other than as permitted or required by the applicable Underlying Plan documents or as required by law;
- (b) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- (c) ensure that any agents, including a subcontractor, to whom the College provides PHI received from the applicable Underlying Plans, agree to implement reasonable

and appropriate security measures to protect electronic PHI, and also agree to the same restrictions and conditions that apply to the College with respect to all PHI;

(d) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(e) not use or disclose PHI in connection with any other benefit or employee benefit plan of the College unless authorized by an individual;

(f) report to the applicable Underlying Plans any PHI use or disclosure that is inconsistent with the uses or disclosures provided for or which it becomes aware;

(g) report to the Plan any security incident of which the College becomes aware;

(h) make PHI available to an individual in accordance with access requirements under 45 CFR Section 164.524;

(i) make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;

(j) make available the information required to provide an accounting of disclosures of individual's PHI, the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

(k) make internal practices, books and records relating to the use and disclosure of PHI received from the applicable Underlying Plans available to the Secretary of Health and Human Services for the purposes of determining compliance with HIPAA; and

(l) if feasible, return or destroy all PHI received from the applicable Underlying Plans that the College still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

VI-5 Adequate Separation Between the Applicable Underlying Plans and the College Must Be Maintained.

In accordance with HIPAA, only Employees of the corporate or divisional Human Resource offices of the College may be given access to PHI.

VI-6. Limitations of PHI Access and Disclosure.

The persons described in Section E may only have access to and use and disclose PHI for plan administration functions that the College performs for the applicable Underlying Plans.

VI-7. Noncompliance Issues.

If the persons described in Section V-5 do not comply with this Part V, the College shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

VI-8. Permitted Uses and Disclosures of Summary Health Information.

The applicable Underlying Plan may disclose "Summary Health Information" to the Company, provided such Summary Health Information is only used by the Company for the purpose of:

- obtaining premium bids from health plan providers for providing health coverage under the Plan; or
- modifying, amending or terminating the Plan.

"Summary Health Information" means information that may be individually identifiable health information:

- that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Employer has provided health benefits under a health plan; and
- from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted.

PART VII ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants will be entitled to:

Receive Information About Your Plan.

Examine without charge, at the Plan Administrator's office and at other specified locations, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the applicable Underlying Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue health care coverage for yourself, Spouse, Domestic Partner or other Dependent(s) if there is a loss of medical coverage under the applicable Underlying Plan as a result of a Qualifying Event. You or your named Dependents may have to pay for such coverage. Review this SPD and the documents governing the applicable Underlying Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, 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 the 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. NOTE: This credit right does not apply to the Health Care Spending Account Plan, which is an "excepted benefit" under HIPAA.

Receive a separate notice from the College (or medical insurers) that outlines its health privacy policies under HIPAA.

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 the 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 prevent you from obtaining a benefit from the Plan, or from exercising your rights under ERISA.

If your claim for a 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 materials 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 Plan Administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the 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 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 the Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, or if you need assistance in obtaining documents

from the Plan Administrator, you should contact the nearest Area Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling EBSA toll free at 1-866-444-EBSA (3272). You may also visit EBSA's website on the internet at <http://www.dol.gov/ebsa>.

PART VIII ADMINISTRATIVE INFORMATION

1. The name of the Plan is the Gettysburg College Flexible Benefits Plan.

2. The name, address and telephone number of the Plan Sponsor are:

Name: Gettysburg College
Address: 300 North Washington Street
Gettysburg, PA 17325
Telephone Number: (717) 337-6200

3. The name and, address and telephone number of the Plan Administrator are:

Name: Gettysburg College
Attn: Human Resources
Address: 300 North Washington Street
Gettysburg, PA 17325
Telephone Number: (717) 337-6200

4. The name, address, telephone number and federal identification number of the College are:

Name: Gettysburg College
Address: 300 North Washington Street
Gettysburg, PA 17325
Telephone Number: (717) 337-6200
Federal Identification Number: 23-1352641

5. The name, address and fax number of the Claims Administrator for the Health Care Spending Account Plan, the Dependent Care Spending Account Plan and the HSA are:

Name: OptumHealth Financial Services, Inc. ("OHFS")
Address: P.O. Box 30516
Salt Lake City, UT 84130-0516
Customer Care Center: 1-800-243-5543
Fax: 855-244-5016

6. The Plan number assigned by the Plan Administrator is 510.

7. The Plan is a "cafeteria plan" governed by Code Section 125.
8. The name and address of the Agent for Service of Legal Process are:

Name: Gettysburg College
Address: 300 North Washington Street
Gettysburg, PA 17325
9. The Plan Year is the calendar year.
10. The source of contributions to the Plan is both from the College and the participants.
11. The type of Plan administration is insurer and contract administration.