BOWDOIN COLLEGE
FLEXIBLE BENEFITS PLAN
HEALTH CARE REIMBURSEMENT PLAN
DEPENDENT CARE REIMBURSEMENT PLAN
SUMMARY PLAN DESCRIPTIONS

Effective as of January 1, 2018

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PART I – UNDERSTANDING YOUR BENEFITS

This booklet describes the basic features of the Bowdoin College Flexible Benefits Plan, Health Care Reimbursement Plan, and Dependent Care Reimbursement Plan (the “Plans”) as in effect on January 1, 2018. Every effort has been made to assure that the information provided here is accurate. However, in the event that this booklet states anything that disagrees with a formal Plan document, then the formal Plan document will be followed.

The Plans are maintained by Bowdoin College. Although the College intends to maintain the Plans indefinitely, it reserves the right to amend or terminate the Plans, in whole or in part, as it may deem necessary or desirable.

The health care reimbursement and dependent care reimbursement benefits described in this booklet are available to employees who participate in the Flexible Benefits Plan. The Flexible Benefits Plan also makes other benefits available on a tax-favored basis. These other benefits are the Bowdoin College Health Plan, Dental Plan, Vision Plan, and Supplemental Group-Term Life Insurance Plan. These benefits are offered under separate plans and are summarized in separate summary materials.

The Plans are administered by the Plan Administrator. The day-to-day administration of the Plans has been delegated, however, to the Contract Administrator, a third-party administrative services provider that specializes in administering employee benefits plans.

If you have any questions after reading this booklet, you should contact the Plan Administrator or Contract Administrator at the addresses and telephone numbers listed in “General Information about the Plans” at the end of this booklet. You (or your beneficiary, in the event of your death) are entitled to examine, without charge, all Plan documents and any other documents or reports maintained by each plan in which you are a participant. If you would like to review any of these documents, you should contact the Plan Administrator.

PART II – FLEXIBLE BENEFITS PLAN

The Flexible Benefits Plan gives you the choice of receiving part of your pay in the form of benefits instead of cash. This election means that your required contributions for these benefits are made on a pre-tax basis, resulting in tax savings to you. The benefits include the following:

- health care benefits
- dental benefits
- vision benefits
- a health care reimbursement account
- a dependent care reimbursement account
- group-term life insurance benefits

You may elect to contribute to a Health Savings Account arrangement; however, the Health Savings Account is not intended to be an ERISA benefit plan sponsored or maintained by the College.
Eligibility

A. Employees. You are eligible to participate in the Flexible Benefits Plan if you are an Employee of the College who is regularly scheduled to work 20 or more hours per week. The first date on which you are regularly scheduled to work 20 or more hours per week is your “eligibility date.” Eligibility requirements for the benefit plans offered under this Plan may vary, and you must satisfy the eligibility requirements for a particular benefit plan in order to receive benefits under that plan.

B. Dependents. An Employee’s spouse and dependents are not eligible to participate in the Flexible Benefits Plan. A Plan participant may, however, receive benefits for his or her spouse and eligible dependents through the Flexible Benefits Plan as follows:

- by electing dependent coverage under the Health Plan, Dental Plan, and/or Vision Plan;
- by receiving reimbursement for expenses incurred for the care of eligible dependents under the Dependent Care Reimbursement Plan; and
- by receiving reimbursement for health care expenses incurred by his or her spouse and eligible dependents under the Health Care Reimbursement Plan.

For purposes of these rules,

“Spouse” means the individual to whom an Employee is legally married (and from whom the Employee is not legally separated) for purposes of federal law.

“Eligible dependent” means, for purposes of the Health Plan, Dental Plan, Vision Plan, and Health Care Reimbursement Plan, the Employee’s son, daughter, stepchild, legally adopted child, or eligible foster child who is under age 26 or any other individual who qualifies as the Employee’s dependent for federal income tax purposes. See the Section entitled “Benefits” in Part IV below for a discussion of “eligible dependent” for purposes of the Dependent Care Reimbursement Plan.

Participation

To participate in the Flexible Benefits Plan and/or to cover an eligible dependent, you (the Employee) must file a benefit election using the written, telephonic, or electronic means required by the Plan Administrator within the appropriate time period. Currently all benefit elections are made on-line. If you are a newly eligible Employee, you must submit your benefit election within 30 days of your eligibility date. When your enrollment becomes effective depends on your eligibility date and the plan in which you enroll.

For the Health Plan, your benefit election will become effective on your eligibility date.

For all other plans, your benefit election will become effective on the first day of the month coincident with or next following your eligibility date.
If you elect dependent coverage, your eligible dependent will begin benefits coverage on the same date as you. You may also add your dependent at a later date as a result of Open Enrollment, Special Enrollment, or a Status Change (described below).

If you are a newly eligible Employee and your benefit election is not submitted within 30 days from your eligibility date, then you generally will not be able to participate in the Flexible Benefits Plan until the first day of the next Plan Year (January 1). That is, you will be able to enroll yourself (and/or your eligible dependents) only during Open Enrollment for the next year, a Special Enrollment Period, or in the event of a Status Change described below, provided the Plan Administrator receives your benefit election by the applicable deadline.

If you terminate employment with the College and then return to eligible employment within thirty (30) days in the same year, you may resume participation in the Plan by continuing the same benefit elections that were in effect when you terminated your employment. You may change your election only if and to the extent that you experience a Special Enrollment or Status Change event described below.

You may submit claims for reimbursement under the Flexible Benefits Plan only for expenses incurred on or after the date on which your benefit election becomes effective even if the expenses are not billed or paid until after the election is effective. For example, if your eligibility date is July 15, 2018 and you submit your election within 30 days of your eligibility date, your benefit election will become effective on August 1, 2018, and you may be reimbursed for expenses incurred on or after August 1, 2018. You may not, however, be reimbursed for any expenses incurred prior to August 1, 2018 (e.g., dependent care expenses for the month of July) even if they were paid in August. Expenses are "incurred" when the care is provided, not when the expenses are billed or paid.

Your participation in the Flexible Benefits Plan will terminate on the date you cease to meet the “Eligibility” requirements described above. Your termination will not affect your entitlement to benefits under any of the benefit plans offered under this Plan. Instead, your entitlement to benefits will be governed by the terms of the benefit plans.

Benefits

You indicate your choice of benefits by filing the appropriate benefit election using the written, telephonic, or electronic means required by the Plan Administrator. Currently all benefit elections are made on-line. The benefits offered under the Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan are summarized in this booklet. The College also provides you with a summary of the Health Plan, the Dental Plan, the Vision Plan, and the Supplemental Group-Term Life Insurance Plan. The plan documents for all of these plans are available for your inspection.
Your selection of benefits is subject to adjustment or restriction by the Plan Administrator to ensure compliance with the Internal Revenue Code. Any such adjustments or restrictions will be made on a uniform and nondiscriminatory basis.

Changing Your Benefits

A. Open Enrollment Period. The Open Enrollment Period is the period designated by the College prior to the start of each Plan Year during which you (the Employee) may change benefit plans, modify your benefit election, or enroll in the Flexible Benefits Plan if not previously enrolled. Except for a Status Change, as outlined below, or a Special Enrollment Period with respect to the Health Plan and/or Dental Plan, the Open Enrollment Period is the only time an Employee may change benefit options or become a participant in the Flexible Benefits Plan. Each year, during the Open Enrollment Period, you will receive new instructions for confirming or changing your benefit election. You must submit your benefit election by the date prescribed in your benefit election package to confirm or change your benefit election.

Default Coverage – If your benefit election is not received by the prescribed date, then you will be deemed to have elected the coverages that were in effect for the prior Plan Year (including no coverage) under the Health Plan, Dental Plan, Vision Plan, and Supplemental Group-Term Life Insurance Plan, but not under the Health Care Reimbursement Plan or the Dependent Care Reimbursement Plan.

You must submit a new benefit election each year in order to elect a dependent care reimbursement account or a health care reimbursement account.

Example. For the 2017 Plan Year, Irene elects family coverage under the Health and Dental Plans, no coverage under the Vision Plan, Supplemental Group-Term Life Insurance equal to one times annual salary, a health care reimbursement account in the amount of $2,000, and a dependent care reimbursement account in the amount of $5,000. Irene fails to properly submit an on-line benefit election by the prescribed date during the Open Enrollment Period for the 2018 Plan Year. Irene will be deemed to have elected family coverage under the Health and Dental Plans, no coverage under the Vision Plan, Supplemental Group-Term Life Insurance equal to one times annual salary, and no health care or dependent care reimbursement accounts for 2018. Irene will be able to add or change this benefit election only if she has a Status Change or qualifies for a Special Enrollment as described below.

B. Special Enrollment Periods. Special Enrollment Periods for Employees and their eligible dependents apply to the Health Plan and the Dental Plan. The Special Enrollment Periods do not apply to the Vision Plan, the Health Care Reimbursement Plan, the Supplemental Group-Term Life Insurance Plan, or the Dependent Care Reimbursement Plan.

1. Special Enrollment for Loss of Other Coverage – A Special Enrollment Period will apply if you are (or your dependent is) eligible to enroll in the Health Plan or Dental Plan, but do not enroll because you have (or your dependent has) other health care coverage, and
then you lose (or your dependent loses) the other coverage. Specifically, you will be offered the opportunity to enroll yourself (or your dependent) in the Health Plan and/or Dental Plan without having to wait until the next regular Open Enrollment Period, provided you (or your dependent) would otherwise be eligible for coverage under the Flexible Benefits Plan and:

(a) the other coverage was under COBRA, and the other coverage is lost due to the exhaustion of your (or your dependent’s) COBRA coverage benefits; or

(b) you lose (or your dependent loses) the other coverage due to a loss of eligibility for coverage (including a loss resulting from a legal separation, divorce, death, termination of employment, or reduction in number of hours of employment); or

(c) the employer contributions towards your (or your dependent’s) other coverage are terminated.

You (or your dependent) are not required to elect and exhaust COBRA coverage under another plan to enroll in the Health Plan or Dental Plan during a Special Enrollment Period. If you (or your dependent) do elect COBRA coverage under another plan, however, then the COBRA coverage under that plan must be exhausted before you (or your dependent) may elect to participate in the Health Plan or Dental Plan. The Special Enrollment rights do not apply if you (or your dependent) lose other coverage because you failed to pay your COBRA premiums or if termination of coverage was for cause (e.g., making a fraudulent or an intentional misrepresentation of fact in connection with the Plan).

You have 30 days from the date of your loss of other coverage to enroll in the Health Plan or Dental Plan and make a benefit election under the Special Enrollment Period. You will be enrolled in the Health Plan and/or Dental Plan effective on the first of the month coincident with or following the date of the Special Enrollment event (provided that the completed request for Special Enrollment is received by the Plan Administrator within 30 days of the loss of other coverage).

2. Special Enrollment for New Dependents - You may elect to enroll a new dependent in the Health Plan or the Dental Plan during a Special Enrollment Period if you acquire the dependent by:

(a) marriage, in which case dependent coverage will be effective on the first of the month coincident with or following the date of the marriage as long as the completed request for Special Enrollment is received by the Plan Administrator within 30 days of the date of the marriage; or

(b) birth, adoption, or placement for adoption, in which case coverage will be effective as of the date of birth, adoption, or placement for adoption.

In the event a new dependent is added because of a birth, adoption, or placement for adoption of a new child, then your spouse may be added as well. An election to add a new dependent in a Special Enrollment Period must be received by the Plan
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Administrator on or before the last day of the 30-day period beginning on the date of marriage, birth, adoption, or placement for adoption.

3. **Special Enrollment Related to Medicaid or CHIP Coverage** – Effective April 1, 2009, a Special Enrollment Period applies if you are (or your dependent is) eligible to enroll in the Health Plan or Dental Plan but are not enrolled, and either –

(a) You are (or your dependent is) covered under Medicaid or a state Children’s Health Insurance Program (“CHIP program”) and coverage is terminated as a result of a loss of eligibility for such coverage; or

(b) You become (or your dependent becomes) eligible for a premium assistance subsidy from a state with respect to coverage under the Plan and the Plan accepts this subsidy. Such subsidies are not currently available in Maine.

You have **60 days** after the date of your loss of Medicaid or CHIP program coverage (or becoming eligible for a premium assistance subsidy) to enroll in the Health Plan or Dental Plan and make a benefit election under the Special Enrollment Period. If your Special Enrollment election is received by the Plan Administrator within 60 days after the date of your loss of Medicaid or CHIP program coverage, then your election will be effective on the first of the month coincident with or following the loss of coverage date.

In the case of any Special Enrollment, the Plan Administrator will direct you in the proper way of making your benefit election.

C. **Status Changes.** With the exception of a Special Enrollment Period described above, your benefit election can be changed during the year only if there is a Status Change described below, that affects your (or your dependent’s) eligibility for coverage under this Plan or a qualified benefits plan maintained by your dependent’s employer (“Family Member Plan”). These Status Change rules apply only to the Health Plan, the Dental Plan, the Health Care Reimbursement Plan, and the Dependent Care Reimbursement Plan. **These rules do not apply to the Vision Plan (except as provided below), and the Supplemental Group-Term Life Insurance Plan.**

1. **Status Changes**

   - an event that changes your legal marital status (including marriage, death of a spouse, divorce, legal separation, or annulment);

   - an event that changes your number of eligible dependents (including birth, adoption, placement for adoption, or death);

   - one of the following events that changes the employment status of you, your spouse, or your eligible dependent: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, or any other change in employment status that results in you, (or your spouse or dependent) becoming or ceasing to be eligible for coverage under this Plan, a benefit option offered under the Plan or a Family Member Plan;
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- a change in place of residence or work for you or your spouse or dependent;
- an event that causes an individual to satisfy or cease to satisfy the requirements for coverage as an eligible dependent under the Flexible Benefits Plan (or one of the benefit options offered under the Flexible Benefits Plan); or
- your status (or the status of your dependent) changes in some other way that under federal law permits you to change your choice of benefits.

Any change to your choice of benefits must be on account of and consistent with one of these Status Changes. If you wish to make a change in your election for coverage under any of the health plans offered under the Flexible Benefits Plan, including the Health Plan, the Dental Plan, and the Health Care Reimbursement Plan (the “Health Benefit Plans”), then the change will be consistent with the Status Change only if the Status Change results in you, your spouse, or your eligible dependent gaining or losing eligibility for coverage under the Health Benefit Plan and the election change corresponds with that gain or loss of coverage.

Also, if the Status Change is (i) your divorce, annulment, or legal separation, (ii) the death of your spouse or dependent, or (iii) a dependent ceasing to be eligible for coverage, then you may elect to cancel coverage only for the affected person and no other individual.

If you, your spouse, or your dependent becomes eligible for coverage under this Plan or a Family Member Plan as a result of a change in marital status or employment status, then you may cancel coverage for an affected person only if that individual starts or increases coverage under the Plan or Family Member Plan.

**Example 1.** Irene marries spouse Bob. Bob is newly eligible for coverage under the Health Benefits Plans and the Flexible Benefits Plan. Irene may elect to cover Bob under the Health Benefit Plans.

**Example 2.** Irene is married to Bob. Bob has health care coverage under the plan of his employer. Bob switches from full-time to part-time and loses coverage under his employer’s plan. Irene may elect to cover Bob under the Health Benefit Plans.

2. **Other Status Changes.** In addition, the Flexible Benefits Plan will permit you to change an election upon the occurrence of one of the following events:

- You may revoke an existing election for coverage under a Health Benefit Plan if you commence a protected family or medical leave and reinstate a revoked election when you return from a protected family or medical leave (see the Section below entitled “Family and Medical Leave”).

- You may change your election if a court order, judgment, or decree (“order”) resulting from a divorce, legal separation, annulment, or change in legal custody requires you to provide health care coverage under a Health Benefit Plan, or you may cancel coverage if the order requires your spouse or former spouse to provide health
care coverage (see the Section below entitled “Qualified Medical Child Support Orders”) and that coverage is, in fact, provided.

- You may cancel health care coverage under a Health Benefit Plan with respect to a covered individual (you, your spouse, or your eligible dependent) who becomes entitled to Medicare or Medicaid coverage (except for coverage relating only to pediatric vaccines), or you may elect or increase coverage under a Health Benefit Plan with respect to a covered individual who loses Medicare or Medicaid coverage.

- You may change your election if there is a significant change in cost or coverage under a benefit plan, or a health coverage option under a Health Benefit Plan (but see paragraph 6, below entitled “Limitations,” of your (or your spouse’s or dependent’s) employer, or you (or your spouse or dependent) lost group health coverage sponsored by a governmental or educational institution.

**Example 1.** Irene is married to Bob. During Open Enrollment, Irene elects family coverage under the Bowdoin College Health Plan and also elects to defer $1,000 under the Health Care Reimbursement Plan. Bob’s employer’s health plan does not offer family coverage, and Bob does not elect coverage with his employer. During the plan year, however, Bob’s employer adds family coverage under its health plan. The addition of family coverage constitutes a new coverage option, and therefore, Bob may elect family coverage under his employer’s plan. Provided Bob actually elects family coverage, Irene may revoke her election for health coverage and elect no coverage for the remainder of the year. Irene may not, however, change her election under the Health Care Reimbursement Plan (see paragraph 5, below, entitled “Limitations.”)

**Example 2.** Irene is married to Bob. Irene elects single coverage under the Bowdoin College Health Plan, which is a calendar-year plan. Bob has single coverage under his employer’s plan, which has a plan year beginning July 1 and ending June 30. During the next open enrollment period for his employer’s plan, Bob elects family coverage effective July 1. Irene may revoke her election for single coverage under the Bowdoin College Health Plan.

**Example 3.** Irene is married to Bob, and they have one child. During Open Enrollment, Irene elects to defer $5,000 under the Dependent Care Reimbursement Plan. In April, Bob’s mother offers to provide child care for Irene and Bob on a full-time basis. The availability of dependent care services from a new child care provider (Bob’s mother) is a significant change in coverage similar to a new benefit package option becoming available. Irene may revoke her election for coverage under the Dependent Care Reimbursement Plan and make a corresponding new election to reflect the cost (if any) of the new child care provider.

**Example 4.** Irene is married to Bob, and they have one child. Irene and Bob’s child is cared for by household employee, Alice, who provides child care services five days a week from 9 a.m. to 6 p.m. During Open Enrollment, Irene elects to defer $5,000 under the Dependent Care Reimbursement Plan. In September, Irene and Bob’s child starts...
school, and Alice’s hours are reduced to 3 p.m. to 6 p.m., five days a week. The change in the number of hours of work performed by Alice is a change in coverage. Thus, Irene may reduce her previous election under the Dependent Care Reimbursement Plan.

3. **Vision Plan Status Changes.** Your coverage under the Vision Plan can be cancelled during the year only upon the occurrence of an event that causes you and/or your spouse or dependent to cease to satisfy the requirements for coverage under the Vision Plan, and you may elect to cancel coverage only for the affected person and no other individual. Also, you may revoke an existing election for coverage under the Vision Plan if you commence a protected family or medical leave and reinstate a revoked election when you return from a protected family or medical leave (see the Section below entitled “Family and Medical Leave”). Finally, you may change your election under the Vision Plan if a court order, judgment, or decree (“order”) resulting from a divorce, legal separation, annulment, or change in legal custody requires you to provide coverage under the Vision Plan, or you may cancel coverage if the order requires your spouse or former spouse to provide health care coverage (see the Section below entitled “Qualified Medical Child Support Orders”) and that coverage is, in fact, provided. You may not change your election under the Vision Plan for any other reason.

4. **Timing.** Any change to your benefit election must be made within 30 days after the date of the Status Change. If your benefit election change is timely, then your change will be effective as of the first day of the month coinciding with or next following the date of the Status Change, except in the case of a change that allows for a Special Enrollment Period described above. If you fail to change your existing benefit election within this time period, then you will have to wait until the next annual Open Enrollment Period to change your existing benefit election.

5. **Limitations.** Under federal law, some of these Status Changes will only permit you to change your choice of certain medical or health care benefits and may not apply to either the Dependent Care Reimbursement Plan or the Health Care Reimbursement Plan. For example, the rules on election changes due to cost or coverage changes do not apply to the Health Care Reimbursement Plan, and you may not change your Health Care Reimbursement Plan election if you make a change to other Health Benefit Plan elections due to cost or coverage of insurance. Also, you may not change your election under the Dependent Care Reimbursement Plan on account of a significant change in cost if such change is imposed by a dependent care provider who is your relative.

**Paying for Benefits**

The College pays for the benefits you choose with the portion of your pay, if any, that you direct to be used to provide benefits. This includes both your contributions toward coverage under the Health Plan, Dental Plan, Vision Plan, and Supplemental Group-Term Life Insurance Plan, and the amounts available to pay your claims under the Health Care Reimbursement Plan and Dependent Care Reimbursement Plan.
Under current federal law, the portion of your pay used to obtain benefits on a pre-tax basis is not considered taxable income to you. Accordingly, if you direct the College to use some of your pay to provide benefits for you on a pre-tax basis, then the College will withhold from each of your paychecks the amount that would otherwise be payable to you as taxable compensation. In short, by reducing your taxable income, it is possible to reduce the amount of taxes you pay and at the same time increase your benefits. For benefits provided on an after-tax basis, the amount the College withholds from your paycheck remains taxable.

PART III – HEALTH CARE REIMBURSEMENT PLAN

The Health Care Reimbursement Plan provides for reimbursement of many expenses that you incur for health care for yourself, your spouse, or your eligible dependents.

Eligibility for and Termination of Benefits

If you are eligible to participate in the Flexible Benefits Plan, then you are eligible to participate in the Health Care Reimbursement Plan. To participate, you must submit an appropriate benefit election as explained under “Participation” in Part II above. Your contributions to your health care reimbursement account will cease on the date you cease to be eligible to participate (unless you elect to continue your participation under COBRA). In addition, you will not be entitled to reimbursement for health care expenses incurred after termination of your participation. You will, however, continue to be entitled to reimbursement, in accordance with the terms of the Health Care Reimbursement Plan, for health care expenses incurred prior to termination of your participation. If you elect COBRA coverage, then you may continue to contribute to your health care reimbursement account on an after-tax basis, and may submit for reimbursement any claims you may incur while you have COBRA coverage. The Contract Administrator will bill you monthly. The maximum period of COBRA continuation coverage with respect to this Plan is the remainder of the Plan year in which the COBRA qualifying event occurs. For more information, see the Section entitled “COBRA Continuation Coverage” in Part V below.

Benefits

A. Reimbursable Expenses. The Health Care Reimbursement Plan will reimburse you for health care expenses that you have paid or are required to pay out of your own pocket for yourself, your spouse, or your son, daughter, stepchild, legally adopted child, or eligible foster child who is under age 26. You will be reimbursed for the following:

- expenses for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;

- expenses for transportation primarily for and essential to health care referred to in the first bullet;

- other expenses that are considered to be health care expenses under the Internal Revenue Code, including health plan co-payments and deductibles and expenses for dental and vision care; and
• expenses for medicines or drugs that are purchased with a prescription and insulin. For this purpose, any prescribed medicine or drug (including an over-the-counter medicine or drug) and insulin will be reimbursable expenses. The Plan Administrator has sole discretion to determine whether a particular item is eligible for reimbursement and whether the requirement of a prescription has been satisfied.

You cannot be reimbursed under the Health Care Reimbursement Plan if the health care expense is covered by other insurance. Similarly, the amounts contributed to your health care reimbursement account may not be used to reimburse you for expenses incurred for a period of time during which your benefit election is not effective (see the Section entitled “Participation” in Part II above). Expenses are incurred when the care is provided, not when the expenses are billed or paid.

B. Limited Use Health Care Reimbursement Account. If you participate in a Health Savings Account arrangement for a Plan Year and also elect to enroll in the Health Care Reimbursement Plan for that Plan Year, you will be automatically enrolled in a Health Care Reimbursement Plan account that allows reimbursement of vision care, dental care, and preventive care (as defined in Code Section 223(c)) only (a “Limited Use Health Care Reimbursement account”) for that Plan Year.

C. Maximum Amount of Reimbursement. The Health Care Reimbursement Plan currently allows you to direct the College to set aside as much as $2,600 each year, or such other amount as may be determined by the Plan Administrator and communicated to you. In deciding on the level of benefits that is best for you, remember that the amount you direct into the reimbursement account can be changed only if you meet the conditions explained under the Section entitled “Changing Your Benefits” in Part II above.

The amount of health care expenses for which you may be reimbursed under the Health Care Reimbursement Plan may not exceed the lesser of (i) $2,600, or (ii) the amount that you have elected to have the College contribute to your health care reimbursement account for the year. Contributions are made to the Health Care Reimbursement Plan through payroll deduction each pay period. The amount contributed each pay period is determined by dividing your annual election amount stated in your benefit election by the number of your pay periods in the Plan Year.

D. Health Care Reimbursement Account Carryover. You may carry over up to $500 of unused amounts remaining in your health care reimbursement account at the end of a Plan Year to be used for reimbursement of health care expenses incurred during the next Plan Year. If you are otherwise eligible for the Health Care Reimbursement Plan for a Plan Year but you do not enroll in the Health Care Reimbursement Plan for that Plan Year, you may still use any carryover amounts from the preceding Plan Year for current or preceding Plan Year health care expenses. However, you must be a participant in the Health Care Reimbursement Plan as of the last day of the Plan Year to benefit from the carryover. Termination of employment and cessation of eligibility will generally result in a loss of carryover eligibility unless a COBRA election is made.
This carryover amount may not be cashed out or converted to any other taxable or nontaxable benefit, and it will not count toward the maximum dollar limit on annual salary reductions under the Health Care Reimbursement Plan.

If you have unused amounts remaining in your general purpose health care reimbursement account at the end of a Plan Year that are available for carryover and you elect to participate in the Health Savings Account arrangement for the next Plan Year, the unused amounts will be automatically carried over to a Limited Use Health Care Reimbursement account. However, you may continue to submit claims for general-purpose health care expenses incurred during the preceding Plan Year for 90 days following the end of that Plan Year. Otherwise, if you (or someone else whose expenses can be reimbursed by your Health Care Reimbursement Plan) would like to contribute to a Health Savings Account arrangement during the next Plan Year, you must waive (decline) the carryover before that Plan Year begins. If you waive the carryover, you may continue to submit claims for expenses incurred during the preceding Plan Year for 90 days following the end of that Plan Year. If those claims do not use up the entire balance of your health care reimbursement account for the preceding Plan Year, any unused amounts will be forfeited in accordance with your waiver.

Paying For Benefits

The College provides for reimbursement under the Health Care Reimbursement Plan with the portion of your pay, if any, that you direct the College to contribute to your health care reimbursement account.

PART IV – DEPENDENT CARE REIMBURSEMENT PLAN

The Dependent Care Reimbursement Plan provides for reimbursement of certain expenses that you incur for your eligible dependents to enable you and your spouse, if applicable, to be gainfully employed.

Eligibility for and Termination of Benefits

If you are eligible to participate in the Flexible Benefits Plan, then you are eligible to participate in the Dependent Care Reimbursement Plan. To participate you must submit an appropriate benefit election with the Plan Administrator as explained under “Participation” in Part II above. In the event that your participation ceases, you continue to be entitled to reimbursement, in accordance with the terms of the Dependent Care Reimbursement Plan, for the remainder of the year in which your participation ceases.

Benefits

A. Reimbursable Expenses. The Dependent Care Reimbursement Plan will reimburse you for expenses described below that you have paid or are required to pay out of your own pocket, if those expenses enable you and your spouse, if applicable, to be gainfully employed, and if they are for care of:
• your spouse, if he or she is physically or mentally incapable of caring for himself or herself;

• a dependent for federal income tax purposes who is less than 13 years old; or

• a dependent for federal income tax purposes who is physically or mentally incapable of caring for himself or herself.

You will be reimbursed for the following:

1. expenses for ordinary and usual services necessary to the maintenance of your household and attributable in part to the care of a person described above; and

2. expenses for the care of a person described above, except that if you incur these expenses outside of your household:

   (a) they must be for (i) a dependent of yours (for federal income tax purposes) who is less than 13 years old for whom you are entitled to a personal exemption on your federal income tax return, or (ii) a dependent of yours (for federal income tax purposes) who is physically or mentally incapable of taking care of himself or herself and who regularly spends at least eight hours each day in your household, and

   (b) if such expenses are for care provided by a dependent care center, such center must comply with applicable laws and regulations of the state or local government.

For purposes of the Dependent Care Reimbursement Plan, a dependent care center is a facility that provides care for more than six individuals (other than individuals who reside at the facility) on a regular basis and that receives a fee, payment, or grant for providing services for any such individuals (even if it is a non-profit facility).

The amounts contributed to your dependent care reimbursement account for one year may not be used to reimburse you for expenses incurred in a different year or for a period of time during which your benefit election is not effective (other than the remainder of the Plan Year in which your participation terminates). Expenses are incurred when the care is provided, not when the expenses are billed or paid.

B. Maximum Amount of Reimbursement. The Dependent Care Reimbursement Plan allows you to direct the College to set aside as much as $5,000 each year if you are single or, if you are married, both you and your spouse work, and you file a joint return. If you are married and file a separate return, you may direct the College to set aside only $2,500 each year.

In deciding on the level of benefits that is best for you, remember three things: First, each year you will forfeit any amounts that you direct into the Dependent Care Reimbursement Plan that are not used to reimburse you for dependent care expenses incurred during that year. Second, the amount you direct into the reimbursement account can be changed only during an Open Enrollment Period or if you meet one of the conditions for a “Status Change” explained under
Part II above. Third, your earned income (or the earned income of your spouse, if that is lower) for a year is the maximum limit on the amount of reimbursement which you may exclude from gross income for that year even if you directed the College to set aside an amount greater than your earned income (or that of your spouse). This limitation is especially important if your spouse does not have any earned income, since that would mean that you would not be able to exclude from gross income any benefits you receive under the Plan. However, if your spouse is a student for at least 5 months during the year at an educational institution which meets certain requirements, or is mentally or physically incapable of taking care of himself or herself, then the following special rules apply: for each month that your spouse is a student or incapable of self-care, he or she will be deemed to have earned income of $250 a month if you have dependent care expenses for one person, and $500 a month if you have dependent care expenses for more than one person.

You are not considered to be married for purposes of the Dependent Care Reimbursement Plan if you are legally separated from your spouse under a decree of divorce or separate maintenance. In addition, if you and your spouse file separate income tax returns and your spouse is not a member of your household at any time during the last 6 months of a year, then you may be considered single under the tax laws for purposes of making a benefit election under the Dependent Care Reimbursement Plan. You should consult your tax advisor regarding your status.

You may not claim reimbursement for amounts owed to a person if either you or your spouse is entitled to claim a personal exemption on your federal income tax return for that person. Nor may you claim reimbursement for amounts owed to your child, if the child is less than 19 years old at the end of the year.

The maximum amount of reimbursement to which you are entitled in any Plan Year is the amount that has been contributed to your account during such Year. The amount of dependent care expenses for which you may be reimbursed under the Dependent Care Reimbursement Plan at any time and exclude from gross income may not exceed the lesser of: (i) the amount that the College has contributed to your dependent care reimbursement account during the year up to that time or (ii) your earned income (or the earned income of your spouse, if that is lower). In calculating earned income, you may not include any pay that you have directed the College to use for dependent care reimbursement under the Dependent Care Reimbursement Plan or amounts received as a pension or annuity, unemployment compensation, or workers’ compensation.

Example: Assume that Irene elects a $5,000 dependent care reimbursement account for the 2018 Plan Year. Assume further that Irene has contributed $2,500 to her account and that she has incurred $5,000 in dependent care expenses by June 30, 2018. The maximum amount that Irene may be reimbursed as of June 30th is $2,500.

Dependent Care Service Provider Information

In order to exclude from income the amounts you receive as reimbursement for dependent care expenses, you are generally required to provide the name, address, and taxpayer identification
PART V – SPECIAL RULES FOR HEALTH BENEFIT PLANS

Qualified Medical Child Support Orders

If the Plan Administrator receives a qualified medical child support order with respect to one of the Health Benefit Plans, then the Plan will provide the child support or health benefit coverage specified in the order to the person or persons (“alternate recipients”) named in the order. “Alternate recipients” include your child who under a qualified medical child support order has a right to enrollment under the Plan. A “qualified medical child support order” is a legal judgment, decree, or order relating to medical child support that clearly specifies the type of coverage that is to be provided to one or more alternate recipients (or the manner in which such type of coverage is to be provided).

Any alternate recipient named in a medical child support order received by the Plan will have the right to designate, by notice in writing to the Plan Administrator, a representative for the receipt of copies of notices that are sent to the alternate recipient with respect to such medical child support order.

Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is qualified. If the Plan Administrator receives a medical child support order relating to one (or more) of your Health Benefit Plans, then you will be notified in writing, and not later than 40 days after receiving the order, you will be informed of the Plan Administrator’s determination of whether or not the order is qualified.

If the Plan Administrator determines that the medical child support order is “qualified,” then the Plan Administrator will comply with the terms of such order. If the Plan Administrator determines that the medical child support order is not a qualified medical child support order, then the notice will describe the specific reason or reasons for the Plan Administrator’s decision.

A National Medical Support Notice will be treated as a qualified medical child support order. If the order substitutes the name and mailing address of an official of a state or political subdivision for that of an alternate recipient, then the Plan Administrator may pay benefits directly to the official named in the order.

Upon request to the Plan Administrator, you may obtain, without charge, a copy of the procedures governing qualified medical child support orders.

Leaves of Absence

A. Leave of Absence (not under the Federal and Family Medical Leave Act of 1993). If you are granted an Approved Leave of Absence, including a Medical Leave of Absence for a work-related injury, then you may be covered under a Health Benefit Plan offered under the Flexible Benefits Plan for a period of up to 24 months in accordance with the College’s leave of absence policies. Payment of the necessary contributions may be required. Please refer to the Section
entitled “COBRA Continuation Coverage” below for more information about continuation of coverage.

B. **Leave of Absence under Federal Family and Medical Leave Act.** If you are absent from work due to a protected family or medical leave under the federal Family and Medical Leave Act (“FMLA leave”), then you are entitled to continue benefits under the Health Benefit Plans at the same levels of contributions and under the same conditions as if you had continued in employment.

If you fail to return from leave for reasons other than the continuation or onset of a serious health condition, or other circumstances beyond your control, then your health care coverage under the Health Benefit Plans will be terminated and the College may recover from you the premiums paid for benefits. If you are unable to return to work because of the continuation, recurrence, or onset of a serious health condition, then the College may require you to provide certification by the health care provider. If you return to work following an approved leave of absence under the FMLA, then you will be eligible to participate in the Health Benefit Plans on the date you return to work.

If your FMLA leave is paid leave, then your contributions toward the Health Benefit Plans will continue to be deducted from your wages. If your FMLA leave is unpaid leave, then you may contribute to the Health Benefit Plans under (i) the prepay option, or (ii) the pay-as-you-go option. Under the pre-pay option, you may elect to pay your contributions to the Health Benefit Plans prior to commencement of your FMLA leave on a pre-tax basis. Under the pay-as-you-go option, you may elect to contribute to the Health Benefit Plans on the same schedule as your payments would be made if you were not on FMLA leave on an after-tax basis.

Instead of electing continued coverage while on FMLA leave, you may instead revoke your existing election for coverage under the Health Benefit Plans for the remaining portion of the coverage period. Upon your return from FMLA leave, you may elect to be reinstated in the Health Benefit Plans on the same terms that applied prior to your taking FMLA leave. If you revoke your election under a Health Benefit Plan, then you will not be entitled to reimbursement for claims incurred while your coverage is terminated. If you return to employment and elect to be reinstated in a Health Benefit Plan, then you may not retroactively elect coverage under the Health Benefit Plan for claims incurred while your coverage was terminated. If you elect reinstatement under the Health Care Reimbursement Plan upon your return from FMLA leave, then your coverage for the remainder of the year will be prorated for the period during which no premiums were paid.

**Example:** Irene elects to contribute $1,200 ($100 per month) to the Health Care Reimbursement Plan. On April 1, she takes FMLA leave after making three months’ worth of contributions totaling $300. On April 1 she also revokes her election to contribute to the Health Care Reimbursement Plan during the months of April, May, and June. When she returns from FMLA leave on July 1, she elects to be reinstated in the Health Care Reimbursement Plan as of that date.

- Irene must resume making premium payments of $100 per month beginning July 1 for the remainder of the Plan Year. Her annual election of $1,200 will be prorated for
the three-month period during which her coverage election was revoked, resulting in $900 of coverage for the year.

- If no reimbursements were made for the period beginning January 1 and ending March 31, Irene will have $900 available for reimbursement of eligible claims. If reimbursements were made for January 1-March 31 period, she will have available $900 minus the amount of reimbursements paid during that period. (That is, if a $200 claim was paid in February, her remaining benefits equal $700.)

- Irene may submit for reimbursement any claims she incurred from January 1 through March 31st and after July 1. She will not, however, be entitled to receive reimbursement for any expenses incurred during the months of April, May, and June.

Information about the College’s leave policies and forms to request FMLA leave are available from the Human Resources Department.

**COBRA Continuation Coverage**

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity for a temporary extension of health care coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plans would otherwise end. These rules apply only with respect to the Health Benefit Plans offered under the Flexible Benefits Plan: the Health Plan, the Dental Plan, the Vision Plan, and the Health Care Reimbursement Plan. These rules do not apply with respect to the Supplemental Group-Term Life Insurance Plan or the Dependent Care Reimbursement Plan.

**A. When Coverage May Be Continued**

1. **Employee** - If you are an Employee covered by a Health Benefit Plan offered under this Flexible Benefits Plan, then you have a right to choose continuation coverage under the Plan if you lose your coverage because of:

   (a) a reduction in your hours of employment; or

   (b) a voluntary or involuntary termination of your employment (for reasons other than gross misconduct).

2. **Spouse** - If you are the spouse of an Employee covered by a Health Benefit Plan offered under this Flexible Benefits Plan, then you have the right to choose continuation coverage for yourself under that Health Benefit Plan if you lose coverage for any of the following reasons:

   (a) the death of your spouse;

   (b) a voluntary or involuntary termination of your spouse’s employment (for reasons other than gross misconduct) or reduction in your spouse’s hours of employment;

   (c) the divorce or legal separation from your spouse; or
Special Rules for Health Benefit Plans

(d) your spouse becomes enrolled in Medicare Part A or Part B.

3. Eligible Dependents - In the case of an eligible dependent child covered by a Health Benefit Plan offered under this Flexible Benefits Plan, he or she has the right to choose continuation coverage under that Plan if coverage is lost for any of the following reasons:

(a) the death of the Employee;

(b) a voluntary or involuntary termination of the Employee’s employment (for reasons other than gross misconduct) or reduction in the Employee’s hours of employment;

(c) his or her parents’ divorce or legal separation;

(d) the Employee’s becoming entitled to Medicare; or

(e) he or she ceases to be an eligible dependent child under the Health Benefit Plan.

A child who is born to, or placed for adoption with, the Employee during a period of continuation coverage is also entitled to continuation coverage.

An Employee, spouse, or dependent also may be considered to have lost coverage under the Plan (and have the right to elect continuation coverage) if he or she experiences an increase in the cost of premiums or required contributions as a result of one of the above qualifying events.

4. Special Provisions for Bankruptcy - If you are a retiree or the spouse, surviving spouse, or eligible dependent child of a retiree and are covered by a Health Benefit Plan offered under this Flexible Benefits Plan, then you have the right to choose continuation coverage under that Health Benefit Plan if a bankruptcy reorganization by the employer causes you to lose coverage. In that event, the maximum continuation coverage period may be for your lifetime.

5. Special Provisions for Disabled Employees - In the event that you lose coverage as a result of your termination of employment or reduction in hours, and you or any of your covered eligible dependents are determined to be disabled in accordance with Title II or Title XVI of Social Security at any time during the first 60 days of continuation coverage, then the 18-month coverage period will be extended by an additional 11 months for you and your covered eligible dependents, so that coverage will continue for up to 29 months following your termination of employment or reduction in hours. The first 60 days of continuation coverage is measured from the date on which you terminate employment or experience a reduction in hours or, if later, the date on which you lose coverage as a result of your termination of employment or reduction in hours. This extended coverage for disability is available to you and your covered eligible dependents only if the Contract Administrator is notified of the disability determination in a timely manner (see “Notice Requirements” below).

B. Type of Coverage. You and your covered eligible dependents do not have to show evidence of insurability to choose continuation coverage under the Health Benefit Plans offered under this Plan. Continuation coverage is provided, however, only subject to eligibility for coverage. The
College reserves the right to terminate continuation coverage retroactively if you or your dependents are determined to be ineligible. You, your spouse, and your eligible dependent child(ren) are each entitled to make a separate election. If you choose continuation coverage, the College is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the Health Benefit Plan to similarly situated Employees and/or their eligible dependents. If Health Benefit Plan benefits are modified for similarly situated active Employees, then they will be modified for you and your eligible dependents as well. You will be eligible to make a change in any election with respect to the Health Benefit Plan (i) during any Open Enrollment Period or Special Enrollment Period for eligible active Employees occurring while you are covered or (ii) in the event of a Status Change.

If you do not choose continuation coverage, your coverage under the Health Benefit Plans will end with the date you would otherwise lose coverage.

C. Notice Requirements. You or your covered eligible dependent must notify the Contract Administrator of a divorce, legal separation, or a child losing eligible dependent status under a health benefit plan within 60 days of the later of (i) the date on which coverage would be lost because of the event, or (ii) the date on which you are sent notice of your right to elect continuation coverage. If you or your dependent is determined by the Social Security Administration to be disabled you must notify the Contract Administrator in writing within 60 days of such determination and before the end of the initial 18-month continuation coverage period.

The College will notify the Contract Administrator of the Employee’s death, termination of employment or reduction in hours, Medicare entitlement, or if it commences a bankruptcy proceeding.

When the Contract Administrator is notified that one of these events has occurred, the Contract Administrator will in turn notify you that you have the right to choose continuation coverage. Notice to an Employee’s spouse is treated as notice to any eligible dependents who reside with the spouse.

An Employee or covered eligible dependent who is determined by the Social Security Administration to no longer be disabled is responsible for notifying the Plan Administrator of such determination within 30 days of the determination. The Employee or covered eligible dependent also is responsible for notifying the Contract Administrator if he or she becomes covered under another group health plan. In addition, the Employee or covered eligible dependent is responsible for notifying the College in the event of the birth or adoption of a child during the COBRA continuation period within 30 days of the birth or adoption. An election for continuation coverage of a newborn child or a newly adopted child may result in an increase in premium payments (see “Cost” below).

All notices made to the Plan Administrator pursuant to this Paragraph C must be in writing (or such other electronic or telephonic form as the Plan Administrator prescribes) and must contain sufficient information to enable the Plan Administrator to identify (i) the plan, (ii) the covered employee or covered dependent, (iii) the qualifying event (or disability determination), and (iv)
Special Rules for Health Benefit Plans

the date of the qualifying event (or disability determination). You, your covered dependent, or any representative acting on behalf of you or your covered dependent, may provide the notices required by this Paragraph C to the Plan Administrator.

D. **Election Procedures and Deadlines.** In order to elect continuation coverage, you must complete the election form(s) provided to you by the Contract Administrator. You have 60 days from (i) the date you would lose coverage for one of the reasons described above, or (ii) the date you are sent notice of your right to elect continuation coverage (whichever is later), to inform the Contract Administrator that you wish to continue coverage. Failure to return the election form within the 60-day period will be considered a waiver, and you will not be allowed to elect continuation coverage.*

E. **Cost.** You will have to pay the entire cost of your continuation coverage. The cost of your continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage, except in the case of disability. During the 11-month period of extended coverage for a disabled person, the cost will not exceed 150% of the applicable premium. The first premium payment after electing continuation coverage will be due 45 days after making your election. Subsequent premiums must be paid within a 30-day grace period following the due date. Failure to pay premiums within this time period will result in automatic termination of your continuation coverage. These payments are not excludable from gross income for purposes of state and federal income taxes. The premium amount may change at the beginning of each Plan Year, or at any other time when costs for active employees change.

Claims incurred during any period will not be paid until your premium payment is received for that period. If you timely elect continuation coverage and pay the applicable premium, however, then continuation coverage will relate back to the first day on which you would have lost regular coverage.

The following example illustrates how the cost of continuation coverage is determined with respect to the Health Care Reimbursement Plan:

**Example.** Irene elects a $1,200 health care reimbursement account at the beginning of the Plan Year (January 1). Irene terminates on April 1. As of that date, $300 has been contributed to Irene’s account, and Irene has received $200 from the Health Care Reimbursement Plan as reimbursement for health care expenses incurred prior to the termination of employment. Irene properly elects continuation coverage. The applicable premium for the remainder of the Plan Year is $918 (102% x $900), which is $102 per month, and the maximum amount Irene may be reimbursed is $1,000 ($1,200 - $200).

* If you are eligible for federal Trade Adjustment Assistance (“TAA”) and you did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, then you will be given the opportunity to elect continuation coverage during a second 60-day period that begins on the first day of the month in which you were determined to be a TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. If you are eligible for TAA and have questions regarding your COBRA rights, you should contact the Plan Administrator.
F. **When Continuation Coverage Ends.** The maximum period for which coverage may be continued is:

- **18 Months** - if continuation is due to voluntary or involuntary termination of employment (other than for gross misconduct) or a reduction in hours. If a second continuation coverage event occurs during the 18-month period, however, then your covered dependents may be entitled to elect up to 18 months of additional coverage for a maximum continuation coverage period of **36 months**.

- **29 months** - if extended continuation coverage is due to disability.

- **36 Months** - if continuation is due to death, divorce, legal separation, ceasing to be an eligible dependent child, or Medicare entitlement.

- **Lifetime** - if continuation is due to a bankruptcy reorganization of the employer, and the person electing continuation coverage is a retiree or the surviving spouse of a retiree who died before the bankruptcy proceeding commenced.

If a covered Employee becomes enrolled in Medicare Part A or B and then experiences a termination of employment or reduction in hours, the maximum continuation coverage period is the later of 36 months from the date of Medicare enrollment or 18 months (29 months if there is a disability extension) after the Employee’s termination of employment or reduction in hours.

For the Health Care Reimbursement Account, the maximum period for which coverage may be continued is the remainder of the Plan Year in which the qualifying event occurs.

However, continuation coverage also ends for any of the following reasons:

- the premium for your continuation coverage is not paid on time;
- after you elect continuation coverage, you first become covered under another group health plan;
- after you elect continuation coverage, you first become entitled to Medicare;
- you (or your dependent) extended coverage for up to 29 months due to disability, and there has been a final determination that you (or your dependent) are no longer disabled; or
- the College no longer provides group health coverage to any of its Employees.

If you choose continuation coverage after termination of employment or a reduction in hours, you may extend this coverage for an additional period if another event occurs for which continuation is allowed. However, continuation coverage can never extend for more than 36
months from the date of the event that originally made you eligible to elect continuation coverage (except in the case of the employer’s bankruptcy).

For further information regarding continuation coverage, please contact the Plan Administrator.

Protected Health Information

The use and disclosure of your personal health information is protected by federal law. Bowdoin College will provide you with a HIPAA Notice of Health Information Privacy Practices, which describes the uses and disclosures a Health Benefit Plan is permitted to make of your individually identifiable health information. In addition, the Notice describes your rights and the Plan’s duties with respect to such information. You are entitled to a copy of the Notice when you first enroll in the Plan and within 60 days of a change in the Notice. You may contact the Human Resources Department to request an electronic version of the Notice. You also have a right to receive a paper copy of the Notice upon written request to Human Resources.

PART VI – PLAN INFORMATION

Your ERISA Rights

As a participant in the Health Plan, the Dental Plan, the Vision Plan, the Health Care Reimbursement Plan, and/or the Supplemental Group-Term Life Insurance Plan (the “Plans”), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants in the Plans shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations (worksites) all documents governing the Plan and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 series) and updated summary plan description. 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 (when such report is required).
- Under certain circumstances, continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plans. The people who operate your Plans, called
“fiduciaries” of the Plans, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from a Plan and do not receive them within 30 days, you may file suit in a federal court. In such 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 on review, then after you have exhausted the administrative remedies under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan Administrator’s decision (or lack thereof) concerning the qualified status of a medical child support order, then you may file suit in federal court. If it should happen that Plan fiduciaries misuse the money in the Plans, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court 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 if, for example, it finds your claim is frivolous.

If you have any questions about the Plans, then you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, 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, DC 20210. For Plan participants who reside in Maine, the nearest Employee Benefits Security Administration office is: Boston Regional Office, J.F.K. Building, Room 575 Boston, MA 02203, (617)565-9600.

Plan Amendment and Termination

The College may amend the Plans, in whole or in part, from time to time as it deems necessary or desirable with or without retroactive effect, to the extent permitted by law, by any means permitted under its by-laws. In addition, while the College expects to continue the Flexible Benefits Plan, the Health Care Reimbursement Plan, and the Dependent Care Reimbursement Plan indefinitely, it necessarily reserves the right to terminate or amend any of them at any time.

If the College terminates the Health Care Reimbursement Plan, then you will not be entitled to reimbursement for health care expenses incurred after such termination. You will, however, continue to be entitled to reimbursement in accordance with the terms of the Health Care Reimbursement Plan for health care expenses incurred prior to such termination. Contributions to the Health Care Reimbursement Plan will cease as of the date that the termination occurs.
If the College terminates the Dependent Care Reimbursement Plan, then you continue to be entitled to reimbursement in accordance with the terms of the Dependent Care Reimbursement Plan for the remainder of the year in which the termination occurs. Contributions to the Dependent Care Reimbursement Plan will cease, however, as of the date that the termination occurs.

**General Information About the Plans**

| Plan Names:                                      | Bowdoin College Flexible Benefits Plan  
|                                                | Bowdoin College Health Care Reimbursement Plan  
|                                                | Bowdoin College Dependent Care Reimbursement Plan  

| Plan Number: | 516 |

| Plan Sponsor: | The President and Trustees of Bowdoin College  
|               | 1 College Street, Hawthorne-Longfellow Hall  
|               | Brunswick, Maine 04011  
|               | (207) 725-3000 |

| Tax Identification Number for Bowdoin College: | 01-0215213 |

| Plan Administrator: | Director of Human Resources  
|                     | Bowdoin College  
|                     | 3500 College Station  
|                     | Brunswick, Maine 04011-8426  
|                     | (207) 725-3837 |

| Contract Administrator (the day-to-day administrator, as the Plan Administrator’s delegate): | Group Dynamic, Inc.  
|                                                                                         | 411 US Route One  
|                                                                                         | Falmouth, Maine 04105  
|                                                                                         | (207) 781-8800 |

| Plan Year: | January 1 to December 31 |

**Service of Legal Process**

While the College believes that all disputes arising under any of the Plans can be resolved fairly and amicably, under rare circumstances a dispute could arise, in which case the agent for service of legal process is the Plan Administrator identified above.

**Employment Rights**

This booklet is not a contract. Participation in the Plans does not give you the right to be retained in the employ of the College or any other right not specified in the Plans. Nor does this booklet constitute tax or legal advice on the part of the College and Plan Administrator.
PART VII – CLAIMS PROCEDURES

Claims Processing

To apply for health care reimbursement benefits or dependent care reimbursement benefits, you must request reimbursement from the Contract Administrator in accordance with the reimbursement procedures described below. The Contract Administrator will assist you in completing the required forms. To apply for benefits under the Health Plan, Dental Plan, Vision Plan, or Supplemental Group-Term Life Insurance Plan, please refer to the claims procedures for those Plans described in the Plans’ respective summary materials.

A. Reimbursement Under the Health Care Reimbursement Plan. You can complete and submit a written claim for reimbursement or use the Electronic Payment Card.

1. *Traditional Paper Claims:* When you incur a health care expense, you file a claim with the Contract Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Contract Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (for example, a receipt, EOB, etc.) associated with each expense that indicates the following:

   - Name of person receiving service
   - Name and address of service provider
   - Nature of expense (for example, what type of service or treatment was provided).
   - If the expense is for an over-the-counter drug or medicine (other than insulin), a copy of the prescription must be provided or, alternatively, you may submit a receipt from the pharmacy with the RX number and identity of the person for whom the prescription was issued.
   - Amount of the expense.
   - Date expense was incurred.

   The Contract Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for eligible health care expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be eligible for reimbursement you will receive notification of this determination.

2. *Electronic Payment Card:* The Electronic Payment Card allows you to pay for eligible health care expenses at the time that you incur the expense. Here is how the Electronic Payment Card works.

   - *You must make an election to use the card.* In order to be eligible for the Electronic Payment Card, you must agree to abide by the terms and conditions of the Program as set forth herein and in the Electronic Payment Cardholder Agreement (the “Cardholder Agreement”) including any fees applicable to participate in 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 any period that you are covered by the Health Care Reimbursement Plan. A Cardholder Agreement will be provided to you. The card will be turned off effective the first day of each Plan Year if you do not affirmatively agree to abide by the terms of the Program during the preceding Open Enrollment period. The Cardholder Agreement is part of the terms and conditions of the Health Care Reimbursement Plan and this booklet.

- **The card will be turned off when employment or coverage terminates.** The card will be turned off when you terminate employment or coverage under the Health Care Reimbursement Plan. You may not use the card during any applicable COBRA continuation coverage period.

- **You must certify proper use of the card.** As specified in the Cardholder Agreement, you certify during the period that you are covered by the Health Care Reimbursement Plan that the amounts in your health care reimbursement account will only be used for eligible health care expenses (that is, medical care expenses incurred by you, your Spouse, and your Eligible dependents), that you have not been reimbursed for the expense, and that you will not seek reimbursement for the expense from any other source. Failure to abide by this certification will result in termination of card use privileges.

- **Reimbursement under the card is limited to health care providers (including pharmacies).** Except with respect to merchants that utilize the Inventory Information Approval System (IIAS) to verify that merchandise begin purchased with the card is an eligible health care expense, use of the card for health care expenses is limited to merchants who are health care providers (doctors, pharmacies, etc.). As set forth in the Cardholder Agreement, you will not be able to use the card at a regular retail store – for example, a supermarket, grocery store, or discount store with a pharmacy.

- **You swipe the card at the health care provider like you do any other credit or debit card.** When you incur an eligible health care expense at a doctor’s office or pharmacy, such as a co-payment or prescription drug expense, you swipe the card at the provider’s office much like you would a typical credit or debit card. The provider is paid for the expense up to the maximum reimbursement amount available under your health care reimbursement account (or as otherwise limited by the Program) at the time that you swipe the card. Every time you swipe the card, you certify to the Health Care Reimbursement Plan that the expense for which payment is being made is an eligible health care expense and that you have not been reimbursed from any other source nor will you seek reimbursement from another source.

- **You must obtain and retain a receipt/third party statement each time you swipe the card.** You must obtain a third party statement from the health care provider (for example, receipt, invoice, etc.) that includes the same information noted above with regard to traditional claims.
• **You must retain this receipt for one year following the close of the Plan year in which the expense is incurred.** Even though payment is made under the card arrangement, a written third party statement is required to be submitted (except as otherwise provided in the Cardholder Agreement). Upon request, you must provide the third party statement to the Contract Administrator within 30 days of the swipe of the card. NOTE: If you purchase an over the counter drug or medicine with your Card from a merchant that does not utilize IIAS, you may be required to present to the Contract Administrator a copy of the prescription or, alternatively, a copy of the receipt that has the RX number and the identity of the individual for whom the prescription was issued. Use of the Card may be subject to additional restrictions established by the Contract Administrator.

• **There are situations where the third party statement may not be required to be provided to the Contract Administrator.** There may be situations in which you will not be required to provide the written statement to the Contract Administrator. More detail as to which situations apply under your Plan is specified in the Cardholder Agreement:

  o **Co-Pay Match:** As specified in the Cardholder Agreement, no written statement is necessary if the Electronic Payment Card payment matches a specific co-payment you have under the component medical plan for the particular service that was provided or a multiple of that copayment not to exceed five times the specific copayment. For example, if you have a $10 co-pay for physician office visits, and the payment was made to a physician office in the amount of $10, you will not be required to provide the third party statement to the Contract Administrator.

  o **Previously Approved Claim Match:** As specified in the Cardholder Agreement, no written statement is required if the expense is the same as the amount, duration, and provider as a previously approved expense. For example, the Contract Administrator approves a 30 count prescription with 3 refills that was purchased at ABC Pharmacy. Each time the card is swiped for subsequent refills at ABC Pharmacy the receipt need not be provided to the Contract Administrator if the expense incurred is the same amount.

  o **Provider Match Program:** As specified in the Cardholder Agreement, no third party statement is required to be submitted to the Contract Administrator if the electronic claim file is accompanied by an electronic or written confirmation from the health care provider (for example, your prescription benefits manager) that identifies the nature of your expense and verifies the amount.

  o **Inventory Information Approval System (available at participating merchants who do not have a health care related merchant category code or certain pharmacies who do not satisfy certain IRS criteria):** Under the Inventory Information Approval System (IIAS), the merchant retains a list of
eligible health care expenses sold by the merchant. The merchant only allows the Card to purchase items identified on that list of eligible health care expenses retained by the merchant. For example, if you place both a prescription drug and a non-medical item on the counter and submit your Card, the merchant will only allow the Card to be used for the prescription drug expense. You must pay for the expenses not on the merchant's eligible health care expenses list with another form of payment (cash, personal credit or debit card, etc.). You will not be permitted to use the Card at any merchant who does not have a health care related merchant category code unless that merchant utilizes this Inventory Information Approval System.

- **Note:** You should still obtain the third party receipt when you incur the expense and swipe the card, even if you think it will not be needed, so that you will have it in the event the Contract Administrator requires it.

- **You must pay back any improperly paid claims.** If you are unable to provide adequate or timely substantiation as required by the Contract Administrator, you must repay the Health Care Reimbursement Plan for the unsubstantiated expense. The deadline for repaying the Health Care Reimbursement Plan is set forth in the Cardholder Agreement. If you do not repay the Health Care Reimbursement 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 your health care reimbursement account. If no claims are submitted prior to the date you terminate coverage in the Health Care Reimbursement Plan, or claims are submitted but they are not sufficient to cover the unsubstantiated expense amount, then the amount may be withheld from your pay (as specified in the Cardholder Agreement). Lastly, the College may treat the unreimbursed amount as a bad business debt, which could have income tax implications for you.

*You can use either the payment card or the traditional paper claims approach.* You have the choice as to how to submit your eligible claims. If you elect not to use the electronic payment card, you may also submit claims under the Traditional Paper Claims approach discussed above. Claims for which the Electronic Payment Card has been used cannot be submitted as Traditional Paper Claims.

**B. Reimbursement Under the Dependent Care Reimbursement Plan.** When you incur an eligible dependent care expense, you file a claim with the Dependent Care Reimbursement Plan's Contract Administrator by completing and submitting a Request for Reimbursement Form. You may obtain a Request for Reimbursement Form from the Plan Administrator or the Contract Administrator. You must include with your Request for Reimbursement Form a written statement from an independent third party (for example, a receipt, etc.) associated with each expense that indicates the following:

- The date the expense was incurred; and
- The amount of the expense.
The Contract Administrator will process the claim once it receives the Request for Reimbursement Form from you. Reimbursement for eligible dependent care expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be a dependent care expense that is eligible for reimbursement, you will receive notification of this determination.

If your claim was for an amount that was more than the your current dependent care reimbursement account balance, the excess part of the claim will be carried over into following months, to be paid out as your balance becomes adequate.

You must incur the expense in order to receive payment. “Incurred” means the service has been provided without regard to whether you have paid for the service. Payments for advance services are not reimbursable because they have not yet been incurred. For example, Employee A pays the monthly day care fee on January 1 and then submits a copy of the receipt on January 3. The expense for the entire month is not reimbursable until the services for that month have been performed. In addition, you must certify with each claim that you have not been reimbursed for the expense(s) from any other source and you will not seek reimbursement from any other source.

You may submit a claim for reimbursement of health care expenses and/or dependent care expenses incurred during any Plan Year up until 90 days after the close of such Plan Year.

**Benefit Determinations (Claims Decisions)**

This section describes ERISA claims procedures in general so that you will understand your rights and responsibilities. *You should also consult any specific information about claims procedures that you receive for a particular plan.*

A. Benefit Plans Other Than Health Benefit Plans. If your claim under a benefit plan other than a Health Benefit Plan (e.g., a claim under the Dependent Care Reimbursement Plan), is denied in whole or in part, you or your beneficiary will receive a written notice providing:

- the specific reason or reasons for the denial;
- reference to the specific provisions of the Plan on which the denial was based;
- a description of any additional information needed to process the claim; and
- an explanation of the claims review (appeals) procedure and the time limits applicable to such procedure, including your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on review.

The notice will be furnished to you within 90 days after receiving your claim. However, if special circumstances require more time for processing your claim, you will be notified in writing before the initial 90 days is up. The notice will explain why an extension is necessary and the date a decision is expected. In no event will an extension go beyond 90 days after the end of the initial 90 days. If we fail to respond within 90 days, you may treat your claim as denied.
B. Health Benefit Plans. If your claim under a Health Benefit Plan (e.g., a claim under the Health Care Reimbursement Plan, Health Plan, Dental Plan, or Vision Plan), is denied in whole or in part, the following procedures will apply, depending upon the type of claim:

1. Post-Service Claims. Post-Service Claims are those claims that are filed for payment of benefits after medical care has been received. **Claims for benefits under the Health Care Reimbursement Plan will always be Post-Service Claims.** If your Post-Service Claim is denied, you will receive a written notice from the Contract Administrator within 30 days of receipt of the claim, as long as all necessary information was provided with the claim. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 30 days are up. The notice will explain why an extension is necessary and the date a decision is expected.

2. Pre-Service Claims. Pre-Service Claims are those claims that require notification or approval prior to receiving medical care. If your Pre-Service Claim is submitted properly with all necessary information, you will receive written notice of the claim decision from the Contract Administrator within 15 days of receipt of the claim. If you file a Pre-Service Claim improperly, the Contract Administrator will notify you of the improper filing and how to correct it within 5 days after the Pre-Service Claim was received. If circumstances beyond the control of the Plan require more time for processing your claim, federal law permits one extension of up to 15 days. You will be notified of any extension before the initial 15 days are up. The notice will explain why an extension is necessary and the date a decision is expected.

3. Additional Information. In the case of both Pre- and Post-Service Claims, if an extension of the decision period is necessary because additional information is needed to decide your claim, then the notice of extension will specifically describe the required information and you will have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Contract Administrator will notify you of the determination within 15 days after the information is received. If you don’t provide the needed information within the 45 day period, your claim will be denied.

4. Urgent Care Claims that Require Immediate Action. Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. In these situations:

- you will receive notice of the benefit determination in writing or electronically within 72-hours after the Contract Administrator receives all necessary information, taking into account the seriousness of your condition.

- notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
If you file an Urgent Care Claim improperly, the Contract Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim is received. If additional information is needed to process the claim, the Contract Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- the Contract Administrator’s receipt of the requested information; or
- the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

5. **Concurrent Care Claims.** If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to Post-Service or Pre-Service timeframes, whichever applies. However, the Contract Administrator must notify you of any reduction or termination of an on-going course of treatment at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

6. **Denial Notice.** If your claim is denied in whole or in part, you will receive written notice of:

- the specific reason or reasons for the denial;
- specific reference to the Plan provisions on which the denial is based;
- if a Plan Rule or guideline was relied on in making the initial benefit decision, either the specific Plan Rule or a statement that a copy of the rule will be provided to you free upon request;
- the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
- the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of ERISA, following an adverse determination appeal;
- if the initial benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provide to you free upon request; and
- if the denial concerned an Urgent Care Claim, a description of the expedited appeal process described below at “Urgent Care Claim Appeals that Require Immediate Action.”
How to Appeal a Claim Decision

If you disagree with a claim determination, you can contact the Contract Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Contract Administrator within 60 days after you receive the claim denial in the case of benefit plans other than Health Benefit Plans and within 180 days after you receive the claim denial in the case of Health Benefit Plans.

Appeal Process

An appropriate, named Plan fiduciary who did not make the initial decision and who is not a subordinate of the individual who made the initial decision will decide the appeal. The review will show no deference to the initial decision. As part of the review, you or your authorized representative may submit documents, issues, and comments in writing. You may also request access to copies of documents, records, and other information that was submitted, considered, or produced by the Contract Administrator in deciding your claim, and know the identity of any medical experts consulted by the Plan in connection with the initial benefit decision. The Plan fiduciary who considers your appeal will take into account all information you submit, regardless of whether it was submitted or considered in the initial decision. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Contract Administrator and the Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process.

Appeals Determinations

A. Benefit Plans Other Than Health Benefit Plans. You or your authorized representative may request review of a denied claim. Your request must be in writing and must be delivered to the Contract Administrator within 60 days after you receive notice of the denial. As part of the review, you or your authorized representative may submit written comments, documents, records, or other information relating to the claim for benefits, and, upon request and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

The Contract Administrator’s review of a denied claim will take into account all comments, documents, records or other information submitted by you or your authorized representative relating to your claim, without regard to whether such information was submitted or considered in the initial determination of your claim. The Contract Administrator will notify you of its decision on review not later than 60 days after receiving your request for review. If special circumstances require more time to reach a decision, it will be made as soon as possible, but not later than 120 days after receiving your request. If an extension of time is necessary, you will receive a written notice explaining why an extension is necessary and the date by which a decision is expected. A denial on review will be in writing and include:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
• a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits; and
• a statement of your right to bring a civil action under Section 502(a) of ERISA.

B. Health Benefit Plans.

1. Pre-Service and Post-Service Claim Appeals. You will be provided written or electronic notification of decision on your appeal as follows within 30 days for the appeal of a Pre-Service Claim and within 60 days for the appeal of a Post-Service Claims. Prior to receiving a final adverse benefit determination based on new or additional evidence or rationale, you will be provided with any new or additional evidence considered, relied upon, or generated in connection with your claim, and any new or additional rationale, and you will have an opportunity to respond prior to the date the final adverse benefit determination is due. If the appeal is denied, you will receive a notice providing –

• the specific reason or reasons for the denial;
• specific reference to the Plan provisions on which the denial is based;
• if a Plan Rule or guideline was relied on in making the initial benefit decision, either the specific Plan Rule or a statement that a copy of the rule will be provided to you free upon request;
• the additional information, if any, needed to approve your claim and an explanation of why such information is necessary;
• the Plan claims review procedure, including a statement of your right to bring an action under Section 502(a) of ERISA, following an adverse determination appeal;
• if the benefit decision was based on a Plan exclusion or limit (such as medical necessity or experimental treatment), either an explanation of the basis for the determination or a statement that such explanation will be provide to you free upon request; and
• 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.”

Please note that the Contract Administrator’s decision is based only on whether or not benefits are available under a plan for the particular treatment or procedure. The determination as to whether the health service is necessary or appropriate for your care is between you and your Doctor. The fact that services or supplies are furnished or prescribed by a Doctor or other licensed provider does not necessarily mean either that the services and supplies are medically required under the terms of a plan or that the charge for such services or supplies is eligible for coverage.

2. Urgent Care Claim Appeals that Require Immediate Action. Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your
health or the ability to regain maximum function or cause severe pain. In these urgent situations the appeal does not need to be submitted in writing. You or your Physician should call the Contract Administrator as soon as possible. The Contract Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For Urgent Care Claim appeals, the Contract Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Contract Administrator’s decisions with respect to Urgent Care Claim appeals are conclusive and binding.

**Exhausting Administrative Remedies**

If your claim is denied on review, then you may bring a civil action in federal or state court. You may not commence such an action, however, until you have exhausted your administrative remedies under the Plan. Unless otherwise expressly stated in the plan document for the applicable plan, you must initiate any civil action on a claim for benefits under the Flexible Benefits Plan within 12 months after exhaustion of your administrative remedies under the Plan.