

**Paul Smith's College of Arts and Sciences**  
**Flexible Benefits Plan**  
**Plan Document and Summary Plan Description**

*Includes: Health Care and Dependent Care Flexible Spending Arrangements*

**Amended and Restated Effective January 1, 2019**

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**The Plan Sponsor reserves the right to amend this Plan at any time or from time-to-time without the consent of any employee or participant. Although the Plan Sponsor expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan feature or component at any time without liability.**

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# Paul Smith's College of Arts and Sciences Flexible Benefits Plan — Plan Document and Summary Plan Description

## Introduction

We are pleased to announce that we have established a Flexible Benefits Plan (the "Plan") under which you may choose to redirect a portion of your wages and/or pay for your share of the costs of available Health and Welfare plans that we sponsor and/or set aside money to pay for unreimbursed medical expenses (Health FSA) and/or dependent care expenses (Dependent Care FSA), all with pre-tax dollars. This means that you will pay less in taxes each year.

Read this document carefully so that you understand the provisions of the Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the Plan both before you enroll and while you are a participant. You should direct any questions you have to the Plan Administrator.

**If there is a conflict between an insurance contract which funds benefits and this document, the insurance contract will prevail.**

## I. Eligibility

### 1.1 When Will I Become Eligible To Participate In This Plan?

You will become eligible to participate in this Plan when you enroll in any of the Plan Sponsor's Health and Welfare plans which include the **Medical, Dental, and/or Vision Plans**, the Health FSA and/or the Dependent Care FSA.

For eligibility rules concerning the Plan Sponsor's Health and Welfare plans, please see the summary plan description for each. You should ask the Plan Administrator for copies of such documents if you need them.

To be eligible for the Health FSA you must be eligible to participate in your Employer's medical plan. To be eligible for the Dependent Care FSA, you must **be regularly scheduled to work at least 30 hours per week and satisfy any applicable waiting period, as communicated by your Employer from time to time.**

Please note that if you are initially classified as an independent contractor (or any other non-employee designation) by your Employer and are subsequently determined to be a common law employee for any purpose, including without limitation, for wage, labor or tax purposes by either the Internal Revenue Service, Department of Labor or any other Federal or state agency, administrative body or court, you will still be ineligible for participation in the Plan. In addition, the following persons are not eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation ("LLC"), any member of the LLC; (iv) if the Employer is a Subchapter S corporation, and any person who owns directly or indirectly more than 2% of the Employer.

### 1.2 What Must I Do To Enroll In The Plan?

You must complete an enrollment form/salary reduction agreement in order to enroll in the Flexible Spending Arrangement Plan, as well as select enrollment in the general purpose or limited purpose Health FSA (if you do not make a selection, the default election is for the general purpose account, unless you are enrolled in the Plan Sponsor's HSA-qualified high deductible health plan, in which case the default election is for the limited purpose Health FSA. However, even if you do not complete an enrollment form/salary reduction agreement, you will automatically be enrolled in the pre-tax contribution component of the Plan (the "Premium Conversion Plan") once you enroll in any one or more of the Plan Sponsor's **medical, dental, and/or vision plans (the "Health and Welfare plans").**

## II. Operation

### 2.1 How Does The Plan Operate?

Before the start of each Plan Year, you may elect **to have a portion of your wages deducted on a pre-tax basis** to pay for the cost of the employee portion of the premiums due under any of the Health and Welfare plans available under the Plan, and/or fund a Health FSA or a Dependent Care FSA.

## III. Contributions

### 3.1 How Is My Compensation Measured Under The Plan?

Compensation under the Plan means the total cash amount that is paid to you each year.

### 3.2 What Contributions Are Made To The Plan?

Contributions to the Plan consist of:

- i) contributions made by your election to reduce your salary or wages by a certain amount

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**Note that the amount of the employer contributions made to the plan on your behalf is within the sole discretion of the employer, and you have no contractual right to any employer contributions. Your employer may increase, decrease or eliminate such contributions at any time within its sole discretion.**

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### 3.3 What Happens To Contributions That Are Made To The Plan?

All contributions to the Plan, including your salary or wage reductions may be used to pay for benefits under the Plan in any way that you elect as long as such benefits are covered under the Plan. Unless otherwise agreed to by the Plan Administrator, your salary or wage reductions for the Plan Year will be taken ratably on a per paycheck basis.

By your election, certain contributions that you defer are set aside into your Health FSA and/or your Dependent Care FSA, only to be reimbursed for eligible expenses, and/or used to pay the cost of the employee portion of applicable premiums in the Health and Welfare plans you choose.

### 3.4 When Must I Decide What Coverage I Want?

Except as described in question 3.6 below, you may elect benefits under the Plan only during the “election period.”

### 3.5 When Is The Election Period For The Plan?

You will be eligible to enroll in the Plan once a year during open enrollment, for coverage effective **January 1**, or as described in Section 3.6.

### 3.6 May I Change My Elections During The Plan Year?

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, you are permitted to change certain elections if you experience an IRS defined “change in status” and/or other special events as described below.

Examples of status changes include these events:

- i) marriage;
- ii) divorce, legal separation or annulment;
- iii) death of your spouse or dependent child;
- iv) birth, adoption or placement for adoption of a child;
- v) termination of the employment of your spouse or dependent child;
- vi) commencement of the employment of your spouse or dependent child;
- vii) your or your spouse’s or dependent child’s commencement or return from an unpaid leave of absence from employment;
- viii) adjustment to your or your spouse’s or dependent child’s work schedule, such as a switch between part-time and full-time work, a strike, a lockout or an increase or reduction in hours of employment, that causes a loss of coverage;
- ix) a change in your, or your spouse’s or dependent child’s worksite or residence that causes a loss of current coverage eligibility;
- x) adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify as a dependent under the Plan;
- xi) significant change in your or your spouse’s health coverage attributable to the spouse’s employment; and
- xii) leave of absence under the Family Medical and Leave Act.

Your election may also be changed if one of these special events occurs:

- i) the issuance of a judgment, decree or order that requires accident or health coverage for your dependent child.
- ii) your or your spouse’s or dependent child’s entitlement to Medicare or Medicaid that causes a loss of coverage.
- iii) a “significant” increase in the cost of any benefit under the Plan; provided that for the Dependent Care Flexible Spending Arrangement Plan, the increase in cost is imposed by a dependent care giver who is not your relative.  
For example, if you or an eligible child are enrolled as a dependent through another employer’s medical plan and there is a significant increase in the cost of that plan, you may choose to accept the corresponding increase in premiums or elect coverage under your Employer’s plan, provided both plans agree to make the change.  
**\*Note:** If the cost of a health plan increases or decreases during the Plan Year, this Plan may, on a reasonable and consistent basis, automatically change your premium contributions in response to the change in cost.
- iv) elimination or “significant” cutback in coverage provided by an insurance company or other third party. You may cancel your election and receive coverage under a similar plan, provided both plans agree to make the change.
- v) your failure to make the required premium payment. Your election will be canceled but you will not be able to make a new election for the rest of the Plan year.
- vi) your separation from service. If you terminate employment, you may cancel your election for any remaining period of coverage. However, if you terminate employment and return to employment within 30 days of your date of termination, your pre-termination elections are automatically reinstated upon your reemployment. If you terminate employment and return to

employment more than 30 days from your termination date, your pre-termination elections are cancelled and you are required to make new elections (subject to the eligibility and participation requirements set forth in the Plan).

- vii) your enrollment in Marketplace coverage. If you enroll or intend to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, the Plan Administrator may permit you to cancel your election for any remaining period of coverage, provided that you (and any related individuals who cease coverage due to the revocation) enroll in a Marketplace plan effective immediately following the revocation. No change is permitted with regard to Health FSA benefits or non-health benefits available under the Plan.
- viii) your permanent change to part-time status. If your employment status changes from full-time status to part-time status and is reasonably expected to remain in part-time status, the Plan Administrator may permit you to cancel your election for any remaining period of coverage, provided that you (and any related individuals who cease coverage due to the revocation) enroll or intend to enroll in another plan no later than the first day of the second full month following the revocation. No change is permitted with regard to Health FSA benefits or non-health benefits available under the Plan.

If you have a status change and you want to cancel or modify your election for a Plan Year, you must file a written application with the Plan Administrator within 30 days of the event. Keep in mind that any change to your election must be consistent with your status change. The Plan Administrator will consider your application and inform you of the decision.

In addition, you may revoke an election for coverage and make a new election under the Plan within 60 days of a "CHIPRA Event". A CHIPRA Event occurs if you or a dependent is covered under Medicaid or a state children's health insurance program ("CHIP") and such coverage is terminated due to a loss of eligibility, provided the request for coverage under the group health plan is made no later than 60 days after the Medicaid/CHIP coverage terminates; or you or a dependent becomes eligible for Medicaid or state CHIP, provided the request for group health plan coverage is made no later than 60 days after you or your dependent is determined to be eligible for premium assistance.

### **3.7 May I Make New Elections In Future Plan Years?**

Yes, you may. For each new Plan Year, you must complete a new enrollment form/salary reduction agreement, regardless of whether or not you are making changes in your elections for the Health FSA or Dependent Care FSA. However, if you do not submit a new enrollment form/salary agreement then you will be deemed to have elected as in the prior Plan Year for the Premium Conversion Plan.

## **IV. Benefits**

### **4.1 What Benefits Are Available Under The Plan?**

The nontaxable benefits under the Plan include:

- i) Pre-tax premium contributions for benefits provided under the Health and Welfare plans, which include the **medical, dental, and or vision plans;**
- ii) A Health FSA, the details of which are described below;
- iii) A Dependent Care FSA, the details of which are described below.

In the case of insured benefits, certain limits may apply on the amount of coverage that we obtain on your behalf. For example, it is possible, though unlikely, that even if you are a participant in the Plan, you might fail to qualify for coverage under the insured benefits offered under the Plan. Here, it is the insurance contracts, and not the terms of the Plan, which will dictate.

The Plan Sponsor may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts. We will not be liable to you if an insurance company fails to provide any of the benefits described above, even if the failure to provide benefits is due to our gross negligence (for example, if we fail to enroll you or pay premiums). In the case of health insurance and the Health FSA, you may have a right by law to continue your benefits that would otherwise terminate when (i) you leave employment, (ii) you are no longer eligible under the terms of any insurance policies, or (iii) when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after you have furnished the Plan Administrator with the necessary enrollment forms.

### **4.2 When will Benefits be Forfeited?**

As a condition of entitlement to a benefit under this Plan, you must keep the Plan Administrator informed of your current mailing address and other relevant contact information. If the Plan is unable to locate you after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator), you are not entitled to a benefit hereunder and forfeit any rights to any benefits. In addition, as a further condition to any benefit entitlement under this Plan, you must present for payment the check evidencing such benefit within one year of the date of issue. If any check for a benefit payable

under the Plan is not presented for payment within one year of the date of issue, the Plan shall have no liability for the benefit payment, the amount of the check shall be deemed a forfeiture, and no funds shall escheat to any state.

## V. Health FSA

### 5.1 What Is A Health FSA?

The Health FSA is intended to pay for health care expenses not covered by your group health plan and/or deductibles and other out-of-pocket expenses associated with your group health plan.

The Health FSA is a tax savings vehicle which enables you to take money pre-tax from your salary to pay for certain unreimbursed medical expenses. Then, as you incur eligible expenses, you are reimbursed from your account. The **minimum amount you can elect to contribute to your Health FSA is \$150 annually** and the maximum amount you can elect to contribute to your HCFSA is **\$2,700** annually (or a ratable portion of this amount for any short plan year), and the maximum amount is available to you as of the first day of the Plan Year. These limits may be adjusted from time to time by the Plan Administrator.

### 5.2 What Health Care Expenses Can Be Reimbursed?

Only "qualifying health care expenses" can be reimbursed. To be eligible an expense must:

- i) be for medical care incurred within the Plan Year;
- ii) not be reimbursable from another source;
- iii) be incurred by you or your spouse or dependents; and
- iv) not be claimed as a tax deduction.

A more detailed description of qualifying health care expenses is set forth in **Appendix B** to this document.

### 5.3 How Does The Health FSA Work?

You elect to participate in the Health FSA by providing a source of pre-tax funds to reimburse yourself for your eligible health care expenses by entering into an election form/salary reduction agreement with your Employer. Under that agreement, you agree to a salary reduction to fund the Health FSA instead of receiving a corresponding amount of your regular pay.

As you incur eligible expenses, you may obtain reimbursement by submitting a claim form to the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. (See Section 12.2 of this Plan.) **However, if the Plan Administrator establishes a debit card program for the reimbursement of eligible prescription drug expenses, you will obtain reimbursement by paying the provider directly for your eligible health care expenses with a debit card that will be provided to you by the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time.**

**Direct Benefit Payments.** The Employer may, in its discretion, pay any or all of the qualifying medical expenses directly to the health care provider in lieu of making reimbursement thereof. In such event, the Employer shall be relieved of all further responsibility with respect to that particular medical expense.

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**Employees who fail to use (spend) 100% of the amount contributed to the HCFSA will forfeit the unused portion at the end of the plan year, unless rollover provisions apply**

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### 5.4 Is My Health Information Protected?

This Plan will operate in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) to the extent it is applicable, including, but not limited to, the privacy and security regulations with respect to protected health information to the fullest extent required by law, but only as applicable.

HIPAA and the privacy regulations issued thereunder give participants certain rights with respect to their health information, and require that a group health plan protect the privacy of personal health information, as defined by HIPAA. The HIPAA requirements are applicable to the Health FSA portion of this Plan.

*Permitted Uses and Disclosures of PHI.* To the extent required by HIPAA, the Plan Sponsor agrees to keep health information about all participants received from the Plan ("Protected Health Information" or "PHI") private and secure and to handle that health information in a way that enables the Plan to follow the rules in HIPAA and certifies to the following:

- Unless it has written permission from the relevant participant, the Plan Sponsor shall use or disclose PHI only for Plan administration, as otherwise permitted by this plan document, or as required by law.
- The Plan Sponsor shall not disclose Protected Health Information to any of its agents or subcontractors unless the agents and subcontractors agree to handle the Protected Health Information and keep it confidential to the same extent as is required of the Plan Sponsor in this Plan document.

- The Plan Sponsor shall not use or disclose Protected Health Information for any employment-related actions or decisions, or with respect to any other benefit or other employee benefit plan sponsored by the Plan Sponsor without specific written permission from the relevant Participant.
- The Plan Sponsor shall report to the Plan's privacy officer if anyone at the Plan Sponsor becomes aware of any use or disclosure of Protected Health Information that is inconsistent with the provisions set forth in this Plan document.
- The Plan Sponsor shall allow participants, to inspect and photocopy their Protected Health Information, to the extent, and in the manner, required by HIPAA.
- The Plan Sponsor shall make available to the Plan participants their Protected Health Information for amendment and incorporation of any such amendments to the extent, and in the manner, required by HIPAA, including permitting an amendment that excludes from any data set any information regarding claims not reimbursed by the Plan.
- The Plan Sponsor shall make available to the Secretary of the U.S. Department of Health and Human Services ("HHS") its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan to allow the Secretary to determine the Plan's compliance with HIPAA.
- The Plan Sponsor shall keep a written record of disclosures it may make of Protected Health Information, so that it may make available to the Plan the information required for the plan to provide an accounting of certain types of disclosures of Protected Health Information in accordance with HIPAA's requirements.
- The Plan Sponsor shall return to the Plan or destroy all Protected Health Information received from the plan when there is no longer a need for the information. If it is not feasible for the Plan Sponsor to return or destroy the Protected Health Information, then the Plan Sponsor shall limit its further use or disclosures of any Protected Health Information that it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
- The Plan Sponsor shall ensure that adequate separation of the Plan and the Plan Sponsor is established as required by 45 C.F.R. 164.504(f)(2)(iii) as described below.

*Certification of the Plan Sponsor.* The Plan (or a health insurance issuer or HMO with respect to the Plan, if applicable) will disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 5.4. The Plan will not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. §164.520(b)(1)(iii)(C) is included in the appropriate notice.

*Separation of Plan and the Plan Sponsor.* Only designated employees in the human resources department of the Plan Sponsor ("Permitted Employees") will be given access to the Protected Health Information. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees. The Permitted Employees may only use the Protected Health Information for Plan administrative functions that the Plan Sponsor performs for the Plan.

There are also some special rules under HIPAA related to "electronic health information." Electronic health information is generally Protected Health Information that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks, and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media.

The Plan Sponsor shall take additional action with respect to the implementation of security measures (as defined in 45 C.F.R. § 164.304) for electronic Protected Health Information, as it deems necessary and suitable.

The Plan Sponsor shall:

- Maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure adequate separation between the Plan and the Plan Sponsor as an employer is supported by reasonable and appropriate administrative, physical, and technical safeguards in its information systems;
- Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information, agrees to implement reasonable and appropriate security measures to protect that information;
- Report to the Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information system; and
- Comply with any other requirements that the Secretary of HHS may require from time to time with respect to electronic Protected Health Information by the issuance of additional regulations or other guidance pursuant to HIPAA, including, without limitation, either complying with the "encryption" or "notice requirements" with respect to breaches of unsecured PHI.

## 5.5 What If My Coverage Under The Health FSA Is Terminated?

COBRA continuation coverage is a continuation of group health plan coverage (including coverage under the Health FSA) when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Domestic partners, however, are not considered “qualified beneficiaries” under COBRA. Under the group health plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the group health plan because either one of the following qualifying events happens:

- i) Your hours of employment are reduced; or
- ii) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the group health plan because any of the following qualifying events happens:

- i) Your spouse dies;
- ii) Your spouse’s hours of employment are reduced;
- iii) Your spouse’s employment ends for any reason other than his or her gross misconduct;
- iv) Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- v) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the group health plan because any of the following qualifying events happens:

- i) The parent-employee dies;
- ii) The parent-employee’s hours of employment are reduced;
- iii) The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- iv) The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- v) The parents become divorced or legally separated; or
- vi) The child stops being eligible for coverage under the plan as a “dependent child.”

The group health plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or entitlement of the employee to Medicare (Part A, Part B, or both), your Employer must notify the Plan Administrator of the qualifying event within 30 days after the event or when you would otherwise lose coverage under the plan.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The group health plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs or the date you would otherwise lose coverage under the group health plan due to a qualifying event, whichever is later. You must send this notice to the Plan Administrator in accordance with the procedures set forth below under “Furnishing Notice to Plan Administrator.”

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that group health plan coverage would otherwise have been lost. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, entitlement of the employee to Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended. However, with respect to continuation coverage under the Health FSA, continuation coverage will extend only until the end of the calendar year in which the qualifying event occurs.

### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the group health plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the SSA’s determination within 60 days after the later of: (i) the date of the SSA determination; (ii) the date of a qualifying event; or (iii) the date you lose

coverage under the plan. This notice should be sent to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

### **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage and such event would result in loss of health coverage if the first qualifying event had not already occurred, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, becomes entitled to Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the group health plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days after the later of (i) the date of the second qualifying event, or (ii) the date coverage under the plan would have been lost if the first qualifying event had not occurred. This notice must be sent to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

### **Furnishing Notice to Plan Administrator**

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**You should follow these procedures when notifying the plan administrator of a qualifying event or a disability determination. Failure to follow these procedures may cause loss of coverage.**

When furnishing a notice to the Plan Administrator with respect to the occurrence of a qualifying event or with respect to a disability determination by the Social Security Administration, such notices shall be delivered to the Human Resources department of the Plan Administrator

- i) by hand-delivery,
- ii) via facsimile, followed by written confirmation by first class mail, or
- iii) by registered or certified mail, return receipt requested.

Such notices shall include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the Plan Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event or disability determination.

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### **If you have questions**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator, or you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### **Keep your plan informed of address changes**

To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **5.6 What Special Rights Come With My Health FSA?**

Group health plans, generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as the case may be.

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits.

## **VI. Dependent Care FSA**

### **6.1 What Is A Dependent Care Flexible Spending Arrangement?**

A Dependent Care Flexible Spending Arrangement (DCFSA) allows eligible employees to set aside, on a pre-tax basis, monies to pay for qualifying dependent care expenses, which include expenses incurred for the care of an eligible dependent, or for related household services, and are incurred to enable you to be gainfully employed.

## 6.2 Who Is Eligible For A Dependent Care FSA?

To be an “eligible employee”, you must satisfy at least one of the following requirements:

- i) both you and your spouse are employed; or
- ii) your spouse is disabled; or
- iii) your spouse is a full time student; or
- iv) you are single.

An “eligible dependent” must live in your home and be one or more of the following:

- i) a dependent (as defined under Section 152 (a) (1) of the Internal Revenue Code of 1986, as amended (the “Code”)) of the Participant who is under age 13 and with respect to who the Participant is entitled to an exemption under Section 151 (c) of the Code.
- ii) a dependent (as defined under Section 152 (a)(1) of the Code or spouse of the Participant who is physically or mentally incapable of caring for himself/herself and who has the same principal place of abode as the Participant for more than one-half of the taxable year.

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**A full explanation of the tax laws as they relate to dependent care expenses is beyond the scope of this document. We encourage you to seek the assistance of a competent tax advisor if you are unsure about how to proceed.**

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To be a qualifying dependent care expense, the money must be paid to any individual or organization ***other than***:

- i) your spouse;
- ii) your child under age 19 at calendar year end;
- iii) your dependent for income tax purposes;
- iv) an overnight camp; or
- v) a childcare facility caring for more than 6 persons but not complying with all state or local requirements.

## 6.3 What Limits Apply?

There is a \$5,000 limit per family, except that if you are married and file separate tax returns, the limit is \$2,500 per person. In addition, for each Plan Year, you are not entitled to any DCFSA reimbursement in excess of your taxable compensation or your spouse’s taxable compensation. **The minimum amount you can elect to contribute to your DCFSA is \$150 annually.**

Any expenses reimbursed from your DCFSA **cannot** be used for Federal Child and Dependent Care tax credit, as described later.

## 6.4 How Does The Dependent Care Flexible Spending Arrangement Account Work?

You elect to participate in the DCFSA by providing a source of pre-tax funds to reimburse yourself for your eligible dependent care expenses by entering into an election form/salary reduction agreement with your Employer. Under that agreement, you agree to a salary reduction to fund the DCFSA instead of receiving a corresponding amount of your regular pay.

As you incur eligible expenses, you may obtain reimbursement by submitting a claim form to the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. (See Section 11.2 of this Plan.)

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**Employees who fail to use (spend) 100% of the amount contributed to the DCFSA will forfeit the unused portion at the end of the plan year.**

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## 6.5 What Is The Dependent Care Tax Credit?

Currently, the amount of federal income taxes (but not FICA) you owe may be reduced by a percentage of the money you have spent on qualifying dependent care expenses. This is called a Dependent Care Tax Credit. The percentage varies depending on the combined income of you and your spouse. The total amount of expenses eligible for the credit is \$3,000 for one qualifying dependent and to \$6,000 for two or more dependents.

These expenses are also eligible for payment through a Dependent Care FSA. **Note: that you are not permitted to use both the Dependent Care Tax Credit and the Dependent Care FSA, so you should evaluate both possibilities. A full explanation of the tax laws as they relate to dependent care expenses is beyond the scope of this document. We encourage you to seek the assistance of a competent tax advisor if you are unsure about how to proceed.**

## VII. Premium Deductions and Flex Benefits

### 7.1 How Are Employee Premiums For Health And Welfare Plans Made?

When you elect to participate in any one or all of the qualified Health and Welfare plans, your regular compensation will be reduced by the amount of your premium payment for the coverage selected under such plan, on a pre-tax basis, under this Plan.

If the cost of coverage provided under the Health and Welfare plan in which you participate increases or decreases during a Plan Year, a corresponding change will be made in your compensation reductions, in an amount to be determined by the Plan Administrator.

Elections made under this Plan automatically terminate on the date on which you cease to be a participant in the Plan. In the event you become a participant again before the end of the same Plan Year, the elections you previously had in effect shall automatically be reinstated for the balance of the Plan Year.

## **7.2 What Rules Apply To Flex Benefits?**

You may elect to purchase or pay the premiums for any of the arrangements available as Flex Benefits.

If you elect to participate in any of these programs, several requirements must be satisfied. Noncompliance with the requirements could result in the loss of some or all of your money allocated to this Plan. Understanding the rules reduces the chances of this happening. The requirements are:

- i) You must enroll, state the amount you wish to defer from your compensation. prior to the first day of the Plan Year or the first day you are eligible.
- ii) Once the Plan Year or your participation has begun you cannot change your elections for any reason other than a change in status or other special event, as more fully described in Section 3.6 of this Plan.
- iii) Any money deferred from your compensation becomes the Employer's money. It can be paid to you only to reimburse eligible expenses.

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**Employees who fail to use (spend) 100% of the amount contributed will forfeit the unused portion at the end of the plan year.**

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## **VIII. Termination of Employment**

### **8.1 What Happens If Your Employment Is Terminated During The Plan Year?**

If your employment is terminated during the Plan Year, you will remain covered by the Plan Sponsor's Health and Welfare Plans, but only to the extent permitted under each such plan and only for the period for which premiums have been paid prior to your termination.

You will remain eligible for reimbursement for qualifying medical expenses incurred under the Plan up to the date of your termination or last payroll deduction, whichever is later to occur, provided that you make proper claims for reimbursement within the time limits for filing claims under the Plan.

You will remain eligible for reimbursement for qualifying dependent care expenses incurred under the Plan up to the date of your termination or last payroll deduction, whichever is later to occur, provided that you make proper claims for reimbursement within the time limits for filing claims under the Plan.

Under federal law, you, your spouse and your dependents may be entitled to continuation of health care coverage. (See Section 5.6 of this Plan.)

## **IX. Highly Compensated and Key Employees**

### **9.1 Do Limitations Apply To Those Who Are Highly Compensated?**

Under the Internal Revenue Code, "highly compensated individuals," "highly compensated employees" and "key employees" are Participants who are generally highly paid employees.

If you are within these categories, the amount of your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor those who are highly paid. Federal tax laws provide that a plan will be considered to unfairly favor the key employees if they as a group receive more than 25% of all of the nontaxable benefits provided for under the Plan. Plan experience will dictate whether contribution limitations on "highly compensated individuals," "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

## **X. General Information About The Plan**

This section contains certain general information which you may need to know about the Plan.

### **10.1 General Plan Information**

The name of the Plan is the **Paul Smith's College of Arts and Sciences** Flexible Benefits Plan.

The Plan Sponsor has assigned Plan Number **520** to your Plan.

The provisions of the Plan, **as amended and restated**, are effective on **January 1, 2019**.

Your Plan's records are maintained on fiscal period known as the Plan Year. Each Plan Year will run from **January 1 through December 31**.

## **10.2 Employer Information**

The Plan Sponsor's name, address, and identification number are:

Paul Smith's College of Arts and Sciences  
PO Box 265  
Paul Smiths, New York 12970

E.I.N.: 15-0533545

## **10.3 Plan Administrator Information**

The name, address, and business telephone number of your Plan Administrator is:

Paul Smith's College of Arts and Sciences  
PO Box 265  
Paul Smiths, New York 12970  
Telephone: 518-327-6291

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan. Questions concerning the Plan should be directed to the Plan Administrator listed above. The Plan Administrator may appoint a third-party administrator from time to time, and the Plan Administrator will notify you of any such third-party administrator.

## **10.4 Service Of Legal Process**

The name and address of the Plan's agent for service of legal process is:

Paul Smith's College of Arts and Sciences  
PO Box 265  
Paul Smiths, New York 12970

## **10.5 Type Of Administration**

Plan Administration is done by the Plan Sponsor. The Plan Sponsor may contract with a Third Party Administrator for claims administration purposes. The type of claim administration is **Third Party**.

# **XI. Additional Plan Information**

## **11.1 ERISA Rights And Protections**

As a participant in the Health Care Flexible Spending Arrangement Plan or any Health or Welfare plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- i) examine, without charge, at the Plan Administrator's office, all Plan documents, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; and
- ii) obtain copies of all Plan documents and other Plan information upon request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a 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 your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court

costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

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**For all non-health care claims under the Plan, the following procedures set forth in Sections 11.2 through 11.5 will apply. For all health care claims, Article XII of this Plan will apply. Despite any other provision of the Plan, the claims procedures of any third-party administrator of the Plan will supersede the procedures set forth below as long as such procedures comply with applicable law.**

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## **11.2 Filing A Claim**

### **Health FSA**

All claims for reimbursement from your Health FSA must be submitted by the 90<sup>th</sup> day following the end of the Plan Year in which the expenses are incurred. In the event that your participation in the Plan is terminated during the Plan Year, claims for reimbursement must be submitted on or before the 90<sup>th</sup> day following the date participation is terminated. With the claim form, you must submit a bill or receipt from the provider which gives the following information:

- i) name and address of the provider and — in some cases — the provider's taxpayer identification number and signature;
- ii) the date(s) services were provided;
- iii) the type of service provided; and
- iv) who received the service.

If you have an amount remaining unused in your Health FSA as of the last day of the Plan Year, you will have up to \$500 of such amount carried over to the immediately following Plan Year. The amount carried over will be referred to as the "Carryover Amount." For purposes of determining the Carryover Amount, the amount remaining unused as of the last day of the Plan Year means the amount remaining unused after all eligible healthcare expenses for such Plan Year have been reimbursed as of the deadline for submitting claims for reimbursement under the Plan. The Carryover Amount does not count against the maximum amount that a participant may elect to contribute to his/her Health FSA for the Plan Year. Reimbursement for qualified medical expenses will first be debited from unused amounts credited for the current Plan Year and then from any Carryover Amount.

### **Dependent Care Flexible Spending Arrangement**

All claims for reimbursement from your spending accounts must be submitted during the Plan Year in which the expenses are incurred or on or before the 90<sup>th</sup> day following the close of the Plan Year. In the event that your participation in the Plan is terminated during the Plan Year, claims for reimbursement must be submitted on or before the 90<sup>th</sup> day following the date participation is terminated. With the claim form, you must submit a bill or receipt from the provider which gives the following information:

- i) name and address of the provider and — in some cases — the provider's taxpayer identification number and signature;
- ii) the date(s) services were provided;
- iii) the type of service provided; and
- iv) who received the service.

## **11.3 Notification Of Your Claim**

You will receive a response to your claim within 90 days after your claim is submitted. More time may be required if there are special circumstances. If so, the Plan Administrator will contact you within the 90-day period. This notice will include an explanation as to why extra time is required and the date you can expect a decision. The extension will not exceed an additional 90 more days.

If the Plan Administrator fails to notify you within the designated time period, your claim will be considered to have been denied.

## **11.4 Claim Denial**

If all or part of your claim is denied, you will receive written notification explaining the reasons for the denial, a description of any additional information or material needed to complete your claim and an explanation of why the information is necessary and appropriate information about the Plan's claims review procedures.

## **11.5 Appealing A Denied Claim**

If your claim is denied and you wish to appeal, you must file your appeal with the Plan Administrator within 60 days after you receive the denial. Your appeal should include any additional information that you wish the Plan Administrator to consider. If your appeal is not filed within this 60-day period, you will not be able to appeal your claim.

The Plan Administrator will notify you in writing within 60 days after your appeal is received. If there are special circumstances, more time may be necessary to review your appeal. You may be asked to wait an additional 60 days for a decision. The decision will be final and binding on all parties and will be communicated to you in writing. If you do not receive a written response from the Plan Administrator within the designated time period, your appeal will be considered to have been denied.

If you are dissatisfied with the decision after you have pursued these steps, you have the right to file a lawsuit in a state or federal court.

## **XII. Health Care Claim Procedures**

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**For all non-health care claims under the plan, the procedures set forth in Sections 11.2 through 11.5 of this document will apply. For all health care claims relating to your Health Care Flexible Spending Arrangement Plan, this Article XII will apply. Despite any other provision of the plan, the claims procedures of any third-party administrator of the plan will supersede the procedures set forth below as long as such procedures comply with applicable law.**

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### **12.1 Health Care Claim Definitions**

How you file a health care claim for benefits depends on the type of claim it is. There are several categories of benefits:

- i) A "concurrent care claim" is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim.
- ii) A "pre-service care claim" is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as precertification) of the benefit in advance of obtaining medical care.
- iii) A "post-service care claim" is a claim for a benefit under the Plan after medical care has been rendered.
- iv) An "urgent care claim" is a claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

### **12.2 Filing A Health Care Claim**

You may file any claim yourself, or you may designate another person as your "authorized representative" by notifying the Plan Administrator in writing of that person's designation. In that case, all subsequent notices will be provided to you through your authorized representative, and decisions concerning that claim will be forwarded to your authorized representative. Your health care service provider may also file a claim on your behalf. All claims must be filed using a written form supplied by the Plan Administrator and may be submitted by U.S. Mail, by hand delivery or by facsimile.

All claims for reimbursement from your Health FSA must be submitted by the 90<sup>th</sup> day following the end of the Plan Year in which the expenses are incurred. In the event that your participation in the Plan is terminated during the Plan Year, claims for reimbursement must be submitted on or before the 90<sup>th</sup> day following the date participation is terminated. The Plan Administrator provides forms for filing claims and authorized representative designations under the Plan that must be filed in writing.

Your claim for benefits should include the following:

- i) the amount of the qualifying health care expense (as described elsewhere in this document under "Health FSA") for which you want to be reimbursed;
- ii) the date that the care giving rise to the qualifying health care expense was provided (date of service);
- iii) the name of the person receiving the care, if such person is not you, and the relationship of such person to you;
- iv) the name of the person to whom, or organization to which, the qualifying health care expense was incurred;
- v) that the qualifying health care expense has not been reimbursed, or is not reimbursable, under any other health plan coverage; and
- vi) a written statement or receipt from an independent third party that the qualifying health care expense has been incurred, the name of the individual receiving the service, the amount of such qualifying health care expense, the date of service and the type of service.

### **12.3 Notification Of Your Health Care Claim**

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

If your claim is one involving concurrent care, the Plan Administrator will notify you of its decision before your ongoing treatment is reduced or terminated (for urgent care, within 24 hours after receiving the claim as long as your claim is filed at

least 24 hours before such treatment is to be reduced or terminated). You will be given time to provide any additional information required to reach a decision.

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

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

#### **12.4 Health Care Claim Denial**

The Plan Administrator will provide you with written notice of the denial of your claim. Such notice will include the following:

- i) the specific reason or reasons for your denial;
- ii) reference to the specific Plan provisions on which the denial is based;
- iii) a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- iv) a description of the review procedures, including a statement of your right to bring a lawsuit following a denial on review;
- v) either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- vi) if the denial is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request; and
- vii) in the case of an urgent care claim, a description of the expedited review process to which you may be entitled.

#### **12.5 Appealing A Denied Health Care Claim**

You have 180 days after the receipt of the denial notice to request a review of the denial. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally.

In connection with your right to appeal the Plan Administrator's initial determination regarding your claim, you also:

- i) may review pertinent documents and submit issues and comments in writing;
- ii) will be given the opportunity to submit written comments, documents, records or any other material relevant to your claim;
- iii) will, at your request and free of charge, receive reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- iv) will be given a review that takes into account all comments, documents, records and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination; and
- v) are entitled to have your claim reviewed by a health care professional retained by the Plan, if the denial was based on a medical judgment, and such individual shall not have participated in the initial denial.

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

- i) Urgent Care Claims - not later than 72 hours after receiving your request for a review.
- ii) Pre-Service Claims - not later than 30 days after receiving your request for a review.
- iii) Post-Service Claims - not later than 60 days after receiving your request for a review.

Similar to the initial claim determination period, these review periods may be extended. If these periods are extended, you will be notified by the Plan Administrator.

Your review decision from the Plan Administrator will include the following:

- i) the specific reason or reasons for the adverse determination;
- ii) reference to the specific Plan provisions on which the benefit determination is based;
- iii) a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- iv) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;

- v) a statement describing the Plan's optional appeals procedures, if any, and your right to receive information about such procedures, as well as your right to bring a lawsuit; and
- vi) 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."

## Appendix B – Qualifying medical expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return (without regard to the 10% of adjusted gross income limitation). They include, for example, expenses you have incurred for:

- (i) Medicine, drugs, birth control pills, vaccines, and vitamins you are prescribed by your physician.
- (ii) Over the counter items prescribed by a physician (determined without regard to whether such drug is available without a prescription) or insulin.
- (iii) Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
- (iv) Medical examination, X-ray and laboratory service, insulin treatment, and whirlpool baths the doctor ordered.
- (v) Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.
- (vi) Hospital care (including meals and lodging), clinic costs, lab fees.
- (vii) Medical treatment at a center for drug addicts or alcoholics.
- (viii) Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
- (ix) Ambulance service and other travel costs to get medical care. If you use your own car, you can claim what you spend for gas and oil to go to and from the place you received the care, or you can claim mileage. Reimbursement amounts per mile are subject to change at any time and will be reimbursed at the current rate at time the claim was incurred. Add parking and tolls to the amount you claim under either method.

You cannot obtain reimbursement for:

- (i) Expenses for which reimbursements are already available under another medical plan, except when the plan's ordering rules require that reimbursement be made from this plan prior to being made from a Health Reimbursement Arrangement plan sponsored by the Employer.
- (ii) Premiums paid for health coverage under any plan maintained by your Employer or any other employer.
- (iii) The basic cost of Medicare insurance (Medicare A).
- (iv) Life insurance or income protection policies.
- (v) The hospital insurance benefits tax withheld from your pay as part of the social security tax or paid as part of social security self-employment tax.
- (vi) Maternity clothes.
- (vii) Diaper service.
- (viii) Nursing care for a healthy baby.
- (ix) Illegal operations or drugs.
- (x) Travel your doctor told you to take for rest or change.
- (xi) Funeral expenses.

Qualifying medical expenses include only those expenses incurred for:

- (i) Yourself.
- (ii) Your spouse for federal tax purposes.
- (iii) Your child (within the meaning of Section 152(f)(1) of the Code) until the end of the year in which the child attains age 26.
- (iv) Any other individual who is your federal tax dependent for group health plan purposes.
- (iv) If you are divorced or separated, any child of yours that is listed as a dependent on his or her other parent's federal income tax return (and certain other individuals in the case of a multiple support agreement).

Note: An employee may be asked to provide proof in a form acceptable to the Plan Sponsor to verify the dependent relationship.

IRS Publication 502, Medical and Dental Expenses, has a information regarding medical expenses that can be deducted and therefore reimbursed under this Plan, and those that cannot. Note that not all expenses described in Publication 502 are eligible for reimbursement under this Plan.

