

Harvey Mudd College

Retiree Health Reimbursement Arrangement Plan

Plan Summary

Plan Administrator: SelectAccount

1. <u>INTRODUCTION</u>	1
2. <u>DETAILS REGARDING THE HRA</u>	1
3. <u>ELIGIBLE RETIRED AND FORMER EMPLOYEES</u>	1
4. <u>DEPENDENTS</u>	2
5. <u>ENROLLMENT</u>	2
6. <u>OBTAINING REIMBURSEMENTS</u>	3
7. <u>CLAIMS AND APPEAL PROCEDURE</u>	4
8. <u>REASONS FOR TERMINATION OF PARTICIPATION</u>	6
9. <u>NOTICE OF COBRA CONTINUATION COVERAGE.</u>	7
10. <u>OTHER LEGAL NOTICES</u>	8
11. <u>PLAN SPECIFICATIONS</u>	10

1. INTRODUCTION

Harvey Mudd College (“HMC”) sponsors the Retiree Health Reimbursement Arrangement Plan (the “Plan”) to provide health reimbursement arrangements (“HRA”) for certain eligible retired and other former employees (“Eligible Retirees”) that allow for reimbursement of Eligible Medical Expenses incurred by such Eligible Retirees and their Dependents. The Plan is funded solely through Employer Contribution Credits. There are no Participant contributions.

Prior to January 1, 2016, the Plan was called the Emeriti Retiree Health Plan for Harvey Mudd College (the “Emeriti Plan”).

This *Summary* describes the Plan. Through the Plan, you can receive tax-free reimbursement from HMC for uninsured Eligible Medical Expenses for yourself and eligible family members. Defined terms are capitalized. For a complete understanding of Plan terms, you should review this *Summary* and the *Plan Document*. A copy of the *Plan Document* can be requested from HMC.

2. DETAILS REGARDING THE HRA

- (a) **Eligible medical expenses.** To be eligible for reimbursement, an expense must be for medical care provided to diagnose, treat, or prevent disease or for sickness or injury and must be included on the list of eligible medical expenses for this Plan. Please refer to www.selectaccount.com for a list of eligible expenses.
- (b) **You must generally request reimbursement.** To receive reimbursement for Medical Expenses, you must submit a completed claim form and independent third-party documentation of the expense.

Debit Card: Since you are eligible for an HRA, you are automatically enrolled with a SelectAccount debit card. Once activated, your SelectAccount debit card can be used for eligible medical expenses up to your available SelectAccount balance.

- (c) **Expenses cannot be reimbursed from any other source, including tax credits or tax deductions.** Duplications of reimbursement or attempts to take tax credits or deductions for reimbursed expenses may constitute tax fraud, and you personally will be responsible for any penalties. It is not the responsibility of your Employer, the Plan Administrator or the Claims Administrator to monitor your personal income tax or other financial affairs.

3. ELIGIBLE RETIREES

Eligibility Criteria for a Retiree HRA from January 1, 2016 through December 31, 2016:

- Met the definition of benefits-eligible while employed by HMC.

- Completed five years of service at the time employment was terminated.
- As of December 31, 2015, had a balance remaining in an Employer-Contribution Account under the Emeriti Plan.
- Retirees have full access to HRA funds for medical, dental, and vision expenses.

4. DEPENDENTS

- (a) The HRA can reimburse medical expenses incurred by yourself or any of your Dependents.
- (b) “Dependent” includes: (i) your spouse (to whom you are legally married); (ii) a person whom you can claim as a dependent on your federal income tax return; and (iii) a child whom you can claim as your health care tax dependent within the meaning of Code sections 105 or 106. This includes your son, daughter, stepson, stepdaughter or foster child who was under the age of 26 at the beginning of the calendar year.

5. ENROLLMENT

- (a) **Continued Enrollment.** Because the Plan is a continuation of the Emeriti Plan, if you met the eligibility requirements described above on December 31, 2015, you were automatically enrolled in the Plan effective January 1, 2016. Notwithstanding the foregoing, you may also permanently opt out of and waive future reimbursements from the HRA at least annually.
- (b) **Amount Credited to HRA.** Your HRA balance on January 1, 2016 is a continuation of the balance in your Employer-Contribution Account under the Emeriti Plan as of December 31, 2015 (minus any reimbursements made on that date, if applicable). No additional amounts will be credited to your HRA after January 1, 2016.
- (c) **Special Enrollment Period for Newly Acquired Dependent.** If you get married and you request enrollment within 31 days after the date of the marriage, you will be permitted to enroll any and all of: (i) yourself; (ii) your spouse; and (iii) any new eligible Dependents acquired as a result of the marriage. The coverage will be effective as of the date of marriage. If you acquire a new child by birth, adoption or placement for adoption and you request enrollment within 31 days after the date of the birth, placement for adoption, or adoption, you will be permitted to enroll any and all of: (1) yourself; (2) your spouse; and (3) the Child. The coverage will be effective as of the date of the birth, placement for adoption or adoption.
- (d) **Enrollment pursuant to a QMCSO.** A court or administrative agency may issue an order requiring you to provide health coverage for your child. If such an order is submitted to the Plan Administrator, the Plan Administrator will determine whether

the order meets the requirements to be considered a Qualified Medical Child Support Order or "QMCSO." If the order is a QMCSO, your child will be added to coverage. If you are not already covered under this Plan, you will also be added to coverage. The Plan Administrator will give you written notice if an order relating to coverage of your child is received and of the Plan Administrator's decision as to whether the order is a QMCSO.

6. OBTAINING REIMBURSEMENTS

- (a) **Amount available for reimbursement.** The amount available for reimbursement is limited to the balance in your HRA at the time that you submit a claim.
- (b) **Expense must be eligible for reimbursement under this plan.** Only Eligible Medical Expenses will be reimbursed. Please refer to www.selectaccount.com for a list of eligible expenses.
- (c) **Expense must have been incurred between January 1, 2016 and December 31, 2016.** You may only use your HRA to pay for Eligible Medical Expenses that you incurred while covered under the Plan. An expense is incurred when the care or service giving rise to the expense is provided. The date of billing or payment does not matter.
- (d) **Deadline for submitting reimbursement claim.** All claims for reimbursement for medical expenses incurred between January 1, 2016 through December 31, 2016 must be submitted by January 31, 2017.
- (e) **Expense cannot be reimbursed out of other accounts.** The HRA cannot be used to reimburse expenses that are reimbursed from any other account, including a Health Care Flexible Spending Account.
- (f) **Expense payment with a debit card.** Eligible Medical Expenses paid with your SelectAccount debit card will be deducted from your HRA account balance. You may be required to submit documentation to substantiate the claim.
- (g) **Claim submission requirements for manual submission.**
 - (1) *Claims must be submitted to the Claims Administrator.* Claims should be sent or faxed directly to the Claims Administrator at the address or number listed on the bottom of the claim form.
 - (2) *Claims must be submitted during the Plan's Claims Submission Period.* Your HRA account balance will be available to reimburse medical expenses incurred through December 31, 2016, the last day of the "spend down" period. After December 31, 2016, you will have until January 31, 2017 to submit reimbursement claims to SelectAccount for medical, dental and vision

expenses you incurred in 2016. Any remaining balances will be forfeited as of February 1, 2017.

- (3) *Documentation must be provided.* To receive reimbursement for Eligible Medical Expenses, you must submit a completed claim form and documentation of the expense from an independent third party (for example, an itemized bill, receipt or an Explanation of Benefits) showing: (i) date of service; (ii) type of service; (iii) cost of service; (iv) name of care provider; and (v) name of person receiving care. If claim information is incomplete, the claim may be denied and payment delayed.
- (4) *Claims cannot be reimbursed by Health Insurance.* You cannot request reimbursement of an expense that has been or will be reimbursed by health insurance.
- (5) *Method of reimbursement.* The Claims Administrator will reimburse Eligible Medical Expenses through a check or, if you so choose, direct deposit. Reimbursements will be issued as scheduled by the Claims Administrator.
- (h) **Recovery of improper reimbursements.** You will be required to repay the Plan for reimbursements the Claims Administrator determines to have been improper. The Claims Administrator may use one or more of the following recovery methods: (i) your repaying the amount to your HRA or to the Plan, as determined by the Claims Administrator; (ii) offsetting the amount from future reimbursements to you for Eligible Medical Expenses incurred in the same Plan Year; or (iii) withholding the amount from your compensation to the extent permitted by law. If these recovery methods are unsuccessful, the improper reimbursement will be treated as a business debt and the amount reimbursed will be included in your W-2 income.

7. CLAIMS AND APPEAL PROCEDURE

- (a) **Initial determination on claim for reimbursement.**
 - (1) *Time Period.* The Claims Administrator will make its decision on the claim within 30 days after receipt of the claim. The 30-day period for the initial determination may be extended by up to 15 additional days if: (i) such an extension is necessary due to special circumstances beyond the control of the Administrator; and (ii) the Administrator provides notice of the extension to you prior to the expiration of the initial 30-day period which indicates the circumstances requiring the extension of time and the date by which the Administrator expects to render its decision. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information you must submit and you will be provided at least 45 days from your receipt of the notice within which to provide the required information. The time period for

making the initial determination will be tolled from the date on which the notification of the extension is provided to you until the date you respond to the request for additional information.

- (2) *Written Notice of Denial.* If a claim is denied, in whole or in part, the Claims Administrator will send written notice of the denial to you, which will include the specific reason for the denial, a reference to the Plan provision on which the denial is based, a description of additional information or documents necessary in order for the claim to be eligible for reimbursement, and a description of the Plan's appeal procedure. If a denial is based on an internal rule or guideline or medical judgment, information regarding the internal rule or guideline or medical judgment will either be included in the written response or you will be able to obtain a copy of the internal rule or guideline or an explanation of the medical judgment on request and free of charge.

(b) Appeal Rights and Procedures.

- (1) *Written Request for Appeal Review.* If your entire claim is not paid, you have the right to appeal the denial to the Claims Administrator. You must send a written request for an appeal review to the Claims Administrator within 180 days of your receipt of the notice of the denial of the claim. Your request for review should include the specific reason(s) you believe the claim is eligible for reimbursement under the terms of the Plan.
- (2) *Right to Review Documents/Submit Comments.* You have the right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether the information was submitted or considered in the initial claim determination.
- (3) *Person Conducting Review.* The review will be conducted by a named fiduciary for the Plan who is neither the individual who made the initial benefit determination nor a subordinate of that individual, and no deference will be afforded to the initial review determination. In deciding an appeal of any adverse benefit determination that is based, in whole or in part, on a medical judgment, the administrator will consult with a medical care professional who has appropriate training and experience in the applicable medical field and who is neither the individual who was consulted in connection with the initial adverse determination nor a subordinate of such individual.
- (4) *Notice of Continued Denial.* If the denial is upheld in whole or part, the Claims Administrator will send notification of the denial to you. You will be notified of

the decision on appeal in writing within 60 days after the Claims Administrator received your appeal. The notice will include the reason for the decision.

- (i) *Level Two Appeal Process.* Following the Level One Appeal Process, you have additional voluntary appeal rights through SelectAccount. If you are not satisfied with our decision, you may elect to further appeal to SelectAccount by sending a letter within 30 days or the later of your run out end date requesting our SelectAccount Corporate Appeals Committee to reconsider the decision. If you have terminated employment during the year or if you are unsure of your plan's run out end date please contact your group representative or our customer service department. You have the option to present your concerns to the SelectAccount Corporate Appeals Committee either in person or via telephone conference call. A written notification of the Committee's decision about your appeal will be sent within 30 days from the date your request is received.
- (ii) *External Review Process.* If you still disagree with the Claims Administrator's decision, you have the right to an external review of the Claims Administrator's denial of your internal appeal unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the Plan's eligibility requirements. Your external appeal must be filed with the Claims Administrator within four (4) months of the date you were served with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. Within five (5) business days following the date of receipt of the external review request, the Claims Administrator will complete a preliminary review of the request to determine whether the adverse benefit determination qualifies for external review. The Claims Administrator will assign an accredited independent review organization (IRO) to conduct the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

8. REASONS FOR TERMINATION OF PARTICIPATION

- (a) Your participation in this Plan can end if:
 - (1) you commit fraud or misrepresent your eligibility to participate or the eligibility of a claim for reimbursement under this Plan;

- (2) HMC terminates the Plan; or
 - (3) if the certifications you made to participate are no longer accurate.
- (b) In addition, your participation in this Plan will end once you have exhausted your HRA account balance.

9. NOTICE OF COBRA CONTINUATION COVERAGE.

- (a) **Continuation.** Your covered Dependents may continue this coverage if coverage ends due to any of the qualifying events listed below. Your eligible Dependents must be covered under this Plan before the qualifying event in order to continue coverage. In all cases, continuation ends if the Plan ends or required charges (if any) are not paid when due.

If you die without a Spouse or other eligible Dependent, your HRA account balance will be forfeited.

- (b) **Qualifying Events.**

If you are the spouse of an Eligible Retiree, you have the right to elect continuation coverage if you lose coverage because of any of the following qualifying events:

- The death of the Eligible Retiree.
- Entering of decree in the event of a divorce or legal separation from the Eligible Retiree. (Also, if the Eligible Retiree eliminates coverage for his or her spouse in anticipation of a divorce, and a divorce later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan Administrator within 60 days after the later divorce and can establish that the coverage was eliminated earlier in anticipation of the divorce, then continuation coverage may be available for the period after the divorce.)

In the case of a Dependent child of a covered Retiree, the Dependent child has the right to elect continuation coverage if he or she loses coverage because of any of the following qualifying events:

- The death of the Eligible Retiree.
- Parents' divorce or legal separation.
- The Dependent ceases to be a "Dependent child" under the Plan.

- (c) **Your Notice of Obligations.** You and your Dependents must notify the Employer of any of the following events within 60 days of the occurrence of the event:

- Divorce or legal separation.
- A Dependent child no longer meets the Plan's eligibility requirements.

If you or your Dependents fail to provide this notice during this 60-day notice period, any Dependent who loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your Dependents fail to provide this notice, and if any claims are mistakenly paid for expenses incurred after the date coverage was to terminate, then you and your Dependents will be required to reimburse the Plan for any claims paid.

When you notify the Employer that a divorce or a loss of Dependent status will cause a loss of coverage, then the Employer will notify the affected family member(s) of the right to elect continuation coverage. If you notify the Employer of a qualifying event or disability determination and the Employer determines that there is no extension available, the Employer will provide an explanation as to why you or your Dependents are not entitled to elect continuation coverage.

- (d) **Employer's and Plan Administrator's Notice Obligations.** The Employer has 30 days to notify the Plan Administrator of events described above. After plan administrators are put on notice of the qualifying event, they have 14 days to send the qualifying event notice. The qualified beneficiaries must be allowed 60 days to elect continuation coverage. The 60-day time frame begins on the date coverage would end due to the qualifying event or the date of the qualifying-event notice, whichever is later.
- (e) **Election Procedures.** Dependents must elect continuation coverage within 60 days after coverage ends, or, if later, 60 days after the Plan Administrator provides you or your family member with notice of the right to elect continuation coverage. If you or your Dependents do not elect continuation coverage within this 60-day election period, they will lose your right to elect continuation coverage.

You or your Dependent spouse may elect continuation coverage for all qualifying family members; however, each qualified beneficiary is entitled to an independent right to elect continuation coverage. Therefore, a spouse may not decline coverage for the other spouse and a parent cannot decline coverage for a non-minor Dependent child eligible for coverage.

- (f) **How to Elect.** Contact the Employer to determine how to elect continuation coverage.

10. **OTHER LEGAL NOTICES.**

- (a) **HIPAA Privacy Rule Notice of Privacy Practices.** The Plan is subject to the HIPAA Privacy Rule ("Privacy Rule"). You can obtain a copy of the Plan's *Notice of Privacy Practices* (which summarizes the Plan's Privacy Rule obligations, your Privacy Rule

rights, and how the Plan may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

- (b) **Statement of ERISA Rights of Plan Participants.** As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

(1) *Receive Information About Your Plan and Benefits.*

- (i) Examine, without charge, at the Plan Administrator's office and at other specified locations, 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.
- (ii) 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 the latest updated summary plan description. This *Summary*, along with the Plan Document for the HRA, comprise the Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.
- (iii) 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.

- (2) *Prudent Actions by Plan Fiduciaries.* In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit provided under this Plan or exercising your rights under ERISA.

- (3) *Enforce Your Rights.* If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to

provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- (4) *Assistance with Your Questions.* If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
- (c) **Company's right to terminate or amend the plan.** HMC reserves the right to amend or terminate the Plan at any time and without notice.
- (d) **No guarantee of employment.** Participation in this Plan is not a guarantee of employment.
- (e) **Plan Administrator's Discretion.** The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the Plan. Benefits under the Plan will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

11. **PLAN SPECIFICATIONS**

Plan year: January 1, 2016 to December 31, 2016

ERISA Plan Number: _____

Your SelectAccount Group Number: 011854