Summary Plan Description
of the
Franklin & Marshall College
Health Reimbursement Account

General Information

WHAT IS THE PURPOSE OF THE PLAN?
The purpose of this Plan is to reimburse employees for Qualifying Medical Expenses not reimbursed by any other plan or taken as a tax deduction.

WHAT BENEFITS ARE PROVIDED BY THE PLAN?
The plan provides benefits, through a Health Reimbursement Account, for certain Qualifying Medical Expenses (which are described below) up to the following amounts each Plan Year. The amount available will be based on the coverage elected by the Employee under the Employer's Health Plan:

Employees Enrolled in HRA Prior to 7/1/19	
Employee Only	$220
Employee Plus One	$420
Employee Plus Two or More	$630

Employees Enrolled in HRA on or After 7/1/19	
Employee Only	$420
Employee Plus One	$840
Employee Plus Two or More	$1,260

WHAT IS THE PLAN YEAR?
The Plan Year is the 12 month period beginning on July 1st and ending on the following June 30th.

WHAT IS THE HEALTH PLAN?
The Health Plan is the PPO Health PLAN $1,500 (High Deductible Health Plan) group health benefit plan sponsored by the Employer, which the employer has identified as including this Health Reimbursement Plan.

WHAT IS A HEALTH REIMBURSEMENT ACCOUNT?
A Health Reimbursement Account is a recordkeeping account established for contributions made by the Employer on behalf of each employee for reimbursement of Qualifying Medical Expenses. All amounts held in these accounts are general assets of the Employer.

WHEN WILL THE FUNDS IN THE HEALTH REIMBURSEMENT ACCOUNT BECOME AVAILABLE?
All Reimbursement Account funds will be available at the beginning of each Plan Year.

WHAT FUNDS ARE AVAILABLE UNDER THIS PLAN WHEN AN EMPLOYEE ENROLLS IN THE HEALTH PLAN IN THE MIDDLE OF THE PLAN YEAR?
If an employee enrolls in the Health Plan in the middle of the Plan Year, the entire Health Reimbursement Account funds shown above will be available on the date of enrollment.

If an employee adds or drops dependents from coverage during a Plan Year (as permitted under the terms of this Plan and the PPO Health Plan $1,500) his/her HRA balance will be increased for the added dependent, but not decreased as a result of the dropped dependent.

WHO CAN PARTICIPATE IN THE PLAN?
Employees of Franklin & Marshall College who are eligible for and who have elected to participate in the Health Plan will automatically be covered under this Plan. Dependents will be covered under this Plan if they participate in the Health Plan. Employees enrolled in a health savings account are not eligible to participate in this HRA.

Employees include any person regularly scheduled to work for the Employer and whose pay is subject to federal income tax withholding and FICA taxes. The following are not considered employees: (1) leased employees, contract workers, independent contractors, temporary employees, or casual employees, whether or not such individual is on the Employer's W-2 payroll; (2) any person who performs services for the Employer but is paid by a staffing agency; (3) any employee covered under a collective bargaining agreement (unless the collective bargaining agreement provides that this plan is available); (4) any self-employed individual; and (5) any more than 2% shareholder in a sub-chapter S corporation.

WHAT ABOUT DEPENDENTS WHO ARE REQUIRED TO BE COVERED UNDER A QUALIFIED MEDICAL CHILD SUPPORT ORDER?
An eligible Dependent child may include a child for whom an Employee is required to provide coverage under a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court or administrative judgment, decree or order that is typically issued as part of a divorce or as part of a state child support order proceeding and that requires health plan coverage for an "alternate recipient" (meaning either a child of Employee or state or political subdivision acting on behalf of a child). The alternate recipient must be treated like any other individual participating in the Plan.

Upon receipt of a child support order, the Employer will promptly send a written notice of receipt of the order to the Employee and all alternate recipient children named in the order and their legal representatives. If the Employer receives a National Medical Support Notice, it will notify the state agency whether coverage for the child is available under the Plan and indicate the effective date of coverage (or any steps necessary to make the coverage effective, including copies of any forms that must be completed). The Employer will also send a description of the coverage.

After sending the notice of receipt, the Employer has the ultimate authority to determine whether or not the order meets the requirements of a QMCSO. Within 40 days after receiving the order, the Employer will notify the Employee and the alternate recipients that either the order is a valid QMCSO or that the order is not a valid QMCSO. If an order is found to be invalid, the parties may "cure" the deficiencies with a subsequent order.

WHEN DOES COVERAGE BECOME EFFECTIVE IN THE PLAN?
Coverage will become effective for eligible Employees when participation in the Health Plan becomes effective. Coverage will become effective for a Dependent when the Dependent's coverage becomes effective under the Health Plan.

WHAT HAPPENS WHEN AN EMPLOYEE'S REIMBURSEMENT ACCOUNT FUNDS ARE NOT USED DURING THE PLAN YEAR?
Any unused funds remaining in an Employee's Reimbursement Account at the end of the Plan Year and the claims submission period will be carried forward to the next Plan Year as long as the employee remains enrolled in the PPO Health Plan $1,500 (High Deductible Health Plan.)

WHAT DO EMPLOYEES HAVE TO PAY TO PARTICIPATE IN THIS PLAN?
Employees are not required to contribute to the cost of coverage under this Plan.

WHAT IF I HAVE A PROBLEM OR QUESTION?
If you have a question or problem, please call the Employer at (717) 358-3996.

Details of the Health Reimbursement Account

HOW DOES THE HEALTH REIMBURSEMENT ACCOUNT WORK?
The Health Reimbursement Account works like this:

- The Claims Administrator records the amount that is available in your Health Reimbursement Account, though the account exists only as a paper record;
- When you have an eligible expense, also called a Qualifying Medical Expense, you will submit an Explanation of Benefits from the insurance company or a detailed receipt from the provider or use your debit card and submit as verification, when applicable, either an Explanation of Benefits from the insurance company or a detailed receipt from the provider to the Claims Administrator; and
- If the claim is eligible for reimbursement and there are sufficient funds in your Health Reimbursement Account, the Claims Administrator will send you or the provider of service a check and subtract the amount paid from your Reimbursement Account balance or, if using the debit card, the amount will be subtracted directly from your balance once the expense has been substantiated.

WHAT EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT?
Amounts considered eligible expenses are any expenses defined under Code 213d.

To be considered “Qualifying”, the expense must also be incurred during the Plan Year. An expense is incurred when the care is provided rather than when you are billed or when you pay for the service.

For employees who enroll in the Plan in the middle of a Plan Year, expenses incurred before coverage becomes effective are not eligible. This is also true for any dependents who enroll during the Plan Year.

Any expenses incurred after participation in the Plan ends are not eligible, though Employees have through September 30th after termination of coverage to submit any expenses incurred during the period of participation. See the section on COBRA continuation for a discussion of extended coverage.

Reimbursement Information

HOW DO EMPLOYEES RECEIVE BENEFITS UNDER THE PLAN?
After incurring a Qualifying Medical Expense, an Employee can submit a claim for reimbursement following the procedures provided by the Employer or Claims Administrator. The claim submission under this Plan should include an Explanation of Benefits. As an alternative you may pay for your eligible expenses using your debit card. When using the debit card, you may be asked to certify your expenses are eligible under the Plan.

For Qualifying Medical Expenses not reimbursable under the medical plan, you will submit a detailed receipt from the provider to the Claims Administrator. If the claim is eligible for reimbursement and there are sufficient funds in your Health Reimbursement Account, the Claims Administrator will send you a check and subtract the amount paid from your Reimbursement Account balance.

Claims can be submitted up through September 30th following the end of the Plan Year (and up through September 30th following the date coverage ends for whatever reason).

All claims will be processed and paid (if eligible under the Plan and if sufficient funds are available) within 30 days of receipt of a completed reimbursement form or as soon as possible thereafter.

WHAT HAPPENS IF A CLAIM IS DENIED?
If a claim is denied because it is incomplete, the Claims Administrator will provide a description of any additional material or information necessary and an explanation of why this material or information is necessary. This notice will be provided within 5 days of receipt of the claim.

After receipt of all the information needed to review a claim, if any claim for benefits under the Plan is wholly or partially denied, the Claims Administrator will give notice in writing of the denial within 30 days after the claim is filed. This notice will include the following information:

- Information that is sufficient to identify the claim involved (including date of service, name of health care provider, claim amount, diagnosis code and its meaning, and the treatment code and its meaning);
- The specific reason or reasons for the denial, including a description of the meaning of any denial code;
- Specific reference to pertinent Plan provision, internal rule, guideline, protocol or similar criteria on which the denial is based;
- A description of the available internal appeals and external review processes, including information on how to initiate an appeal;
- Information about the availability of any health insurance consumer assistance or ombudsman to assist with appeals, including contact information; and
- An explanation that a full and fair review of the decision denying the claim (including the right to present evidence and testimony) may be requested by you or your authorized representative by filing an appeal within 180 days after such notice of denial has been received.

If you request a review of the claim denial, you may review pertinent documents and submit issues and comments in writing. The decision of the Claims Administrator on review will be made promptly, but not later than 30 days after receipt of the request for review, unless special circumstances require an extension of time for processing. The decision on review will be made in writing and will include specific reasons for the denial, written in a manner that you can understand and will include references to the Plan provisions on which the denial is based. The notice of denial will include a discussion of the decision.

The Claims Administrator will provide you with any new or additional information that was considered, relied upon or generated in connection with the claim. This information will be provided in advance of the final determination so that you have a reasonable opportunity to respond prior to that date.

Upon exhaustion of the internal review process (or earlier if the Claims Administrator does not follow the requirements of the applicable law), you have the right to initiate an external review of the denial. The Claims Administrator will provide a description of the applicable external appeal process.

IF I AM ENROLLED IN A HEALTH CARE FLEXIBLE SPENDING ACCOUNT, WHICH PLAN PAYS FIRST?
Benefits under this Plan are intended to pay for Qualifying Medical Expenses not reimbursed or reimbursable by another plan. If a Qualifying Medical Expense is covered by both this Plan and a health care flexible spending account, then this Plan is not available for reimbursement until after amounts available for reimbursement under the flexible spending account have been exhausted.

WHAT HAPPENS IF I RECEIVE REIMBURSEMENT FOR A QUALIFYING MEDICAL EXPENSE AND I RECEIVE REIMBURSEMENT UNDER THIS PLAN?
If you receive a reimbursement under this Plan and reimbursement for the same expense is made under another plan, you will be required to refund the reimbursement to the Employer. The amount of your Reimbursement Account will be increased by the amount of the reimbursement, but this change will be made for the Plan Year in which the expense was originally paid. Any amount not refunded becomes taxable income to the Employee.

Information about Termination of Coverage

WHEN DOES COVERAGE TERMINATE UNDER THIS PLAN?
An Employee and/or Dependent will no longer participate in this Plan on the earlier of:

- The termination of this Plan; or
- The date that the Employee or Dependent is no longer enrolled in the Health Plan (though coverage may continue under COBRA, if all of the conditions described below are met).

WHAT HAPPENS TO MY REIMBURSEMENT ACCOUNT FUNDS WHEN MY COVERAGE TERMINATES?
When coverage terminates, any amounts remaining in an Employee's Reimbursement Account after September 30th following the date of termination, shall be forfeited. If a Dependent terminates coverage during a Plan Year, the Employee's Reimbursement Account will not be re-adjusted until the next Plan Year.

WHAT HAPPENS TO MY REIMBURSEMENT ACCOUNT IF I RE-ENROLL AFTER COVERAGE TERMINATES?
If a covered Employee terminates his or her employment for any reason, including disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less, the Employee's reimbursement account will be reinstated to the date of termination with the same balance that the individual had before termination, pending reinstatement in the Health Plan.

In addition, retired employees and surviving spouses and/or eligible dependents of retired employees upon the death of a current plan participant will have the option to spend down any balance remaining in the account at the time of termination for a period of 4 years. If a retired employee dies, their surviving spouse and/or eligible dependents would only be able to spend down the balance for the balance of the 4 years from the date of the employee's retirement. If an active employee dies, their surviving spouse and/or eligible dependents would be able to spend down the balance for 4 years from the date of the active employee's death.

The 4 year spend down period for retirees and surviving spouses and/or eligible dependents prior to the effective date of this Plan amendment, will begin January 1, 2015.

WHAT HAPPENS TO MY REIMBURSEMENT ACCOUNT IF I TAKE A LEAVE OF ABSENCE?

If the Employer is subject to the FMLA and an Employee takes a qualifying leave under the Family and Medical Leave Act (the FMLA) then to the extent and under the conditions required by the FMLA, the Employer will continue to maintain the Employee's Reimbursement Account on the same terms and conditions as if the Employee were still an active Employee.

If you take a leave of absence under the Uniformed Services Employment and Re-employment Act (USERRA), the Employer will maintain your Reimbursement Account on the same terms and conditions as if you were still an active Employee.

If an employee reenrolls in the Health Plan immediately upon returning to work after a sabbatical, research or other medical leave of absence, the HRA account balance will be restored.

Continued coverage under this Plan for employees who are on other leaves of absence will be determined in accordance with the policies of the Employer.

CAN I ELECT COBRA IF I LOSE COVERAGE UNDER THIS PLAN?

If an Employee's and/or Dependent's coverage under this HRA Plan terminates because of a "qualifying event," each individual has a right to purchase continued coverage for a temporary period of time. COBRA coverage is available under this Plan, only if the individual also elects COBRA under the Health Plan.

Qualifying events include termination of employment, reduction in hours to a non-qualified status, divorce, death, or a child ceasing to meet the definition of Dependent. A participating Employee or Dependent must notify the Administrator of any divorce, legal separation, or a child ceasing to be considered a Dependent under the Plan within 60 days after the event. This notice must be in writing and addressed to the Administrator. In addition, if a second qualifying event occurs during COBRA continuation coverage or if the former Employee becomes entitled to Medicare or dies during the COBRA coverage, the former Employee or Dependent (as applicable) must notify the Administrator. Finally, an Employee must notify the Administrator of the start or end of any disability that is determined under the Social Security Act to be a covered disability. The Administrator will provide Employees and Dependents with the forms needed to make the required notifications.

Any notice described in the above paragraph must be provided in writing to the Administrator within 60 days of the occurrence of the event (except that if there is a change in the Employee's disability status, notice must be given within 30 days). If the Employee or Dependent fails to provide notice within the required time period, he or she may no longer be eligible for COBRA continuation coverage. In this event, the Administrator may send Notice of Unavailability of COBRA Coverage upon receipt of the late notice.

If you have any questions about your COBRA rights, please read the COBRA notice, which has been provided to you and your spouse (if covered) at the time of your enrollment in the Plan. You can contact the Administrator if you need another copy.

You will need to follow the procedures set forth in the Notice that you will receive when your participation ends and you will be required to make premium payments for continued coverage.

HOW LONG WILL THE PLAN REMAIN IN EFFECT?
Although the Employer expects to maintain the Plan indefinitely, it has the right to amend or terminate all or any part of the Plan at any time for any reason. It is also possible that future changes in state or federal tax law may require that the Plan be amended accordingly.

Additional Information about the Plan:

Plan Name:	Franklin & Marshall College Health Reimbursement Plan
Type of Plan:	Health reimbursement arrangement
Plan Year:	July 1st – June 30th
Plan Number:	501
Effective Date:	January 1, 2007; This Plan was amended and restated on January 1, 2019
Employer/Plan Sponsor:	Franklin & Marshall College PO Box 3003 Lancaster, PA 17604 (717) 358-3996
Name and Address of Other Participating Affiliated Employers:	None
Plan Sponsor's Employer Identification number:	23-1352635
Plan Administrator:	Franklin & Marshall College PO Box 3003 Lancaster, PA 17604 (717) 358-3996 The Employer is the Plan Administrator.
Claims Administrator:	Benecon CDH Services PO Box 5406 Lancaster, PA 17606-5406 (833) 738-6729
Named Fiduciary:	Franklin & Marshall College PO Box 3003 Lancaster, PA 17604 Attention: Director Human Resources (717) 358-4353
Agent for Service of Legal Process:	Franklin & Marshall College PO Box 3003 Lancaster, PA 17604 Attention: Director, Human Resources (717) 358-4353

Additional Notices:

Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 requires group health plans, insurance companies, and HMO's that cover hospital stays following childbirth to provide coverage for a minimum period of time. In general, hospital coverage for the mother and newborn must be provided for a minimum of 48 hours following normal delivery, or 96 hours following a cesarean section. Group health plans may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

The Plan provides coverage in compliance with The Newborns' and Mothers' Health Protection Act.

Women's Health and Cancer Rights Protection Act

The benefits of most health plans must include coverage for the following post-mastectomy services and supplies in a manner determined in consultation with the attending physician and the patient:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Health Plan and the terms of this plan.

Statement of ERISA Rights

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 are entitled to:

Receive Information about the Plan and its Benefits

You are entitled to examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if there are 100 or more participants, 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.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), any updated summary plan description and, if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

If there are more than 100 participants in the Plan, you are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

During any Plan Year in which the Employer is subject to COBRA, you are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. You are also entitled to review this summary plan description and the documents governing your COBRA continuation coverage rights.

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 the Employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in 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 that 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 it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court shall 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.

Assistance with Questions
If you have any questions about the 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, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.