SUMMARY PLAN DESCRIPTION

FOR

MARIST COLLEGE

RETIREE EXCHANGE

HEALTH REIMBURSEMENT ARRANGEMENT

JANUARY 1, 2015 – DECEMBER 31, 2015
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PLAN INFORMATION APPENDIX
INTRODUCTION

Marist College (the “Sponsor” or “Employer” or “Marist”) has established the Marist College Retiree Exchange Health Reimbursement Arrangement (the “Plan”) for the benefit of its eligible retirees and their eligible Dependents, as defined below. The purpose of the Plan is to reimburse eligible retirees for certain medical expenses which are not otherwise reimbursed. The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (“Code”), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. Further, because the Plan is a “retiree-only plan,” it is intended that the Plan be exempt from the application of the Patient Protection and Affordable Care Act.

The material provisions of the Plan as of the Effective Date are summarized below, but this summary plan description (“SPD”) is qualified in its entirety by reference to the full text of the formal plan document, a copy of which is available for inspection at the Sponsor’s offices. In the event of any conflict between the terms of this SPD and the terms of the plan document, the terms of the plan document will control. Participants seeking to obtain additional information about the Plan should contact the Sponsor.

Note that capitalized terms used in this SPD are generally defined the first time they are used or are defined in the Plan Information Appendix at the end of this booklet. Please note that “you,” “your” and “my” when used in this SPD refer to you, the retiree, or your participating dependents.

PART I
GENERAL INFORMATION ABOUT THE PLAN

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

The purpose of the Plan is to reimburse Participants (as defined in Q-2 and Q-3) for Eligible Medical Expenses (as defined in Q-6) which are not otherwise reimbursed by any other plan or program. Reimbursements for Eligible Medical Expenses under the Plan generally are excludable from the Participant’s taxable income.

Q-2.  Who can participate in the Plan?

Retired employees of the Employer are eligible to participate in the Plan if they meet all requirements to be an Eligible Retiree as defined in Section 1 of the Plan Information Appendix entitled “Plan Terms.” Eligible Retirees who become covered under the Plan, as explained in Q-4, are called “Participants.”

Q-3.  Can my spouse participate in the Plan?

Yes, separate Health Reimbursement Arrangement (HRA) Contributions are available to your spouse who meets all requirements to be an Eligible Spouse, as reflected in Section 2 of the Plan Information Appendix entitled “Plan Terms,” and they may become Participants in the Plan. Your spouse means your legal spouse. You are required to provide proof of your marital status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in benefits provided under the Plan.
Marist does not provide any HRA Contribution for the children of Eligible Retirees or Eligible Spouses. However, to the extent permitted by the Internal Revenue Code, Eligible Retirees and Eligible Spouses may be able to use their HRA balances to cover Eligible Medical Expenses for their children.

If your legal spouse does not satisfy the requirements to become a Participant in the Plan, the Plan will nonetheless allow reimbursement of Eligible Medical Expenses (from your HRA Account) for your spouse, any child of yours that has not yet attained age 26, and any other individual who is your dependent for federal income tax purposes. In addition, the Plan will allow reimbursement of Eligible Medical Expenses for a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order (“QMCSO”) to the extent the QMCSO does not require coverage not otherwise offered under this Plan. The Plan Administrator will make a determination as to whether the order is a QMCSO in accordance with the Plan’s QMCSO procedures. The Plan Administrator will notify both you and the affected child once a determination has been made.

Q-4. When do I actually become a Participant in the Plan?

An Eligible Retiree, or an Eligible Spouse, actually becomes a Participant in the Plan on the later of the Effective Date of the Plan as provided in the Plan Information Appendix entitled “General Plan Information” or the date that he or she has satisfied all of the following requirements:

- He or she has coverage under both Part A and Part B of Medicare. All individuals must register for Medicare as coverage is not automatic. Eligible Retirees and Eligible Spouses must timely and properly enroll in, and must continuously maintain their enrollment in, Part A and Part B of Medicare.

- He or she must maintain their continuous enrollment in one of the medical insurance products that is available through Marist’s OneExchange program (unless an exception applies). Eligible retirees and spouses may choose one or more additional insurance products available through OneExchange, based on their individual needs and circumstances, and will have the opportunity to change their selections during open enrollment each year.

- He or she has completed any enrollment forms or procedures required by the Plan Administrator.

Q-5. How does the Plan work?

The Sponsor has elected a Combined Account structure, as reflected in Section 5 of the Plan Information Appendix, meaning one Health Reimbursement Arrangement Account (“HRA Account”) will be established for all Participants in your family. HRA Contributions for all Participants in your family will be credited to that HRA Account. A Combined Account is created only if both the retiree and the dependent qualify for the funding.

HRA Contributions will be credited to HRA Accounts by the Employer in the amount and at the times specified in Sections 6 and 7 of the Plan Information Appendix entitled “Plan Terms” and will be reduced from time to time by the amount of any Eligible Medical Expenses for which a Participant is reimbursed under the Plan. At any time, a Participant may receive reimbursement
for Eligible Medical Expenses up to the amount in his or her HRA Account. Note that the law does not permit Participants to make any contributions to their HRA Accounts.

An HRA Account is merely a bookkeeping account on the Employer’s records; it is not funded (i.e., the HRA Contributions are merely notational credits to your HRA Account) and does not bear interest or accrue earnings of any kind. All reimbursements under the Plan are paid entirely from the Sponsor’s general assets.

Q-6. What is an “Eligible Medical Expense”?

An Eligible Medical Expense is any expense incurred for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of Eligible Medical Expenses include:

- Medications (in reasonable quantities)

  **NOTE:** Effective for expenses incurred in Plan Years beginning after December 31, 2010, medications are considered Eligible Medical Expenses only if they are prescribed by a doctor (without regard to whether the medication is available without a prescription) or is insulin.

- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Birth control pills;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision or long-term care insurance.

Some examples of common items that are not Eligible Medical Expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
• Funeral and burial expenses;
• Household and domestic help;
• Massage therapy;
• Custodial care;
• Health club or fitness program dues; and
• Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not Eligible Medical Expenses, consult IRS Publication 502, “Medical and Dental Expenses,” under the headings “What Medical Expenses Are Includible” and “What Expenses Are Not Includible.” (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an Eligible Medical Expense under the Plan, contact the Third Party Administrator as provided in the Plan Information Appendix entitled “General Plan Information.”

Only Eligible Medical Expenses incurred while you are a Participant in the Plan may be reimbursed from your HRA Account. Similarly, only Eligible Medical Expenses incurred while your Eligible Spouse is a Participant in the Plan may be reimbursed from his or her HRA Account. Eligible Medical Expenses are “incurred” when the medical care is provided, not when you or your Eligible Spouse are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

• expenses incurred prior to the date that you became a Participant in the HRA;
• expenses incurred after the date that you cease to be a Participant in the HRA; and
• expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

Q-7. When do I cease participation in the Plan?

If you are an Eligible Retiree, you will cease being a Participant in the Plan on the earlier of:

• the date you cease to be an Eligible Retiree for any reason;
• the date you are rehired by the Employer as an active full-time employee;
• the date you cease to be enrolled in Part A and Part B of Medicare, if eligible;
• your date of death;
• the effective date of any amendment terminating your eligibility under the Plan; or
• the date the Plan is terminated.

If you are an Eligible Spouse, you will cease being a Participant in the Plan on the earlier of:
• the date you cease to be an Eligible Spouse for any reason;
• the date you cease to be enrolled in Part A and Part B of Medicare if eligible;
• your date of death;
• in the case of an Eligible Spouse, the date you divorce the Eligible Retiree;
• the effective date of any amendment terminating your eligibility under the Plan; or
• the date the Plan is terminated.

You may not obtain reimbursement of any Eligible Medical Expenses incurred after the date
your eligibility ceases. (For the definition of “incurred,” see Q-6.) You have 180 days after your
eligibility ceases, however, to request reimbursement of Eligible Medical Expenses you incurred
before your eligibility ceased.

In addition, your Eligible Spouse may be eligible to continue coverage under the Plan beyond the
date that their coverage would otherwise end if coverage is lost for certain reasons. Their
continuation of coverage rights and responsibilities are described in Q-16 below.

Q-8. What happens if I do not use all of the HRA Contributions credited to my HRA Account
during the Plan Year?

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those
amounts will be carried over to subsequent Plan Years, as reflected in Section 8 of the Plan
Information Appendix entitled “Plan Terms.”

Q-9. How do I receive reimbursement under the Plan?

You must complete a reimbursement form and mail or fax it to the Claims Submission Agent as
indicated below, as well as provided in the Plan Information Appendix, along with a copy of
your insurance premium bill, an “explanation of benefits” or “EOB,” or, if no EOB is provided, a
written statement from the service provider. The written statement from the service provider
must contain the following: (a) the name of the patient, (b) the date service or treatment was
provided, (c) a description of the service or treatment; and (d) the amount incurred. You can
obtain a reimbursement form from the Third Party Administrator identified in the Plan
Information Appendix. Your claim is deemed filed when it is received by the Claims
Submission Agent. (Do not mail your form to the Plan Administrator or the Third Party
Administrator as this may result in a delay in processing.)
If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent.

Claims Submission Agent:

Towers Watson
P.O. Box 2396
Omaha, NE 68103-2396
Fax: 855-321-2605

Q-10. What happens if my claim for benefits is denied?

The Plan has two levels of appeals. If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to substantiate your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan’s appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. The Claims Submission Agent is not a fiduciary of the Plan thus you should file your appeal with the Plan Administrator at the address provided in the Plan Information Appendix entitled “General Plan Information” no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to substantiate your claim and any additional information that you believe would support your claim. The Plan Administrator has the authority to approve or deny all claims.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. If the Plan Administrator also denies your claim, the denial notice from the Plan Administrator will contain the same type of information provided in the first notice of denial provided by the Claims Submission Agent.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures.
Q-11  What happens if I die?

If the Eligible Retiree dies without an Eligible Spouse who is a Participant in the Plan, his or her HRA Account is immediately forfeited upon death, but the deceased Eligible Retiree’s estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Retiree and his or her spouse, child or other tax-dependent before the Eligible Retiree’s death. Claims must be submitted within 180 days of the Eligible Retiree’s death.

If the Eligible Retiree dies with an Eligible Spouse who is a Participant, his or her HRA Account shall not continue. Eligible Spouses who are Participants can continue to submit Eligible Medical Expenses for reimbursement if the Sponsor elected to continue making HRA Contributions to such Eligible Spouses after the Eligible Retiree’s death, as reflected in Section 9 of the Plan Information Appendix entitled “Plan Terms.” The deceased Eligible Spouse’s estate or representatives may submit claims for Eligible Medical Expenses incurred by the Eligible Spouse, child or other tax-dependent before the Eligible Spouse’s death. Claims must be submitted within 180 days of the Eligible Spouse’s death.

Q-12. Are reimbursements under the Plan taxable?

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Sponsor cannot guarantee the tax treatment to any given Participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

Q-13. What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account?

If it is later determined that you or your Eligible Spouse received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your Eligible Spouse will be required to refund the overpayment or erroneous reimbursement to the Employer.

If you do not refund the overpayment or erroneous payment, the Employer reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Employer. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you.

Q-14. How long will the Plan remain in effect?

Although the Sponsor expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, the amount credited to HRA Accounts or to reduce or eliminate any amounts currently credited to a Participant’s HRA Account.

Employers participating in the Plan other than the Sponsor (such as a related affiliate of the Sponsor) may terminate their participation in the Plan at any time upon 60 days written notice to the Sponsor and Plan Administrator.
**Q-15. How does the Plan interact with other medical plans?**

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement.

If you are also a participant in a health flexible spending account sponsored by your Employer, the expenses covered both by this Plan and the health flexible spending account must be submitted first to the health flexible spending account.

**Q-16. What is “continuation coverage” and how does it work?**

Under a federal law called “COBRA,” your spouse, former spouse, child or other tax dependent (a “COBRA Eligible Individual”) may be able to elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, the Participant’s death, or occurrence of another event that would cause a Participant’s child or other tax dependent to cease to be eligible for reimbursements from the Participant’s HRA Account (for example, a child’s attainment of age 26; provided the child is not a tax dependent). These are called “qualifying events.”

Note that COBRA Eligible Individuals are required to notify the Plan Administrator in writing of a divorce, legal separation, 26th birthday, or loss of tax-dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan.

If a COBRA Eligible Individual elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event and will be referred to as a “qualified beneficiary.”

In order to continue coverage, the qualified beneficiary must pay a monthly premium of up to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event. Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary’s HRA Account is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- The date any required monthly premium is not paid when due or during the applicable grace period; or
- The date the Employer ceases to provide any group health plan.

**Q-17. What is alternative coverage?**

The Sponsor may make available to a qualified beneficiary (as defined in Q-16 above) coverage in lieu of the continued coverage described in Q-16 above. The Sponsor will provide more
information on any alternative coverage that may be available under the Plan upon the occurrence of a qualifying event (as defined in Q-16 above).

If the qualified beneficiary chooses the continuation coverage above, he or she waives the right to the alternative coverage. If the qualified beneficiary chooses the alternative coverage, he or she waives the right to continuation coverage as described above.

Q-18. **Who do I contact if I have questions about the Plan?**

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the section of the Plan Information Appendix entitled “General Plan Information.”

Q-19. **What about Catastrophic Coverage Reimbursement?**

If you have prescription drug expenses that have reached the Catastrophic Coverage level (as defined by Medicare) you may submit a claim for reimbursement of these expenses. A catastrophic coverage specific claim form can be received by contacting customer service.

Benefits are paid as claims are submitted. Once qualified, all eligible claims incurred through the end of the Plan Year will be reimbursed without limit.
PART II
ERISA RIGHTS

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing 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 Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for benefits under the Plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from 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 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 domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan’s fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g., if it finds your claim is frivolous).

**Assistance with Your 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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your 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.

**PART III
LEGAL NOTICES**

**Mothers’ And Newborns’ Health Protection Act**

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

**Women’s Health And Cancer Rights Act**

To the extent the Plan provides benefits with respect to mastectomy, it will provide, in the case of an individual who is receiving benefits in connection with a mastectomy and who elects reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which a mastectomy was performed, surgery and reconstruction of the other breast to provide a symmetrical appearance, prostheses, and coverage of physical complications at all stages of the mastectomy, including lymphedemas.
Health Insurance Portability And Accountability Act

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or “Protected Health Information” (“PHI”) and to inform you about:

- the Plan’s uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan’s duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan’s privacy practices.

The term “Protected Health Information” or “PHI” includes all individually identifiable health information (including “genetic information”) transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is changed, a revised version of this Notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual’s rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for administrative plan purposes as permitted by federal law.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.
A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan’s compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for administrative purposes permitted by law and related to treatment, payment or health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

The Plan may also use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this Notice or permitted or required by applicable law. In addition, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your mental health professional. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time in writing. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- the Plan has taken action in reliance on your authorization before it received your written revocation; and
- you were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend’s involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

E. Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm.
For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor’s parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor’s PHI.

- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual’s agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual’s agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan’s best judgment.

- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

- For research, subject to conditions.

- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

- When authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.
The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI. “Designated Record Set” includes enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used by the Plan to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Plan at the address provided at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

C. Right to Amend PHI

You have the right to request the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the Plan at the address provided at the end of this Notice.

D. Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to you about your own PHI; or (3) pursuant to your authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the accounting will be provided.
be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. You or your personal representative will be required to complete a form to request an accounting. Requests for an accounting should be made to the Plan at the address provided at the end of this Notice.

**E. The Right to Receive a Paper Copy of This Notice Upon Request**

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor’s intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

**F. A Note About Personal Representatives**

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

**G. The Right to be Notified if there is a Breach of Unsecured PHI**

The Plan does everything in its power to secure the privacy of your PHI. If, however, there is an unauthorized acquisition, use, or access of your unsecured PHI that is a reportable “breach” (as that term is defined under HIPAA’s breach notification rules), the Plan will notify you in writing. This notification will explain the incident, the steps the Plan is taking to lessen any harm that might be caused by the incident, and any steps that you should take to protect yourself from any potential harm resulting from the incident. The notification will also include information about who you should contact for more information about the incident. If you have any questions about the Plan’s procedures in the event of a breach of your unsecured PHI, you should contact the Plan Administrator.

**Section 4. Your Right to File a Complaint With the Plan or the Secretary of HHS**

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. The Plan requests that you first attempt to resolve your complaint by contacting the Plan Administrator. However, if you believe the Plan has violated your privacy rights, you may also file a complaint with the Office of Civil Rights (“OCR”), the division of the U.S. Department of Health and Human Services responsible for enforcement of the HIPAA privacy rules. You can file a complaint by mail or fax to the appropriate OCR regional office (see the Plan Administrator or www.hhs.gov/ocr/office/about/rgn-hqaddresses.html). You may also complete OCR’s complaint package online at the website below.
http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintform.pdf. If you need assistance or have questions you can also email OCRMail@hhs.gov. Neither the Plan nor Sponsor will retaliate against you for filing a complaint.

Section 5. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 6. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.
# PLAN INFORMATION APPENDIX

## GENERAL PLAN INFORMATION

<table>
<thead>
<tr>
<th>Name of Plan:</th>
<th>Marist College Retiree Exchange Health Reimbursement Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective Date:</td>
<td>January 1, 2015</td>
</tr>
<tr>
<td>Name, address, and telephone number of the Plan Sponsor:</td>
<td>Refer to Plan Administrator Information</td>
</tr>
<tr>
<td>Name, address, and telephone number of participating Employers (other than Sponsor):</td>
<td>Refer to Plan Administrator Information</td>
</tr>
</tbody>
</table>
| Name, address, and telephone number of the Plan Administrator: | Marist College  
Office of Human Resources  
3399 North Road  
Poughkeepsie, NY 12601  
845-575-3349  
www.marist.edu |
| Claims Submission Agent: | Towers Watson  
P.O. Box 2396  
Omaha, NE 68103-2396  
Fax: 855-321-2605 |
| Agent for Service of Legal Process: | Towers Watson |
| Sponsor’s federal tax identification number: | 14-1442493 |
| Plan Number: | 504 |
| Plan Year: | January 1, 2015 – December 31, 2015 |
| Third Party Administrator: | Towers Watson  
| 10975 South Sterling View Drive, Suite A-1  
| South Jordan, UT 84905  
| Medicare: 1-844-887-2802  
| medicare.oneexchange.com/marist  
| Non-Medicare: 1-855-241-5719  
| oneexchange.com/marist  |
| Funding: | Benefits are paid from the Employer’s general assets. There is no trust or other fund from which benefits are paid. |
PLAN TERMS

1. **Eligible Retiree:** Eligible Retiree means:

(a) A Marist retiree participating in the Marist group medical plan as of December 31, 2014.

(b) A former full-time employee of Marist who retires from service with Marist on or after January 1, 2015, who:

(1) Has been enrolled in the Marist’s group medical plan for a minimum of two years immediately prior to the date of retirement with Marist and,

(2) Has either:

   (i) Completed ten (10) or more years of continuous full-time service with Marist immediately prior to retirement, and attained at least age 65 as of the date of retirement; or

   (ii) Completed fifteen (15) or more years of continuous full-time service with Marist immediately prior to retirement, and attained at least age 62 as of the date of retirement.

(c) Employees who separate under Marist’s Long-Term Disability Plan and who satisfied the coverage, age and service conditions described above as of the employee’s last day of active employment.

(d) As a limited exception to the age condition described in (b) above (but not the coverage or service conditions), employees who began a Marist-approved early or phase-down retirement prior to January 1, 2015 (if the coverage and service conditions are satisfied).

(e) Employees who have not satisfied the coverage, age and service conditions described above prior to the actual date of separation are not eligible for post-retirement benefits, regardless of their age at the time of separation.

(f) The only opportunity an Eligible Retiree has to enroll in Marist’s post-retirement health plan is at the time of the employee’s retirement. Those who elect not to enroll at the time of retirement may not enroll in the plan at a later date. Similarly, enrollment cannot be reinstated if coverage is interrupted or discontinued for any reason after retirement.

(g) Eligible Retirees under age 65 will be supported by OneExchange until they reach age 65, at which time they must enroll in Part A and Part B of Medicare and must transition into the OneExchange features that apply to all other covered individuals who are age 65 or older.

(h) Marist does not provide any HRA Contribution for the children of Eligible Retirees or Eligible Spouses. However, to the extent permitted by the Internal Revenue Code, Eligible Retirees and Eligible Spouses may be able to use their HRA balances to cover eligible healthcare costs for their qualifying dependent children.
2. **Eligible Spouse:**

(a) The covered spouse of a Marist retiree participating in the Marist group medical plan as of January 1, 2015.

(b) Spousal eligibility is determined by the following requirements:

1. The spouse must be the legal spouse of an employee who completed ten (10) or more years of continuous full-time service with Marist as of September 1, 2014.

2. The spouse must have been enrolled in Marist’s group medical plan for a minimum of two (2) consecutive years prior to September 1, 2014.

3. A spouse will not be eligible to become a Participant in the Plan if:

   (i) He or she is the spouse of an employee who has completed fewer than ten (10) years of service as of September 1, 2014, regardless of the employee’s age; or

   (ii) He or she has not been enrolled in Marist’s group medical plan for a minimum of two (2) consecutive years prior to September 1, 2014.

(c) The only opportunity an Eligible Spouse has to enroll in the Plan is at the time of the employee’s retirement. Those who elect not to enroll at the time of retirement may not enroll in the Plan at a later date. Similarly, enrollment cannot be reinstated if coverage is interrupted or discontinued for any reason after the employee’s retirement.

(d) Eligible Spouses under age 65 will be supported by OneExchange until they reach age 65, at which time they must enroll in Part A and Part B of Medicare and must transition into the OneExchange features that apply to all other covered individuals who are age 65 or older.

(e) Marist does not provide any HRA Contribution for the children of Eligible Retirees or Eligible Spouses. However, to the extent permitted by the Internal Revenue Code, Eligible Retirees and Eligible Spouses may be able to use their HRA balances to cover eligible healthcare costs for their qualifying dependent children.

3. **HRA Contributions for Eligible Spouses:**

An Eligible Spouse for whom the Sponsor elects to make a HRA Contribution is eligible to be a Participant under the Plan.

4. **Insurance Coverage Exception:**

In lieu of obtaining an individual medical insurance policy through Towers Watson, an Eligible Retiree or Eligible Spouse may establish that he or she:

(a) Has health coverage under TRICARE.

(b) Has health coverage under Veterans Benefit Administration.
5. **Account Structure:**

*Combined Account:* only one HRA Account will be established for all Participants in a single family and all HRA Contributions for such family members will be credited to such Combined Account. A Combined Account is created only if both the retiree and his or her spouse are Participants and qualify for the funding.

6. **HRA Contributions:**

(a) Eligible Retirees: The following amount will be credited *quarterly* on behalf of Participants who are Eligible Retirees:

1. Fixed Dollar Amount for Eligible Retirees who retired prior to January 1, 2001:
   
   (i) $875 ($3,500.00 on an annual basis)

2. Fixed Dollar Amount based on Years of Service for Eligible Retirees who retired on or after January 1, 2001, but prior to January 1, 2014:
   
   (i) Up to 29 Years of Service: $468.75 ($1,875.00 on an annual basis)
   
   (ii) 30 – 34 Years of Service: $562.50 ($2,250.00 on an annual basis)
   
   (iii) 35+ Years of Service: $656.25 ($2,625.00 on an annual basis)

3. Fixed Dollar Amount based on Years of Service for Eligible Retirees who retired on or after January 1, 2014:
   
   (i) 10 -14 Years of Service: $187.50 ($750.00 on an annual basis)
   
   (ii) 15 - 19 Years of Service: $281.25 ($1,125.00 on an annual basis)
   
   (iii) 20 - 24 Years of Service: $375.00 ($1,500.00 on an annual basis)
   
   (iv) 25 – 29 Years of Service: $468.75 ($1,875.00 on an annual basis)
   
   (v) 30 – 34 Years of Service: $562.50 ($2,250.00 on an annual basis)
   
   (vi) 35+ Years of Service: $656.25 ($2,625.00 on an annual basis)

(b) Eligible Spouses: The following amount will be credited *quarterly* on behalf of Participants who Eligible Spouses (the Eligible Spouse’s HRA Contributions will be based on the employment and retirement date of the Eligible Retiree to whom the Eligible Spouse is married):

1. Fixed Dollar Amount for Eligible Spouses of Eligible Retirees who retired prior to January 1, 2001:
   
   (i) $875 ($3,500.00 on an annual basis)
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(2) **Fixed Dollar Amount based on Years of Service for Eligible Spouses of Eligible Retirees who retired on or after January 1, 2001, but prior to January 1, 2014:**

(i) Up to 29 Years of Service: $468.75 ($1,875.00 on an annual basis)

(ii) 30 – 34 Years of Service: $562.50 ($2,250.00 on an annual basis)

(iii) 35+ Years of Service: $656.25 ($2,625.00 on an annual basis)

(3) **Fixed Dollar Amount based on Years of Service for Eligible Spouses of Eligible Retirees who retired on or after January 1, 2014:**

(i) 10 -14 Years of Service: $187.50 ($750.00 on an annual basis)

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(iv) 25 – 29 Years of Service: $468.75 ($1,875.00 on an annual basis)

(v) 30 – 34 Years of Service: $562.50 ($2,250.00 on an annual basis)

(vi) 35+ Years of Service: $656.25 ($2,625.00 on an annual basis)

7. **Timing of HRA Contributions:**

HRA Contributions will be credited to HRA Accounts on the first day of each calendar quarter (January, April, July, October).

8. **Carryover of Accounts:**

HRA Contributions remaining in an HRA Account at the end of a Plan Year (after the expiration of the claims run-out period) shall be carried over to the following Plan Year to reimburse Participants for Eligible Medical Expenses incurred during subsequent Plan Years.

9. **Death:**

Participants who are Eligible Spouses shall continue to receive HRA Contributions for 18 months after the Eligible Retiree’s death.
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