Wellesley College Employee Welfare Benefits Plan and Summary Plan Description

Effective January 1, 2011

Summary Plan Description Includes the following Benefit Programs:

Medical, Dental, Employee Assistance Plan, Life Insurance, Short Term Disability, Long Term Disability, Long Term Care Insurance, and Flexible Spending Accounts

This booklet, together with the separate benefit booklets provided to you by Wellesley College that contain the specific details about your benefit coverages, constitute the Summary Plan Description for the Wellesley College Employee Welfare Benefits Plan, the Health Care Reimbursement Plan and the Dependent Care Reimbursement Account Plan. Please read this booklet carefully and keep it along with your separate benefit booklets for future reference. If you require further information or have any questions, we encourage you to contact the Wellesley College Human Resources Office.

TABLE OF CONTENTS

WELLESLEY COLLEGE EMPLOYEE WELFARE BENEFITS PLAN AND SUMMARY PLAN DESCRIPTION

WELLESLEY COLLEGE EMPLOYEE WELFARE BENEFITS PLAN AND SUMMARY PLAN DESCRIPTION

SUMMARY PLAN DESCRIPTION NOTICE

This document, together with any separate benefit plan certificates or booklets for the benefits you have selected, constitute the Summary Plan Description for your health and welfare benefits, and is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA). You should use these materials to understand the health and welfare benefits Wellesley College provides for you and your family. This SPD does not serve as a guarantee of continued employment or benefits. Wellesley College policies on hiring, discharge, layoff and discipline are in no way affected by the programs described here.

In addition, Wellesley College reserves the right to amend, modify or terminate the Wellesley College Employee Welfare Benefits Plan (the "Plan"), the Health Care Reimbursement Plan and the Dependent Care Reimbursement Account Plan (the latter two plans, the "Reimbursement Plans") or any part thereof with or without notice, at any time at its sole discretion. If there is a discrepancy between this document and the terms of the official document(s) of the Plan or of the Reimbursement Plans, the provisions of the Plan (or, as applicable, Reimbursement Plan) document(s) and/or any related insurance contracts are controlling and will govern.

This document presents basic information about the health and welfare benefits provided by the Plan and the Reimbursement Plans, as of the effective date of January 1, 2011, and your rights to benefits as a participant in the Plan and Reimbursement Plans. This document, together with any separate benefit plan certificate, summary, or booklet for the health and welfare benefits you have selected, constitute the Summary Plan Description ("SPD") for your health and welfare benefits. The Plan and the Reimbursement Plans are maintained for the benefit of eligible employees and their covered eligible dependents, and are intended to provide health and welfare benefits to those individuals enrolled in the Plan and the Reimbursement Plans. You and any of your dependents covered under the Plan or the Reimbursement Plans should review this entire document and the applicable insurance certificates, summaries, or booklets for the benefits you have selected. The term "employee" herein refers to faculty, administrative staff and union employees unless otherwise noted in the SPD.

Your enrollment in health and welfare coverage provided under the Plan and the Reimbursement Plans is subject to all limitations of the Plan and Reimbursement Plans (as applicable) and any related insurance contracts, including any pre-existing condition exclusions, elimination periods, actively at-work requirements and hourly eligibility requirements.

In the event that the content of this Plan and SPD, or any oral or written representations made by any person regarding this Plan or the Reimbursement Plans, conflicts or is inconsistent with the provisions of any additional benefit summaries or other Plan (or, as applicable, Reimbursement Plan) materials, the provisions of this Plan (or, as applicable, the Reimbursement Plan) and/or any related insurance contracts are controlling and will govern. The Plan Sponsor reserves the right to amend, modify or terminate the Plan and the Reimbursement Plans, in whole or in part, at any time.

I. PARTICIPATION IN THE PLAN

Employee Eligibility

Eligible Employees
To enroll in a benefit program offered by Wellesley College, you must be eligible for that program. Your eligibility is based on employment criteria, including the hours you are regularly scheduled to work each week and any collective bargaining agreement relating to your employment. The programs currently available are:

- Medical Coverage (HMO or PPO)
- Dental Coverage (Delta Dental Premier or DeltaCare)
- Employee Assistance Plan (EAP)
- Life Insurance (Basic, Contributory, Spouse)
- Short Term Disability (STD) Insurance – Union only
- Long Term Disability (LTD) Insurance
- Long Term Care (LTC) Insurance
- Flexible Spending Accounts (FSAs)

The two tables below list the employment criteria required to become eligible for a specific benefit program. To determine your eligibility for a program, and your effective date of coverage once you elect to enroll in a program, refer to the appropriate table:

I: FACULTY and ADMINISTRATIVE STAFF

Your Job Classification:	Your Eligibility:	Your Enrollment Date:
• Faculty or Administrative Staff	• You must work at least 17.5 hours per week to enroll in: Medical and/or Dental coverage, or the Reimbursement Plans. • You must work at least 35 hours per week to enroll in Life Insurance and LTD.	• Medical, Dental, and the Reimbursement Plans: the 1st of the month co-incident with or following your date of hire • EAP: on your date of hire • Basic Life Insurance and Contributory/Spouse Life Insurance: the 1st of the month co-incident with or following your date of hire • Long Term Disability: the 1st of

		the month co-incident with or following your date of hire • Long Term Care Insurance**:** within the first thirty days of employment

II: UNION EMPLOYEES

Your Job Classification:	**Your Eligibility:**	**Your Enrollment Date:**
• Union Employees	• You must be scheduled to work at least 20 hours per week to enroll in Medical, Dental, or the Reimbursement Plans. • You must work at least 40 hours per week, for at least 9 months of a year, to enroll in Life Insurance and LTD.	• Medical, Dental, and the Reimbursement Plans: the 1st of the month co-incident with or following your date of hire. • EAP: Your date of hire • Basic Life Insurance and Contributory/Spouse Life Insurance: after 12 consecutive months of being actively at work 40 hours per week • Long Term Disability: after 12 consecutive months of being actively at work 40 hours per week • Long Term Care: Insurance: within the first thirty days of employment

Short Term Disability (STD) Eligibility

Administrative Staff: STD coverage for administrative staff is a payroll practice and is not included in the Employee Welfare Benefits Plan. Please refer to the Administrative Handbook which is available on the Human Resources website for further information.

Faculty: Faculty are not eligible for STD coverage.

Union Employees: STD is provided through the Employee Welfare Benefits Plan and coverage is outlined in this SPD. Eligible employees are automatically enrolled, and the College pays the cost of coverage.

Employees Ineligible for College Benefit Programs
An individual who is employed in a division, department, unit, or job classification designated as *not eligible* for benefits, regardless of the individual's work schedule or number of hours worked, is not eligible for benefits under the Plan. This *not eligible* designation includes all casual wage and contract employees.

Dependent Eligibility for Medical and Dental Coverage

Eligible employees who are enrolled for medical and/or dental coverage under the Plan may enroll their eligible spouse and eligible dependents for coverage, if and to the extent such coverage is available. Your dependents must be enrolled in the same medical and/or dental coverage in which you enroll. If you enroll a dependent you will be asked to provide proof of the dependent's eligibility.

Eligible Dependents

For medical and dental coverage, your eligible dependents can include:

- Your spouse
- Children up to age 26 (regardless of tax dependent status). If your adult child is eligible for another employer group health plan (other than their parent's plan) they are not eligible to be covered under Wellesley College's medical and/or dental plan. It is your responsibility to notify the Human Resources Office if your child is no longer eligible for the plan(s).

Proof of dependent eligibility includes the following:

- Valid marriage certificate for spousal coverage

Dependent Children

Eligible dependent children include:

- Your biological children,
- Your adopted children (including children placed with you for adoption)
- Your stepchildren
- Your foster children
- Children of your spouse
- Children for whom you are the legal guardian
- Dependent children of an unmarried eligible dependent

Children Who Are Incapacitated

Your unmarried children who are physically or mentally disabled and incapable of self-support are eligible for benefits regardless of age, as long as your own coverage remains in effect (this requires proof of incapacitation approved by your specific health insurance medical provider).

How to Enroll in a Benefits Program

You must Complete and Return Enrollment Paperwork

When you are hired or become newly eligible for benefits at Wellesley College, you receive a "New Employee Packet" from the Wellesley College Human Resources Office. This packet contains enrollment forms which you must complete and return to Wellesley College's Human Resources Office to enroll in Medical, Dental, Contributory and Spouse Life Insurance, Long Term Care insurance and Flexible Spending Accounts. To enroll in Contributory and/or Spouse Life you must complete and return the applicable enrollment form to the Human Resources Office within 30 days of your date of hire. To enroll in Long Term Care insurance, you must complete the appropriate LTC form and return it directly to the LTC insurer as directed. To enroll in one or both of the Reimbursement Plans you must complete the appropriate form for such Reimbursement Plan(s) and return it to the Human Resources Office. Enrollment in Basic Life, Short Term and Long Term Disability (LTD) coverage is automatic, with no enrollment paperwork.

If you do **not** enroll in Wellesley College's medical plan, you must complete an Employee Health Insurance Responsibility Disclosure (HIRD) form annually. This form will be provided to you, generally during the annual Open Enrollment period, and must be returned to the Wellesley College Human Resources Office no later than the December 30th of a given calendar year.

Coverage Levels of Specific Benefit Programs

You may elect Medical and/or Dental coverage at the individual or family level:

- Individual coverage is for you.
- Family coverage is for you and your eligible dependents.
- Same-sex marriage coverage for you and your spouse (equivalent to family coverage). If you have a same-sex spouse and are electing family coverage for the first time, call the Wellesley College Human Resources Office to speak with a Benefits Representative about the enrollment process and the tax implications.

When you elect to enroll in the Health Care Reimbursement Plan, you make an annual pre-tax salary deferral to cover eligible health care expenses, as defined by the IRS, and not reimbursed from another source (e.g., your medical and dental program). When you elect to enroll in the Dependent Care Reimbursement Plan, you make an annual pre-tax salary deferral to cover eligible dependent care expenses for children under age 13.

For in-depth descriptions of the above programs, go to the ***Benefit Programs*** section in this SPD**.**

You have 30 Days to Return Your Enrollment Paperwork

When you become newly eligible for Wellesley College's Employee Welfare Benefits Plan you have 30 days from your date of hire (or from your date of benefits eligibility, if that date is different from your date of hire), to complete, sign, and return your enrollment forms for Medical, Dental, Contributory and Spouse Life Insurance or to enroll in one of the Reimbursement Plans.

All enrollment forms with the appropriate documentation must be returned to the Wellesley College, Human Resources Office, 106 Central Street, Wellesley, MA 02481. If you do not return your paperwork within 30 days of your date of hire, or the date of benefits eligibility if you are not a new hire, you will not be allowed to enroll in Medical, Dental, Contributory or Spouse Life Insurance or one of the Reimbursement Plans until the next annual Open Enrollment. Open Enrollment is held each fall, with coverage to begin the following January 1st.

Since your medical, dental and Reimbursement Plan elections are taken on a pre-tax basis you will only be able to make a benefits election change outside of your 30-day enrollment period, if you experience a qualified change in family or employment status (see ***When You May Change Your Benefit Elections***, in this SPD).

Should you decide to elect Contributory and/or Spouse Life Insurance or Long Term Care insurance after the 30 day enrollment period, you will be subject to certain restrictions and may be asked to submit evidence of good health.

Your Effective Date of Coverage

When you enroll in Medical or Dental coverage, or elect to participate in a Reimbursement Plan, your participation in these programs becomes effective the 1st of the month co-incident with or following your date of hire. Deductions for your benefits are based on your date of participation. Faculty and administrative staff gain eligibility for Life Insurance and Long Term Disability coverage on the first of the month following date of hire provided you are actively at work and work at least 35 hours per week. Union employees gain eligibility for Life, Short Term and Long Term Disability coverage after one year of continuous full time employment.

Once you enroll in coverage, circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits, are described in the appropriate Subscriber Certificate (the benefit contract between Wellesley College and the insurance carrier of a specific benefit program). You should review the applicable Subscriber Certificate(s) in order to acquaint yourself with these provisions. You may lose coverage under the Plan or the Reimbursement Plans if Wellesley terminates the Plan or Reimbursement Plans or amends them to reduce or eliminate your coverage. Your coverage under the Plan and the Reimbursement Plans generally terminates when you terminate employment with Wellesley College or otherwise cease to be an eligible employee.

When You Enroll in Wellesley's College's Employee Welfare Benefits Plan You Are Entitled to Certain Rights

As a participant in Wellesley College's Employee Welfare Benefits Plan and the Health Care Reimbursement Plan, you have specific rights and protections related to the administration of your benefit programs. See **Employee Retirement Income Security Act of 1974 (ERISA)** found in the ***Your Rights as a Participant*** section of this SPD**.** Once you enroll have enrolled in the medical or dental coverage or in the Health Care Reimbursement Plan, you also have the right to elect continuation coverage should your coverage end. See **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** also found in the ***Rights*** section.

Paying for the Benefits You Elect

When you enroll in a benefits program, you begin to pay for the benefits you have elected as of the effective date of your coverage. Automatic payroll deductions will be taken during each of your pay periods throughout the course of the year. The amount you pay per pay period depends upon which benefits you elect, your coverage level, and how often you are paid.

Please refer to the fall issue of the Illuminator for the current costs of programs and per pay period costs. You may also access this information on the Wellesley College Human Resources website.

Pre-Tax Deduction of Premiums from Your Salary

Medical and Dental premiums, along with Reimbursement Plan contributions, are deducted from your gross salary before taxes are applied to your pay. If you elect Contributory and/or Spouse Life Insurance, your premium is deducted from your post-tax pay. If you elect Long Term Care Insurance, the insurer will send the bill directly to you at your home address (payroll deduction does not apply to LTC insurance).

Any deductions for benefits do not lower the dollar figure used in computing salary increases, pension contributions, Life Insurance amounts, or disability benefits, which remain based on your total, actual salary before benefit deductions are made from your salary.

Your future Social Security benefits are based on your reduced salary. When you pay for benefits on a pre-tax basis the cost of your coverage is deducted from your salary before Federal, Social Security, and state income taxes are withheld. As a result, your taxable income is reduced, thereby saving you money. Paying for Medical or Dental coverage or making Reimbursement Plan contributions on a pre-tax basis could slightly reduce future Social Security benefits. However, in most cases, any reduction in future benefits is offset by current tax savings. If you have any questions regarding this, consult your tax advisor to determine your personal tax consequences.

Medical and Dental Coverage: You and Wellesley College Share the Cost

Your share of the cost of Medical or Dental coverage is paid through pre-tax payroll deductions. Wellesley College pays the remainder of the premium. Refer to the fall edition of the Illuminator or the most recent rate information on the Human Resources website for the cost of the various plans and coverage levels.

Employee Assistance Plan

The cost of the EAP coverage is paid 100% by Wellesley College.

Life Insurance Cost

The cost of Basic Life is paid 100% by Wellesley College. The cost of Contributory Life Insurance is paid 100% by the employee through post-tax payroll deduction, and is based on age and amount of coverage elected. The cost of Spouse Life Insurance for your spouse is also paid on a post-tax basis and is based on the employee's age and the amount of coverage elected. To obtain rate information, visit the Human Resource's website.

Short Term Disability Cost

The cost of STD coverage is paid 100% by Wellesley College.

Long Term Disability Cost

The cost of LTD coverage is paid 100% by Wellesley College.

Long Term Care Cost

The employee pays for this coverage directly upon receipt of a premium invoice from the LTC carrier.

Flexible Spending Account Contributions

There is no cost to employees to enroll in a Reimbursement Plan. When you elect to establish an FSA under a Reimbursement Plan you have dollar contributions reduced directly from your pre-tax gross salary, to pay for eligible medical or dental expenses, as defined by the IRS. These expenses include medical, dental, prescription and vision expenses not reimbursed by another source (e.g., your medical or dental coverage). You may also set aside pre-tax dollars to pay for eligible dependent care costs. See the **Benefit Programs** section in this SPD for specific Reimbursement program information.

Payroll Deduction Process for Same Sex Marriage Coverage

If you enroll in same-sex marriage Medical or Dental coverage you will have the individual premium rate for employees deducted pre-tax from your gross earnings. Then the difference between the family premium rate and the individual premium rate will be deducted from your gross earnings before state taxes are applied to the remaining paycheck amount (this is because same-sex marriage is recognized by the Commonwealth of Massachusetts). However, Federal taxes are applied to the gross paycheck amount before this deduction occurs (the marriage is not recognized by the Federal government).

Deductions for Summer Months for Academic Year Employees

The Payroll Office will make additional payroll deductions to cover Medical, Dental, and Contributory and Spouse Life Insurance for employees who do not work in the summer months of June, July or August.

Imputed Income for Medical, Dental, and Life Insurance Costs

Life Insurance Imputed Income

IRS guidelines require that you pay imputed income on amounts of employer provided group term Life Insurance in excess of $50,000. The imputed income amount is determined by using the IRC Section 79 table I rates and will be added to your W-2 and is subject to Federal, state, Social Security and Medicare taxes.

Same-Sex Marriage Imputed Income

The imputed income dollar amount for the Medical or Dental cost for same-sex marriage coverage is the difference between what Wellesley College contributes toward the premium cost of the individual and family coverage levels. The Federal government views this premium subsidy by Wellesley College as taxable income to the employee. For same-sex marriage you are not assessed imputed income by the state of Massachusetts, and therefore none of the premium cost made by Wellesley, which is seen as a subsidy by the Federal government, is added to your gross income for state tax purposes (same-sex marriage is recognized by the Commonwealth of Massachusetts as of May 2004).

When You May Change Your Benefit Elections

Changes to Medical, Dental, and Flexible Spending Accounts

When you become newly eligible for benefits at Wellesley College you have a 30-day enrollment period in which to elect or to waive benefits. Because special Internal Revenue Service (IRS) rules apply to benefits that are deducted on a pre-tax basis, once your initial 30-day enrollment period ends, changes to your Medical, Dental, or Flexible Spending Accounts may only be made when you experience a qualified change in your family or employment status, or during Wellesley College's annual Open Enrollment.

Changes to Contributory Life Insurance

Because you pay for Contributory Life on a post-tax basis, you may enroll in or make changes to Contributory Life Insurance coverage outside the 30-day enrollment window and throughout the calendar year. However, proof of good health may be required, if you elect or increase the amount of your coverage at a future date. See **Contributory Life Insurance** in the ***Benefit Programs*** section of this SPD.

Changes in Spouse Life Insurance

Because you pay for Spouse Life on a post-tax basis, you may enroll in or make changes to Spouse Life Insurance coverage outside the 30-day enrollment window and throughout the calendar year. However, proof of good health may be required, if you decide to elect or increase

the amount of spouse Life Insurance at a future date. See **Spouse Life Insurance** in the ***Benefit Programs*** section of the SPD.

Benefit Changes Are Allowed During the Annual Open Enrollment Period

Open Enrollment is held each fall at Wellesley College. During Open Enrollment you are allowed to make changes to your benefit elections.

Any changes to your benefits that you elect during the annual Open Enrollment period become effective January 1st of the new calendar year, and remain effective for the duration of the calendar year, unless you experience a qualified change in family or employment status.

During the annual Open Enrollment period, you may elect to:

- Enroll in a program;
- Change your coverage level in a program;
- Add an eligible dependent to your medical or dental coverage;
- Drop a dependent from your medical or dental coverage;
- Stop your participation in a program.

If you do not make any changes or new elections, you will keep the same Medical and Dental coverage for the new calendar year that you had in the previous calendar year.

However, if you want to participate in a Flexible Spending Account, you must make an active election during Open Enrollment each year. If you do not make a new election under a Reimbursement Plan, you will not be enrolled in a Reimbursement Plan in the following calendar year.

Each year, you will be notified of the annual Open Enrollment period, enrollment procedures, coverage costs, and time period available to enroll in or change your benefit elections for the upcoming calendar year. Wellesley College may make changes to benefit coverages at any time, so it is important to review your annual Open Enrollment materials carefully when you receive them.

Qualified Change in Status

Outside of the annual Open Enrollment period, Federal law allows you to change certain benefit elections if you experience a change in status. Any change in benefit elections must be consistent with your change in status. A change in status includes, but is not limited to, the following types of life events:

- Changes in your legal marital status, as defined under Federal law (marriage, divorce, death of a spouse, legal separation).
- Changes in the number of your dependents (birth, death, adoption, placement for adoption).

- Change in employment status (termination or commencement of your own, your spouse's, or your eligible dependents employment, or your own, your spouse's, or your eligible dependents commencement of or return from an unpaid leave of absence).
- Work schedule changes (reduction or increase in hours by you, your spouse, or your eligible dependents).
- Changes in your dependent's eligibility (change in age, marital, student, or disability status).

How to Request a Change in Your Benefit Elections

Any requested change in coverage must be consistent with your change in status. You must notify the Wellesley College Human Resources Office within 30 days of the date of your life event. If you do not request a change to your benefit elections within 30 days of your life event, you must wait until the next annual enrollment period, or until you experience another life event recognized as a qualified change in status, to make a change.

The effective date of your change in coverage generally will be the date that your change in status occurred—the date of the life event. Any resulting change in the cost of your coverage (for example, going from individual coverage to family coverage) is effective on the first pay period following the date of your requested change in coverage as a result of a change in status. There may, however, be additional or prorated amounts due to payroll timing.

You will need to provide the following information to request a change:

- The type of family or employment status change
- Proof of the change (documentation showing the change)
- The effective date of the change
- The benefit coverage to be dropped or added

Special Enrollment Periods – Health Insurance Portability and Accountability Act

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in one of the health care options offered by the Plan Sponsor if (a) the other coverage was COBRA coverage and such coverage was exhausted, (b) the other coverage is terminated due to your or your dependents' loss of eligibility, or (c) employer contributions toward such other coverage ceased, provided that, in all cases, you request enrollment within 30 days after the other coverage is exhausted or ends or after employer contributions cease. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Special Enrollment Relating to Termination of Medicaid or CHIP Coverage and Eligibility for Employment Assistance Under Medicaid or CHIP

If you are an employee who is eligible but not enrolled for medical coverage under the terms of Wellesley College's Employee Welfare Benefits Plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under the Plan), Wellesley must allow you to enroll for medical coverage under the Plan if either of the following conditions is met:

- The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child medical plan ("CHIP") under Title XXI of such Act and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under Wellesley College's group medical coverage not later than 60 days after the date of termination of such coverage.
- The employee or dependent becomes eligible for assistance, with respect to coverage under Wellesley College's group medical coverage, while under such Medicaid plan or State child medical plan (including under any waiver or demonstration project conducted under or in relation to such a plan), and if the employee requests coverage under Wellesley College's group medical coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact Wellesley College's Human Resources Office at the address and phone number listed in this SPD.

When Your Participation Ends

You may elect to end your coverage in a particular benefit program during the annual Open Enrollment period, or in the event that you experience a change in family or employment status which allows you to do so. There are also other circumstances that may cause your participation to end in a particular benefit program. Other circumstances which may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits, are described in the appropriate Subscriber Certificate (which outlines in detail the coverage and benefits provided by an insurance carrier of a specific benefit program). You should review the applicable Subscriber Certificate(s) in order to acquaint yourself with these provisions.

You may also lose coverage under the Wellesley College Employee Welfare Benefits Plan if the College terminates the Plan or amends it to reduce or eliminate your coverage. However, your coverage under this Plan generally terminates when you end employment with Wellesley College or otherwise cease to be an eligible employee, though you may be eligible to receive continuation coverage under the Wellesley College group health plan through COBRA, as described below in greater detail. Your coverage under the Employee Welfare Benefits Plan ends at the earliest of the date when:

- You no longer meet the eligibility requirements to participate
- You fail to make the required premium contributions

- Your employment with Wellesley College ends
- Wellesley College cancels the Plan or a benefit program

What Happens When Your Participation Ends?

If You (Or a Dependent) Lose Benefits Eligibility

The following benefits end the last day of the month in which you (or any dependent under your coverage) no longer meet the eligibility requirements to participate in the Plan (or the Reimbursement Plans, as applicable):

- You (and any affected dependents) become ineligible for Medical or Dental coverage through Wellesley College and may elect continuation coverage under COBRA (see **COBRA,** under ***Your Rights as a Participant***)
- Note: When a dependent loses eligibility under the Medical or Dental plan, they are removed from the plan as of the date on which eligibility is lost. Their benefits do not continue to the end of the month.
- The following benefits end the day after you (or any dependent under your coverage) no longer meet the eligibility requirements to participate in the Plan:
- Your Employee Assistance Plan coverage ends
- Your Long Term Disability coverage ends
- Your Basic Life, Contributory and Spouse Life Insurance coverage ends (you have a right to continue coverage under the conversion or portability option (see **Life Insurance**, under ***When Your Life Insurance Ends***).
- Your Health Care Reimbursement Plan eligibility and contributions (if you were enrolled in the Health Care Reimbursement Plan) end; you may submit claims for reimbursement of FSA expenses incurred through your last day of eligibility. If you elect COBRA, you must continue contributing to your account under the Health Care Reimbursement Plan under COBRA, on a post-tax basis, if you are continuing to submit claims to use up any remaining balance through the end of the calendar year in which your coverage terminated.
- Your Dependent Care Reimbursement Plan eligibility and contributions (if you were enrolled in the Dependent Care Reimbursement Plan) end; you may submit claims for reimbursement of expenses incurred through the end of the calendar year in which your coverage terminated. There is no COBRA continuation for the Dependent Care Reimbursement Plan.

If you or a covered dependent should become ineligible for a group health plan benefit, Crosby Benefit Systems will mail a packet to your address of record explaining your rights and eligibility for COBRA continuation coverage.

If You Divorce

Should you divorce, your former spouse, and his or her dependent children, may continue Medical or dental coverage to the extent that Federal law would usually apply (see **COBRA,** under ***Your Rights as a Participant***).

If You Die As an Active Employee

Wellesley College allows surviving family members of deceased employees the option of retaining group coverage at the employee cost for five months following the employee's death. After five months the surviving family members may maintain their coverage under COBRA at 102% of the premium cost.

Your spouse and eligible dependent family members may continue medical and/or dental coverage under COBRA for up to 36 months from the date of your death.

Leave of Absence / Sabbatical Coverage

You may be eligible for benefit continuation while you are on a leave of absence or sabbatical. See below for details as the length of time benefits continue varies by benefit and type. Contact the Wellesley College Human Resources Office with any questions.

Deduction Process for Leave of Absence or Sabbatical

If you are on an unpaid Leave of Absence, you will be billed for your benefits by Wellesley College on a post-tax basis. You will receive instructions along with payment coupons. You have the option to pay your premiums to Wellesley College on a monthly basis via check or in one lump sum so coverage remains active during your leave of absence.

If premium payments are not made, your participation in benefit programs you have elected will end. Once terminated, you will have to wait until the next Open Enrollment period to re-enroll or you may be able to re-enroll upon your return to work from unpaid leave (as permitted by law).

Your Medical & Dental Eligibility Continues If You Go on a Leave of Absence

Your Medical and Dental coverage automatically continues while you are on leave. You have 30 days from the start of your leave to stop your coverage or to change coverage. If you cancel coverage you can re-enroll when you return from leave, or at the next open enrollment. If you want coverage to stop, you must submit this in writing.

- If on an unpaid, personal leave, you will be billed monthly for continued coverage by Wellesley College at 100% of the cost of coverage (employee and employer cost).
- If on an unpaid, medical leave, you will be billed monthly for the employee portion of the premium.
- If on a paid leave, you will be continue to pay the employee portion of the premium through payroll deduction.
- If on Long Term Disability, you will be billed the employee portion of the premium.

Your Life Insurance Eligibility While on a Leave of Absence

If you are not a faculty member, your Basic Life coverage continues to the end of 60 days or, if earlier, the period of leave approved by the College. If your leave of absence extends beyond 60 days you will be terminated from the Life Insurance plan and offered conversion.

The Contributory and/or Spouse Life Insurance that you pay for may be continued to the end of 60 days, or if earlier, the period of leave approved by the College. You have the option to pay your premiums to Wellesley College on a monthly basis or in a one lump sum so coverage remains active during your leave of absence. If your leave of absence extends beyond 60 days you will be terminated from the contributory Life Insurance plan and provided portability and conversion paperwork.

If you return from your leave of absence within the allowed 60 day period your insurance never becomes inactive. If you return to active work within 90 days of the end of the 60 day leave of absence period you are reinstated at the benefit amount you had in effect prior to your leave and do not have to submit evidence of good health. If you return more than 90 days after the end of the 60 day period, you will be considered a new employee and evidence of insurability will need to be completed for amounts over the guarantee issue.

If you are a faculty member going on a leave of absence, your Basic Life coverage continues to the end of 12 months, or, if earlier, the period of leave approved by the College. If your leave of absence extends beyond 12 months you will be terminated from the Life Insurance plan and offered conversion.

The Contributory and/or Spouse Life Insurance that you pay for may be continued to the end of 12 months, or, if earlier, the period of leave approved by the College. You have the option to pay your premiums to Wellesley College on a monthly basis or in one lump sum, so coverage remains active during your leave of absence. If your leave of absence extends beyond 12 months you will be terminated from the Contributory and/or Spouse Life Insurance plan and provided portability and conversion paperwork.

If you return from your leave of absence within the allowed 12 month period your insurance never becomes inactive. If you return to active work within 90 days of the end of the 12 month leave of absence period you are reinstated at the benefit amount you had in effect prior to your leave and do not have to submit evidence of insurability. If you return more than 90 days after the end of the 12 month period, you will be considered a new employee and evidence of good health will need to be completed for amounts over the guarantee issue.

Your Life Insurance Eligibility While on a Sabbatical Leave

Your Basic Life coverage continues to the end of 12 months, or if earlier, the period of leave approved by the College. If your sabbatical is greater than 12 months you will be terminated from the Life Insurance plan after 12 months and offered conversion.

The Contributory and/or Spouse Life Insurance that you pay for may be continued to the end of 12 months, or if earlier, the period of leave approved by the College. You have the option to pay your premium to Wellesley College on a monthly basis or in one lump sum so coverage remains

active during your sabbatical leave. If your sabbatical is greater than 12 months you will be terminated from the Contributory Life Insurance plan after 12 months and provided portability and conversion paperwork.

If you return from your sabbatical within the allowed 12 month period your insurance never becomes inactive. If your return to active work within 90 days of the end of the 12 month sabbatical period you are reinstated at the benefit amount you had in effect prior to your leave and don not have to submit evidence of insurability. If you return more than 90 days after the end of the 12 month period, you will be considered a new employee and evidence of insurability will need to be completed for amounts over the guarantee issues.

Your LTD Coverage Continues If You Go on a Leave of Absence

If you are an administrative staff member or union employee, your LTD insurance through Wellesley College may be continued to the end of 90 days, or if earlier, the period of leave approved by the College. If your leave of absence extends beyond 90 days you will be terminated from the LTD Plan.

If you return from your leave of absence with the allowed 90 day period your insurance never becomes inactive. If you do not return to active work within the 90 day period you have 90 days from the end of the 90 day period to return to work after which time you will be considered a new employee.

If you are a faculty member, your LTD insurance through Wellesley College may be continued to the end of 12 months, or if earlier, the period of leave approved by the College. If your leave of absence extends beyond 12 months you will be terminated from the LTD plan.

If you return from your leave of absence within the allowed 12 month period your insurance never becomes inactive. If you do not return to active work within the 12 month period you have 90 days from the end of the 12 month period to return to work after which time you will be considered a new employee.

Your LTD Coverage Continues If You Go on a Sabbatical

If you are a faculty member, your LTD insurance through Wellesley College may be continued to the end of 12 months, or if earlier, the period of leave approved by the College. If your leave of absence extends beyond 12 months you will be terminated from the LTD plan.

If you return from your sabbatical within the allowed 12 month period your insurance never becomes inactive. If you do not return to active work within the 12 month period you have 90 days from the end of the 12 month period to return to work after which time you will be considered a new employee.

Flexible Spending Accounts

If you go on an unpaid leave of absence your Reimbursement Plan contributions will stop. You do not have a paycheck therefore no contributions can be deducted.

Health Care Reimbursement Plan
Claims incurred under the Health Care Reimbursement Plan during your leave will not be eligible for reimbursement unless you elect to continue participation through COBRA.

If you have a balance you have not used, COBRA will allow you to use that balance during your leave of absence (and before the end of the calendar year, if your leave extends beyond that).

However, you will have to continue your contributions post-tax if you elect COBRA, in order to use your existing pre-tax balance. You can stop COBRA once you have used your balance.

Dependent Care Reimbursement Plan
Claims incurred under the Dependent Care Reimbursement Plan during unpaid leave are not eligible for reimbursement. There is no COBRA for the Dependent Care Reimbursement Plan.

Returning from Leave
If you elected COBRA under the Health Care Reimbursement Plan , and you return to work during the same calendar year, your deductions will begin again based on your remaining pay periods and your total election for that calendar year (minus what you had contributed post-tax on COBRA).

If you did not elect COBRA, and you return to work in the same calendar year, your deductions for either Reimbursement Plan will begin again based on your remaining pay periods and your total election for that calendar year.

If you return in another calendar year, you must make a new election under the appropriate Reimbursement Plan to participate. Your coming back from an unpaid leave of absence in another calendar year is considered a qualifying event to elect to make deductions under a Reimbursement Plan.

II. BENEFIT PROGRAMS FOR PARTICIPANTS

Wellesley College offers a range of benefit programs designed to provide employees with comprehensive coverage and quality care. The content provided in this section can help you make informed benefits enrollment decisions and allow you to take full advantage of the benefit programs available to you. This section provides plan design information to help you choose the program and coverage that's best for you. You should carefully consider the information provided below in conjunction with the separate benefit plan certificates and booklets Wellesley College makes available to you. They may provide more detailed information regarding the benefits described below. Wellesley College's Employee Welfare Benefits Plan is currently made up of the benefit programs listed below, and Wellesley College also offers Flexible Spending Accounts through the Reimbursement Plans.:

- Medical Coverage (HMO or PPO)
- Dental Coverage (Delta Dental Premier or DeltaCare)
- Employee Assistance Plan (EAP)
- Life Insurance (Basic, Contributory, Spouse)
- Short Term Disability (STD) Insurance
- Long Term Disability (LTD) Insurance
- Long Term Care (LTC) Insurance
- Flexible Spending Accounts (FSAs) (through the Reimbursement Plans)

Medical Coverage

Wellesley College offers medical coverage through Harvard Pilgrim Health Care, providing employees with comprehensive coverage for a range of medical needs—from life-threatening illnesses to preventive and emergency care, along with prescription drug coverage. To participate in medical coverage, you must actively enroll (see ***Participation in the Plan***). There are two medical options you may choose:

- Harvard Pilgrim Health Care HMO, and
- Harvard Pilgrim Health Care PPO

HMO Option

An HMO is comprised of a network of health care providers who deliver managed care at a center or as part of a network. HMOs require you to select a primary care physician (PCP) who coordinates your care and authorizes visits to specialists or other providers. Your covered family members also select a PCP to coordinate their care. You can change your PCP at any time.

When you require specialist care your PCP makes referrals to specialists in and outside the HMO network, as appropriate. You pay a copayment at the time you visit your PCP or Specialist, or receive a service from an in-network provider, or are referred to a provider other than your PCP (in or outside the HMO network).

Harvard Pilgrim Health Care HMO offers a variety of choices for each family member. The Harvard Pilgrim network includes Harvard Vanguard Centers, which offer most services at a single location. It also includes Medical Group Practices, which offer many services at a single location, along with thousands of independent primary and specialty care physician providers in the traditional private office setting.

Each family member can choose a distinct PCP and choose to receive care at a location which provides the best accommodation for them. PCP directories and practice locations are available on the web at www.harvardpilgrim.org. Paper copies will be made available upon request from Harvard Pilgrim or at the Wellesley College Human Resources Office, free of charge. Contact Harvard Pilgrim directly for current PCP networks.

PPO Option

The PPO (preferred provider organization) allows you the additional feature of visiting doctors and providers outside the HMO network without a referral from a PCP. This can be a valuable feature if you want the flexibility to choose a doctor outside of the HMO provider network. You pay more per month for the PPO option, along with any applicable deductibles and co-insurance (when you choose to receive out-of-network care) in return for more flexibility when making health care choices.

In a PPO, you coordinate your own care and are not required to get referrals from a PCP to see specialists or other providers. The PPO does use a network of doctors (like the HMO design) and when you seek care from these in-network providers, you are not subject to the applicable deductibles or co-insurance. Under this approach, the Harvard Pilgrim Health Care PPO provides incentives for you to work with physicians in the network (which is the same network as the Harvard Pilgrim HMO), but also allows you the flexibility to seek care outside the network. Because of the freedom of choice offered by this plan, the premium is higher.

Coverage, Copayment, Deductible, and Co-insurance Information

Wellesley College's medical coverage offers comprehensive services, including hospitalization coverage, physician services, mental health and substance abuse services, prescription drug coverage, and emergency care. There are no pre-existing condition exclusions and no annual or lifetime maximum dollar limits for medically necessary covered services.

Wellesley College's medical coverage complies with the requirements of the Massachusetts Health Care Reform Law, which requires that Massachusetts residents age 18 and older have health coverage that meets the Minimum Creditable Coverage standards in effect as of January 1, 2010.

The *Wellesley College Benefits Comparison Chart* summarizes the covered services as well as the required co-payments, deductibles, and co-insurance. The Comparison Chart is available on the Human Resources website or at the Wellesley College Human Resources Office.

The Harvard Pilgrim *Schedule of Benefits*, along with the Harvard Pilgrim *Subscriber Certificate*, which are incorporated by reference, outline specific coverage details and are available in the Wellesley College Human Resources Office, or at www.harvardpilgrim.org. This material provides detailed coverage information, along with any other plan limits, including coverage for preventive services, coverage for existing or new drugs, coverage for medical tests, devices and procedures, the use of and access to in-network and out-of-network providers, any conditions or limits on the selection of primary care or specialty care providers, any restrictions on emergency medical care, and any pre-authorization and utilization review procedures.

If You Turn Age 65 While Actively Employed

If you turn age 65 while actively working (and don't retire), your medical coverage remains the same as it was prior to age 65. If you are enrolled in Wellesley College's sponsored medical coverage, however, it is not necessary for you to enroll in Medicare Part B until you retire or end your employment.

If You Move Out of the HMO Service Area

If you are moving out of the Harvard Pilgrim HMO network service area, you must cancel coverage or change to Harvard Pilgrim PPO. You have 30 days from the start of your leave to stop your coverage or to change coverage. If you cancel coverage you can re-enroll when you return from leave, or at the next open enrollment.

If You Receive Payment of Medical Benefits from Another Source

If you or a covered dependent are (or become) entitled to benefits from another source which pays all or part of your expenses incurred for medical care, benefits payable from the College may be reduced, to the extent allowed by law. In no case will the amount a Wellesley College benefit program pays exceed what it would pay if there were no other benefit plan. This does not reduce your coverage. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis of coordination between the provider and Wellesley College.

HIPPA: Maintenance and Confidentiality of Medical Records

Your enrollment paperwork for Wellesley-sponsored medical coverage is kept on file in the Wellesley College Human Resources Office. Your medical records are retained by Harvard Pilgrim Health Care and are kept confidential. Those medical records (or any copies of them) are not at Wellesley College. The Plan is administered in accordance with the Health Insurance Portability and Accountability Act of 1996.

Federal Laws that May Affect Your Medical Coverage

When you enroll in medical coverage you have specific rights related to your coverage. The following Federal laws may affect how your medical coverage is applied (see ***Your Rights as a Participant*** in this SPD):

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
- Family and Medical Leave Act (FMLA)
- Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)
- Women's Health and Cancer Rights Act of 1998 (WHCRA)
- Mental Health Parity and Addiction Equity Act of 2008 (MHPA)
- Qualified Medical Child Support Orders (QMSCOs)
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Employee Assistance Plan (EAP)

Wellesley College offers an EAP to eligible employees and members of their households through The Wellness Corporation. You will be automatically enrolled in the EAP. To determine if you are eligible see **Participation in the Plan** in this SPD.

Dental Coverage

Wellesley College offers dental benefits to eligible employees and their dependents through Delta Dental of Massachusetts. You must enroll to participate in dental coverage. To determine if you are eligible to enroll see ***Participation in the Plan*** in this SPD. There are two dental options you may choose from:

- Delta Dental Premier, or
- DeltaCare

Delta Dental Premier

When you enroll in Delta Dental Premier, you have access to the most extensive dental network in Massachusetts. You may choose your dentist from among 7,000 practices (see www.deltadentalma.com). Diagnostic and preventive services are fully covered at 100%. After an individual deductible of $50, or a family deductible of $100, basic restorative services are covered at 80% while major restorative services are covered 50%**.** In addition, orthodontic services are covered at 50% of up to a plan allowance maximum of $2,000 per lifetime**.** Fees for services are generally discounted when you see a dentist in the Delta Dental Premier network. Therefore, seeing a dentist in-network allows your annual $2,000 benefit to go further.

DeltaCare

When you enroll in DeltaCare you and each family member who is enrolled must choose a Primary Care Dentist (PCD) in the DeltaCare network. You and your family will receive all of your care from your PCD. The emphasis in DeltaCare is on diagnostic and preventive services and most services are covered at 100%. Minor and major restorative services require applicable co-pays.

If you receive care from a non-participating dentist (outside the DeltaCare network), there is a $100 annual deductible that applies to all out-of-network care. Each member who receives care from a non-participating provider must satisfy the deductible before receiving benefits.

When you require specialty services, your PCD can give you a recommendation for a specialist in the DeltaCare network. You will receive the most value, when you receive care from a participating DeltaCare specialist because the cost for care is set. Note that there is a $1,000 calendar year maximum on certain specialty services, such as oral surgery, endodontic services, and periodontal services. After the $1,000 annual limit for specialty services in the network, the specialty fees are no longer set and the specialist may then charge you at the usual rate for services rendered.

To select or change your PCD go to the Directory of Participating Dentists at www.deltadentalma.com. For coverage and cost of specific care, call DeltaCare customer service directly at 1-800-327-6277.

For more information on about these dental plan options, please refer to your Delta Dental Premier and DeltaCare Summary of Benefits, which are incorporated by reference, and can also be found on the web at the address above, or in the Wellesley College Human Resources Office.

If You Turn Age 65 While Actively Employed

If you turn age 65 while actively working (and don't retire), your dental coverage remains the same as it was prior to age 65.

If You Receive Payment of Dental Benefits from Another Source

If you or a covered dependent are (or become) entitled to benefits from another source which pays all or part of your expenses incurred for dental care, benefits payable from the College may be reduced, to the extent allowed by law. In no case will the amount a Wellesley College benefit program pays exceed what it would pay if there were no other benefit plan. This does not reduce your coverage. If benefits are provided in the form of services, or if a provider of services is paid under a capitation arrangement, the reasonable value of such services will be used as the basis of coordination between the provider and Wellesley.

Life Insurance (Basic, Contributory, Spouse)

Wellesley College's group term Life Insurance program is underwritten by The Standard Insurance Company. Term Life Insurance pays a benefit only in the event of your death as a covered employee. There is no cash value to group term Life Insurance.

The College's group term Life Insurance coverage is comprised of Basic Life Insurance, Contributory Life Insurance, and Spouse Life Insurance. For employee eligibility and effective date of coverage see the **Employee Eligibility** section under **Participation in the Plan** in this SPD.

Life Insurance Enrollment and Beneficiaries

Basic Life

Eligible employees are automatically covered for Basic Life Insurance. You remain covered as long as you remain eligible. Upon entry into the Plan you will be asked to complete a Beneficiary form to designate your beneficiaries. The form should be returned to the Human Resources Office. Over the course of your employment at Wellesley College, you will want to be sure to update this information. Notify the Human Resources Office if you would like to update or modify your beneficiary designation.

Contributory Life

Eligible employees must apply to enroll in Contributory Life. If you apply at the time of your first eligibility, for amounts up to 2 times your salary you are not required to provide evidence of insurability. However, for amounts greater than 2 times salary, and if you apply at a date later than your first eligibility, you must provide evidence of good health (see ***Evidence of Insurability*** below). To apply for Contributory Life contact the Wellesley College Human Resources Office for the appropriate forms and to designate your beneficiaries.

Spouse Life
Eligible employees must apply to enroll in Spouse Life. If you have elected Contributory Life Insurance, you may elect to purchase $15,000 or 50% of your Basic Life Insurance amount on your spouse. However, your spouse will need to submit evidence of good health for amounts of insurance in excess of $15,000. If you do not apply when first eligible you must provide evidence of insurability for all amounts.

Designating Beneficiaries and Assignment of Ownership

When you enroll in Life Insurance coverage, you must designate a beneficiary. This beneficiary may be any person or persons, including your estate, but not Wellesley College. You may change your beneficiary at any time by completing a new beneficiary form.

It's important to keep your Life Insurance beneficiaries current. For example, should you divorce or remarry, the current beneficiary you have designated is the legal beneficiary and your benefit will go to that beneficiary.

You may not assign ownership of your Life Insurance to another person or estate.

Life Insurance Coverage Limits

Basic Life
Your coverage is 1 times your annual salary, rounded to the next higher $1,000, to a maximum of $450,000.

Contributory Life
If you are hired on or after November 1, 2010, you may elect one of the following 4 options:

- **Option 1**: 1 times your annual salary, rounded to the next higher $1,000, to a maximum of $900,000 (including your Basic amount).
- **Option 2**: 2 times your annual salary, rounded to the next higher $1,000, to a maximum of $900,000 (including your Basic amount).
- **Option 3**: 3 times your annual salary, rounded to the next higher $1,000, to a maximum of $900,000 (including your Basic amount)
- **Option 4**: 4 times your annual salary, rounded to the next higher $1,000, to a maximum of $900,000 (including your Basic amount)

Basic and Contributory Life Combined
Your combined amount of Basic and Contributory Life cannot exceed $900,000.

Evidence of Insurability

Basic Life
For Basic Life you are not required to provide evidence of insurability.

Contributory Life
Evidence of insurability is required, when:

- You apply to elect Contributory Life outside your initial 30 day new hire period (even during the annual enrollment).
- You apply for more than 2 times your salary during your initial 30 day new hire period (or at the time of your first eligibility).
- You apply to increase your coverage option above 2 times salary during the annual enrollment.

Spouse Life
Evidence of insurability is required for:

- Amounts in excess of $15,000 if applying during initial 30 day new hire period (or at the time of your first eligibility).
- All amounts if applying outside of your initial eligibility period, including the annual enrollment period.

No Age Reductions

The amount of your insurance will not be reduced because of your age unless your insurance is subject to termination under the Waiver of Premium provision.

Disability and Waiver of Premium

If you become disabled (as defined by Wellesley College's LTD coverage) prior to age 60 and are no longer able to work, your premium payments will be waived after a period of 180 days of consecutive total disability.

Accelerated Benefit

If you become terminally ill and are not expected to live more than twelve months, you may request up to 75% of your Life Insurance amount up to $500,000, without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary(ies). You must be approved for waiver of premium to be eligible for the accelerated benefit.

Travel Insurance Component

The Standard has partnered with MEDEX Assistance Corporation to provide you with a comprehensive program of information, referral, assistance, and transportation and evacuation services. Whether your travel is for business or pleasure, if an unexpected emergency occurs you may call anytime of the day or night and you, your spouse and dependent children can get immediate assistance anywhere in the world. Travel assistance is available to you when you travel to any foreign country, including neighboring Canada or Mexico. It is also available anywhere in the United States for those traveling more than 100 miles from home. Your spouse and dependent children do not have to be traveling with you to be eligible. However, spouses traveling on business for their employer are not covered by this program.

Life Insurance Amount at Retirement

If you are a faculty and exempt administrative staff employee who was hired prior to January 1, 1995 and retired under the Wellesley College Retirement Plan, the College will provide you with $2,500 of Life Insurance coverage. If you are Non-exempt administrative staff employee or union employee who was hired prior to January 1, 1995 and retired from the Wellesley College Retirement Plan will provide you with $1,000 of Life Insurance coverage. The College pays the full cost of this coverage. Employees hired on or after January 1, 1995 are not eligible for this benefit.

When Your Life Insurance Ends

Portability Option

If your insurance under the Group Policy ends because your employment with Wellesley College terminates, you have a 31 day period in which to buy portable *group insurance coverage* for your current benefit up to $300,000**.** You may request less than your current coverage, but not more coverage than you had currently in effect. Evidence of insurability is not required. There are rate increases in 5 year age band increments. .

Conversion Option

If your insurance under the Group Policy ends because your employment ends or you are no longer eligible for the plan, you have a 31 day period in which to buy conversion *individual whole Life Insurance* coverage. You may convert all of coverage that you had in effect. You do not have to submit evidence of good health. There are no rate increases as you age. Should you die during this 31-day period, the current amount of your Life Insurance will be paid whether or not you have used the conversion option.

Contact the Wellesley Human Resources Office or The Standard Insurance Company for more information and the appropriate forms

Short Term Disability (STD)

You are eligible for Short Term Disability coverage if you are a regular employee of the College who is covered by a collective bargaining agreement between the College and the union and you are working at least 40 hours per week for at least nine months per year. You must also be a citizen or resident of the United States or Canada. You are eligible for benefits on the first day following one calendar year as an STD-eligible employee**.**

STD coverage is paid for by the College. Short Term Disability pays 60% of your weekly earnings up to a maximum of $1,000 per week for up to 180 days. Your STD disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include amounts you receive or are entitled to receive under: workers' compensation or similar occupational benefit laws, state compulsory benefit laws, and other group or association disability programs or insurance.

Definition of Disability and When Benefits are Paid
You are considered disabled when you are unable to perform with reasonable continuity the material duties of your own occupation, *and* you lose at least 20% of your pre-disability earnings in your occupation. You must be continuously disabled during a waiting period, before STD benefits become payable:

- If your disability is caused by an accident, your waiting period is 7 days;
- If your disability is caused by physical disease, pregnancy, or mental disorder, your waiting period is 7 days;
- If you are confined in a hospital for at least 4 hours during a benefit waiting period, the remainder of the waiting period will be waived. STD benefits will become payable on the 1st day of hospital confinement. Your Maximum Benefit Period will begin on the date STD benefits become payable. You must be under the ongoing care of a doctor during your hospital confinement**.**

How to File a Claim
To file a claim, contact Human Resources.

Administrative Staff
The Short Term Disability program for administrative staff is a payroll practice and is not included in the Welfare Benefits Plan. Refer to the Administrative Handbook, which is available on the Human Resources website, for further information.

Faculty Staff
Wellesley College faculty members are not eligible for Short Term Disability.

Long Term Disability (LTD)

LTD coverage is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. Wellesley College's LTD benefit replaces a portion of your income if you are unable to work for more than 180 days due to a disability, thus helping you to meet your financial commitments in a time of need.

Wellesley College pays the cost of LTD coverage. There is no enrollment process for eligible employees. To determine your eligibility and effective date of coverage see the **Employee Eligibility** section under **Participation in the Plan** in this SPD.

Monthly LTD Benefit Amount

The program pays 60% of your pre-disability salary at the time you become disabled up to a monthly maximum:

Union Employees

- 60% of your monthly earnings
- To a monthly maximum of $3,000

Administrative Staff and Faculty

- 60% of your monthly earnings
- To a monthly maximum of $15,000

Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include amounts you receive or are entitled to receive under: workers' compensation or similar occupational benefit laws, state compulsory benefit laws, salary continuation or sick leave plans, other group or association disability programs or insurance, and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs.

Administrative staff and faculty participating in Wellesley College's 403(b) retirement program receive a monthly annuity premium benefit equal to 9% of pre-disability earnings up to the one-half of the Social Security Wage Base, plus 12% of pre-disability earnings above the Social Security Wage base. The monthly annuity benefit is not reduced by deductible income and is paid as a contribution to the employee's retirement program.

Administrative staff and faculty employees are eligible for a COLA Benefit if, on each April 1, they have been disabled for the preceding calendar year (January 1, through December 31) and are receiving LTD Benefits. The union program does not include a COLA benefit.

Benefit Waiting Period

The benefit waiting period is the period you must be continuously disabled before LTD benefits become payable. LTD benefits would begin after 180 days of disability. During your benefit

waiting period you will be considered disabled if you are unable to perform the day to day work and duties of your own occupation, and you are under the regular care of a physician.

Definition of Disability

After the benefit waiting period, LTD coverage pays benefits for up to two years if you are unable to perform your *own* occupation. After two years, the program only pays a benefit if you are unable to perform *any* occupation (up to the end of the maximum benefit period).

Own Occupation Definition of Disability

You are considered disabled during the two years after your 180 day benefit waiting period if, as a result of disease, injury, pregnancy, or mental disorder, you are unable to perform the day to day work and duties of your own occupation *and* you lose at least 20% of your pre-disability earnings (when working in your own occupation).

Any Occupation Definition of Disability

You are considered disabled from all occupations if, as a result of disease, injury, pregnancy or mental disorder, you are unable to perform the day to day work and duties of any occupation.

Any Occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your indexed pre-disability earnings within twelve months following your return to work, regardless of whether you are working in that or any other occupation.

Maximum Benefit Duration

Your duration of benefits is based on your age when your disability occurs. Your LTD benefits are payable for the period during which you continue to meet the definition of disability. If your disability occurs before age 60, benefits will be payable until age 65. If your disability occurs at or after age 60, benefits would be paid according to a benefit duration schedule:

- At age 60 through 64, benefits would be paid for 5 years
- At age 65 through 68, benefits would be paid to age 70
- At age 69 or older, benefits would be paid for one year.

Rehabilitation Plan

While you are disabled you may qualify to participate in a formal rehabilitation plan, consisting of a program or course of vocational training or education that is intended to prepare you to return to work.

An approved rehabilitation plan may include our payment of some or all of the expenses you incur in connection with the plan, including:

- Training and education expenses
- Family care expenses
- Job-related expenses

- Job search expenses

Survivor Benefit

If you die while LTD benefits are payable, and on the date you die you have been continuously disabled for at least 180 days, your coverage provides a Survivor Benefit. The Survivor Benefit is a lump sum equal to 3 times your monthly LTD benefit. The Survivor Benefit will be paid to one of the following:

- Your Spouse
- Your unmarried children under the age of 25
- Any person providing the care and support of any person listed above

Reasonable Accommodation Benefit

If you return to work in any occupation for any employer, not including self-employment, as a result of a reasonable accommodation made by such employer, that employer is eligible to receive a reasonable accommodation expense of up to $25,000.

The reasonable accommodation expense benefit is payable only if approved by the Standard Insurance Company in writing prior to its implementation.

Pre-Existing Condition Exclusion

Pre-existing condition means a mental or physical condition whether or not diagnosed or misdiagnosed for which you have received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage.

You are not covered for any disability caused or contributed to by a pre-existing condition or medical or surgical treatment of a pre-existing condition unless, on the date you become disabled, you have been continuously insured under the group policy for 12 months, and have been actively at work for at least one full day after the end of that 12 months.

Disabilities Subject to Limited Pay Periods

Payment of LTD benefits is limited to 24 months during your entire lifetime for a disability caused or contributed to by any one or more of the following, or medical or surgical treatment of one or more of the following:

- Mental disorders
- Substance abuse, or
- Other limited conditions *(see Standard LTD Certificate for definition)*

However, if you are confined in a hospital solely because of a mental disorder at the end of the 24 months, this limitation will not apply while you are continuously confined.

Continued Benefit Coverage for Employees on LTD

LTD Claims

Union Employees: If on STD, The Standard will initiate the LTD claims process.
Faculty and Administrative Staff: To file a claim, contact the Human Resources office.

Long Term Care Insurance

Benefit eligible employees may enroll in the College's long term care insurance coverage, without evidence of good health, (regardless of health status) within the first 30 days of employment only. Spouse and parents are also eligible for this coverage with difference levels of underwriting. (Such coverage is not guaranteed, however, as it is for the employee.)

Flexible Spending Accounts (FSAs)

FSAs allow you to set aside tax-free dollars to pay for eligible medical, dental, vision and dependent care expenses. When you enroll in an FSA, contributions are deducted from your gross earnings before taxes are applied to your paycheck, lowering your Federal, Social Security, and state income taxes. Wellesley College offers two FSAs:

- The Health Care Flexible Spending Account
- The Dependent Care Flexible Spending Account

You must enroll to participate. To determine if you are eligible to enroll, see the **Employee Eligibility** section found under **Participation in the Plan** in this SPD. Eligible employees may enroll when beginning employment, or when experiencing a change in family status which allows enrollment, or during Wellesley College's annual open Enrollment period held each fall.

Once enrolled, Reimbursement Plan elections do not carry over from one calendar year to the next and you must make an active election each fall during Open Enrollment in order to continue your participation in the next following year. For further information on qualified status changes and enrollment, see **Enrolling in a Benefits Program** under **Participation in the Plan.**

Grace Period

Wellesley College's Flexible Spending Account plans include a 2.5 month Grace Period (both health care and dependent care). This means that plan participants who have not used all of their annual contribution by December 31st, will have until March 15th of the following year to incur expenses that can be reimbursed from their prior year's contributions. Claim forms, for expenses incurred between January 1 and March 15th, still must be postmarked or otherwise submitted to Crosby Benefit Systems for processing by March 31.

Expenses incurred prior to March 15th will be applied first to the previous plan year's account if it has a remaining balance. Remaining amounts will be applied to the new plan year contributions. This Grace Period ensure you have more time to incur expenses and benefit from the Federal, Sate and FICA tax savings associated with participating in the Plan.

Health Care Reimbursement Plan

The Health Care Reimbursement Plan allows you to be reimbursed with tax-free dollars for eligible expenses, as defined by the IRS and not covered under your medical or dental insurance. These eligible expenses include copayments for office visits, and any coinsurance or deductibles related to your dental coverage or to using PPO out-of-network medical coverage.

Federal Health Care Reform legislation has introduced some changes that impact Health Care Flexible Spending Accounts effective January 1, 2011. The regulations require that any over-

the-counter (OTC) medicines or drugs purchased on or after January 1, 2011, must be accompanied by a prescription in order to be reimbursable out of a Health Care FSA. This change will apply to the 2010 plan year (for Grace Period claims only) as well as 2011 claims. Expenses for OTC medications or drugs incurred during the Grace Period or during subsequent plan years will be denied unless you also submit a prescription written prior to the date the OTC medications or drugs were purchased.

Allowable expenses can be incurred by you, your spouse, or your dependents, and enrollment in a Wellesley College's medical or dental coverage (whether at the individual or the family level) is not required for you or your dependents to receive eligible reimbursements.

Eligible Dependents
For the Health Care Reimbursement Plan, an eligible dependent is a federal tax dependent (as defined in Section 152 of the Internal Revenue Code, determined without regard to subsections (b)(1), (b)(2) and d(1)(B) thereof), including your child (as defined in Section 152(f)(1) of the Code) who, as of the end of your tax year, has not reached age 27. To determine if your dependent is a tax dependent, see IRS Publication 502 at **www.irs.gov/publications/p502/.**

You may not submit for reimbursement expenses incurred by your same-sex spouse or your same-sex spouse's dependents unless they qualify as your Federal tax dependents.

Contribution Level for Health Care Reimbursement Plan
If you choose to participate in the Health Care Reimbursement Plan, you decide how much to contribute for the year based on the limits established by the Health Care Reimbursement Plan and on what you expect your eligible expenses will be for the year. It is important to estimate your expenses carefully as any unused dollars are forfeited.

You may choose to contribute between $300 and $5,000 for the calendar year. If you are married and you and your spouse are both employed at Wellesley College, you may each elect $5,000 for the Health Care Reimbursement Plan, for a total maximum of $10,000 per calendar year. Your contributions will be deducted from your paycheck in equal amounts during the year.

Once you enroll, your election is effective through the end of the calendar year. Your deductions are based on that time period. You make a separate election for each Reimbursement Plan account you enroll in: deductions in your FSA under the Health Care Reimbursement Plan cannot be transferred to pay for expenses in your FSA under the Dependent Care Reimbursement Plan, or vice-versa.

Examples of Eligible Health Care Expenses
To help you determine your yearly election amount, you should familiarize yourself with a list of eligible expenses. To be reimbursable, services and/or supplies must be performed and/or prescribed by a licensed practitioner, unless otherwise noted. Generally, allowable medical or dental expenses are generally those that the IRS allows as itemized deductions on a federal income tax return with some notable exceptions (for example, insurance premiums). Note that you cannot take a federal tax deduction or credit on your income taxes for expenses reimbursed

through a Reimbursement Plan. Only allowable expenses that are adequately documented (see reimbursement process below) and are not covered by insurance and are necessary for medical or dental treatment are reimbursable:

- Medical or dental copayments, coinsurance, or deductibles
- Non-prescription, over-the-counter medications used to alleviate or treat a specific medical condition of the enrolled member or covered dependent. Provided you have a physician's prescription
- Medical supplies and equipment not covered by your health insurance, including crutches, wheelchairs, bandages and diagnostic devices such as blood sugar test kits
- Chiropractic treatments and acupuncture
- Massage, if prescribed by a medical practitioner
- Orthodontia expenses
- The cost of eyeglasses, lenses, contact lenses and supplies
- The cost of hearing aids
- Mental health and substance abuse treatments
- Orthodontia

Examples of Ineligible Health Care Expenses

- Monthly insurance premiums for any medical (including Medicare), dental or vision coverage, including premiums or expenses for long term care coverage
- Any expenses reimbursable by health or dental insurance, Workers' Compensation, or any other expenses for which you were or can be reimbursed under any insurance or by other means
- Cosmetic procedures
- Toiletries or cosmetics, such as toothpaste, deodorant or face creams
- Dietary supplements for general good health are not reimbursable. The eligibility of expenses for non-prescription medications and other medical supplies is based upon IRS regulations. These regulations state that the items must be used to treat a specific medical condition and not for general wellness. For example, an over-the-counter dietary supplement would be eligible for reimbursement if it were purchased to treat a specific condition (as verified by a doctor's note), but not if it were purchased to promote the general health of the individual.
- In addition, according to the Internal Revenue Code, expenses incurred by a same-sex spouse or QDP are not eligible for reimbursement through the Reimbursement Plans.

The above eligible and ineligible expenses are suggestive, not exhaustive. Wellesley College does not maintain a comprehensive list of IRS eligible expenses. For a more extensive list, go online at **www.crosbybenefits.com** or contact Crosby Benefits Systems at 1-866-918-9711.

For more information about eligible and ineligible expenses, see IRS Publication 502, Medical and Dental Expenses. This publication is available online at **www.irs.gov/publications/p502/**. Please note that Publication 502 states as allowable some expenses which are not reimbursable under a Health Care FSA (for example, insurance premiums).

Estimate Your Health Care Reimbursement Plan Contribution
Because unused dollars under the Health Care Reimbursement Plan do not roll over and are not returned to you, it is important to estimate your medical and dental expenses carefully. Visit the online FSA calculator available at **www.crosbybenefits.com/ParticipantArea/Calculators.aspx**

The Health Care FSA calculator will help you determine your annual contribution by asking you to estimate your out-of-pocket expenses and other expenses not covered by your medical/dental coverage. It also shows an estimate of your potential tax savings.

Dependent Care Reimbursement Plan

The Dependent Care Reimbursement Plan allows you to be reimbursed with tax-free dollars for eligible dependent day-care expenses. The Dependent Care Reimbursement Plan is used for dependent care expenses for children who are under age 13 and disabled dependents. It is not for expenses relating to a dependent's health care.

If you are married, you can participate in the Dependent Care Reimbursement Plan only if your spouse is:

- Employed, looking for work, or a full-time student while you are working; or
- Disabled and unable to provide for his or her own care.

Eligible Dependents
If you have predictable expenses associated with the care of a dependent child under age 13, or a disabled dependent eligible to be claimed on your tax return, you may want to consider signing up for a dependent care account. To use this account, your eligible dependent must require day care or elder care to allow you to work.

If you use your FSA under the Dependent Care Reimbursement Plan for care rendered outside of your home whether for your spouse or for dependents of any age who are mentally or physically disabled, that person must spend at least 8 hours in your home each day. This restriction does not apply to dependents under age 13. If you are divorced or legally separated, child care expenses are eligible for reimbursement only if you have custody of the child for a longer period during the calendar year than does the other parent.

Contribution Level for Dependent Care Reimbursement Plan
You may choose to contribute between $300 and $5,000 for the year, unless one of the following IRS guidelines applies to you:

- If you are married and file separate tax returns the most you and your spouse can each contribute on your own to a Dependent Care FSA is $2,500. If your spouse contributes less than $2,500, you cannot make up the difference.
- If you are married and your spouse also contributes to a dependent care account through his or her employer, the $5,000 annual maximum is the total amount that you and your spouse may contribute to both accounts combined. You cannot do $10,000 in aggregate, as with the Health Care FSA.

- If you or your spouse earn less than $5,000 a year, the most you can contribute is the lower of your two incomes.
- If your spouse has no income but is a full-time student or disabled, the most you can contribute is $3,000 per year if you have one eligible dependent or $6,000 per year if you have two or more eligible dependents.
- If you are single, you may contribute up to the lesser of $5,000 or 50% of your income if less than $5,000.

Your Dependent Care Reimbursement Plan election will be deducted from each paycheck in equal amounts during the year.

Once you enroll, your election is effective through the end of the calendar year. Your deductions are based on that time period. You make a separate election for each FSA account you enroll in: deductions in your FSA under the Health Care Reimbursement Plan cannot be transferred to pay for expenses in your FSA under the Dependent Care Reimbursement Plan or vice-versa.

Because unused dollars under the Dependent Care Reimbursement Plan do not roll over and are not returned to you, it is important to estimate your dependent care expenses carefully.

Examples of Eligible Dependent Care Expenses
To help you determine your yearly election, you should familiarize yourself with a list of eligible expenses:

- A dependent care center, babysitter, nurse (as caretaker), nanny, au pair, or day-care provider inside or outside your home, including a senior center
- A nursery school or day-care center, even if lunch and/or educational services are provided
- Before-school and after-school programs
- Day camps (summer or otherwise), but only when the primary purpose of the camp is care: that is, when the primary purpose of the camp is to ensure the child's well-being and protection during the period the child attends the camp. If camp hours exceed the employee's working hours, submit only that portion of expenses incurred for work-related hours.
- Deposits required by day-care providers (eligible once applied to the cost of the care provided)
- FICA tax paid on behalf of a provider

If you have a Dependent Care FSA, the IRS requires you to provide on your tax returns the names and Social Security numbers (or other taxpayer identification numbers) of your dependent care providers (a taxpayer identification number is not required for some tax-exempt providers.)

Examples of Ineligible Dependent Care Expenses

- Education, including tuition for private schools
- Baby-sitting for reasons other than to enable you to work

- Cleaning and cooking services
- After-school specialty or educational programs
- Summer or day camp providing overnight stays
- Transportation between your home and dependent care services
- Child support payments
- Food, clothing, and diapers
- Expenses for which a dependent care tax credit is taken
- Activity fees and late payment fees for services
- Liability insurance premiums
- Kindergarten expenses itemized as educational expenses

Wellesley College does not maintain a comprehensive list of IRS eligible expenses. If you have a question about the eligibility of a dependent care expense, contact Crosby Benefits Systems at 1-866-918-9711, or go online at **www.crosbybenefits.com.**

For more information about eligible and ineligible expenses, see IRS Publication 503, Child and Dependent Care Expenses. This publication is available online at **www.irs.gov/publications/p503/**.

How to Look Up Your Health Care Reimbursement Plan or Dependent Care Reimbursement Plan Account Balance

When you elect a yearly FSA amount, contributions are deducted from your paycheck in equal amounts over the course of the calendar year of the election. Crosby Benefit Systems administers the FSA program for Wellesley College.

If you elect to contribute to an FSA, you will receive an account statement from Crosby Benefit Systems twice per year notifying you of your current balance. You may also check you balance by going online at www.mycrosbybenefits.com.

How To Request A Reimbursement

Health Care Reimbursement Plan

You can be reimbursed up to your annual Health Care Reimbursement Plan election amount.

To be reimbursed for eligible medical/dental expenses, you must submit a Health Care FSA Reimbursement Request along with original receipts to Crosby Benefits (see Crosby address below). Forms are located in the Wellesley College Human Resources Office and online at www.crosbybenefits.com/ParticipantArea/Forms.aspx. You also have the option of submitting claims online at www.MyCrosbyBenefits.com.

Dependent Care Reimbursement Plan

You can be reimbursed only for amounts up to the current balance in your Dependent Care FSA at the time you file your claim.

To be reimbursed for eligible dependent day care expenses, you must submit a Dependent Care FSA Reimbursement Request along with original receipts, dates of service, the name of the dependent receiving the care and the name of the provider to Crosby Benefit Systems

The Date of a Reimbursable Expense
An expense is incurred when the service is rendered, not when you are charged or billed or when you paid the expense. Expenses for future service dates are not eligible.

Frequency of Reimbursements
Reimbursements for the Health Care Reimbursement Plan and the Dependent Care Reimbursement Plan are made upon receipt of reimbursement requests throughout the calendar year.

FSA Direct Deposit
You can choose to have your reimbursements directly deposited at your bank. You can sign up for direct deposit by going to www.MyCrosbyBenefits.com or completing the form found at http://www.crosbybenefits.com/ParticipantArea/Forms.aspxComplete the direct deposit form with the appropriate information, and mail to the Crosby Benefits address on the form.

Deadline for Spending Your FSA Balance(s)

You must incur expenses for your total elected amounts before the end of the calendar year of the election, or by the conclusion of the 2.5 month grace period. Under IRS regulations, at the end of the year, or at the end of the grace period, you will forfeit any unused contributions. The College uses any money forfeited from accounts to offset the cost of administering the program.

Yearly Deadline for Submitting Claims for Reimbursement

You have until March 31st of any current calendar year to submit claims for expenses incurred during the previous calendar year and the 2.5 month grace period.

You must submit your reimbursements by that date. Under IRS regulations, you will forfeit any non-reimbursed balance left in your account at that time.

When Can You Change or Stop Your FSA Election Amount?

Because Flexible Spending Accounts operate under IRS guidelines, once you make a calendar year election amount, you cannot change your amount or stop your contributions during that year unless you experience a qualified change in family or employment status which allows you to make the change.

If you do experience a qualified change, you have 30 days from the date of the event to make the change. See **When You May Change Your Benefit Elections** under **Participation in the Plan** for examples of what would allow you to make a change to your Flexible Spending Account. In addition to qualified status changes, you may be permitted to change your Dependent Care Reimbursement Plan election amount if the cost of child care changes significantly with a current provider.

An Annual Election Required to Enroll

To continue to participate from one calendar year to the next, you must make an active FSA election during the annual Open Enrollment period. Any current FSA election does not carry over from one year to the next.

If you do not make a new election during Wellesley College's annual Open Enrollment, you will not be enrolled in an FSA in the following calendar year. If you experience a qualified change in family or employment status you may be able to make an election outside of the annual Open Enrollment period.

What Happens When Your Employment Ends, You Become Benefits Ineligible, or You Retire?

If you are enrolled and you end employment, become ineligible to participate, or you retire, your pre-tax contributions stop.

For the Health Care and Dependent Care Reimbursement Plans

You may receive reimbursement up to your annual contribution amount to the Health Care FSA for expenses incurred during the calendar year prior to the date you became ineligible to participate. You must submit reimbursement by March 31st of the next year following the calendar year you elected to participate. You may receive reimbursement up to your account balance in the Dependent Care FSA for expenses incurred during the calendar year prior to the date you became ineligible to participate. Similar to the Health Care FSA, you must submit reimbursement by March 31st of the next year following the calendar year you elected to participate.

Health Care FSA COBRA Continuation

You may elect to continue contributing to your Health Care FSA on COBRA, up to the end of the calendar year in which you enrolled in COBRA.

You cannot continue to contribute to your Dependent Care FSA while on COBRA.

At the time you become ineligible, Health Care FSA COBRA paperwork is sent to your home address on record.

COBRA coverage need not be offered to qualified beneficiaries who have "overspent" their account as of the date of COBRA eligibility.

For those with "underspent" accounts, COBRA must be offered but may be terminated at the end of the year in which the qualifying event that allows COBRA eligibility occurs.

Why Enroll in Health Care FSA COBRA

If you have had Health Care FSA deductions taken from your paycheck, and you have not incurred expenses to use those deductions before the date of the loss of your Wellesley College medical or dental coverage, enrolling in COBRA will allow you to incur expenses after that date and seek reimbursement for those expenses.

If You Do Not Enroll in Health Care FSA COBRA You Will Not Be Able to Use Your Remaining Balance

If you do not enroll in Medical/Dental FSA COBRA, and you do not have enough claims at the time you lose eligibility to take your balance to zero, you will not be able to be reimbursed for the remaining FSA balance that you have in your account at the time you lose benefits eligibility.

COBRA FSA Contributions are Post-Tax Contributions

It only makes sense to continue your FSA on COBRA if you have an unused balance in your FSA, because you must continue to make contributions into your FSA account while on COBRA, according to the dollar election that you made while eligible. Your contributions are post-tax, and you must also use up these additional contributions while on COBRA, or lose them.

Flexible Spending Accounts and Federal Tax Law

The IRS will not provide two tax benefits on the same expense, so you cannot take a federal tax deduction or credit on your income taxes for expenses reimbursed through a flexible spending account.

Health Care Reimbursement Plan

In general, you may be reimbursed through your FSA for a medical care expense which is eligible to be deducted for federal income tax purposes, but which has not and will not be reimbursed by any other source, and which has not been and will not be deducted on your federal income tax return.

So if you use your Health Care FSA for a particular reimbursement you may not use that expense as an itemized deduction on your income taxes. When you are deciding whether to use a federal deduction or a Health Care FSA reimbursement you should consult a tax advisor to find out which approach is better for you.

Dependent Care Reimbursement Plan

The federal government allows you to take a tax credit for eligible dependent care expenses. Under the IRC, the tax credit is a percentage of your dependent care expenses. This amount may change from year to year, and you should consult with a tax advisor to determine if the tax credit is more advantageous than participating in the Dependent Care Reimbursement Plan.

III. YOUR RIGHTS AS A PARTICIPANT IN THE PLAN

Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Wellesley College Employee Welfare Benefits Plan and the Health Care Reimbursement Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants in the Plan and the Health Care Reimbursement Plan shall be entitled to:

Receive Benefits Plan and Program Information

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 and 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 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 administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuation of Group Medical and Dental Coverage

Continue medical and dental 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. Review this summary plan description and the documents governing the Employee Welfare Benefits Plan and the Health Care Reimbursement Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Employee Welfare Benefits Plan and Health Care Reimbursement Plan participants, ERISA imposes duties upon the people who are responsible for the operation of those plans. The people who operate those plans, called "fiduciaries" of those plans, have a duty to do so prudently and in the interest of you and other plan participants and dependents. 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a plan 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 right described above. For instance:

- If you request a copy of the 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 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 a 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 a federal court. The court will decide who should pay court costs and 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 Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about the ERISA information provided here 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 your telephone directory, or contact 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 also may obtain certain publications about your rights and responsibilities under ERISA by going online at the Employee Benefits Security Administration at **http://www.dol.gov/ebsa/.**

- ERISA at the Department of Labor: **http://www.dol.gov/dol/topic/health-plans/erisa.htm**

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

In the event that you stop working at Wellesley College, the Heath Insurance Portability and Accountability Act restricts, in certain instances, the right of your new employer to limit your

coverage because of pre-existing conditions, provided that you had medical coverage with Wellesley College.

While HIPAA allows an employer to limit coverage by reason of a pre-existing condition for up to 12 months (18 months for late enrollees), this limit may be reduced in certain circumstances by the period of time during which you were covered under Wellesley's (or any predecessor employer's) medical coverage. For example, if you were covered under one of Wellesley College's medical plans in the Employee Welfare Benefits Plan for more than one year, your new employer cannot limit or exclude coverage for any condition that was covered under Wellesley College's medical program, assuming you did not have a 63-day or longer break in coverage.

In the event that your Wellesley College medical coverage ceases, you are entitled to a Certificate of Prior Health Coverage. This certificate is issued by the appropriate Wellesley College medical insurance carrier, not by the College.

Under HIPPA your protected health information (PHI), which is health information identifiable directly to you, cannot be used except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted by applicable law. By law, the Plan will require all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Wellesley College.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the applicable plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact Wellesley College's Human Resources Office. If you have questions about the privacy of your health information, please contact the Wellesley College Human Resources Benefits Manager, the College's designated privacy official.

Further HIPAA information can be found at the Department of Labor: **http://www.dol.gov/dol/topic/health-plans/portability.htm**

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

COBRA Medical and Dental Continuation Coverage

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible to continue coverage after group medical and dental coverage ends if you were enrolled in such coverage and you experience a qualifying event which would cause you to lose group medical and dental coverage. Note that same-sex marriages legally entered into in Massachusetts are not recognized under federal law. Federal COBRA continuation provisions therefore do not apply to same-sex spouses.

COBRA requires that most employers sponsoring group medical plans offer employees and their families ("qualified beneficiaries") the opportunity to elect and pay for a temporary extension of medical coverage called "continuation coverage" at group rates in certain instances ("qualifying events") where coverage under the employer's medical plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of that law. (Both you and your spouse should take time to read this notice carefully.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for the coverage.

If you are an employee of Wellesley College and enrolled in the medical and/or dental coverage offered by the Wellesley College Employee Welfare Benefits Plan, you will become a qualified beneficiary if you lose your group health coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee covered by the Plan, you will become a qualified beneficiary if you lose your coverage under the Plan because *any* one of the following qualifying events happens:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan, because *any* one of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
- The child ceases to be eligible for coverage under the Plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Plan Sponsor and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse or surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator (Wellesley College Human Resources Office) has been notified that one of the following qualifying events has occurred for the employee: the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator (Wellesley College Human Resources Office) within 60 days of the later of the date of the qualifying event or the date on which coverage would be lost because of such event. You must provide this notice to the Plan Contact listed at the end of this summary, along with documentation substantiating the divorce, legal separation or loss of dependent status and the effective date of such event.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary and be added to the covered employee's COBRA continuation coverage. You must notify the Plan Administrator within 60 days after the birth or placement for adoption occurs. You must also provide this notice to the Plan Contact listed at the end of this summary, along with copies of legal documents substantiating the birth or placement for adoption and the effective date of such event.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Under the law, you have at least 60 days from the date you lost coverage because of one of the events described above to inform the Plan Administrator that you want to elect continuation coverage. If you do not elect continuation coverage, your group medical coverage under the Plan will end, *as of the date of the qualifying event*. If you elect continuation coverage, the Plan Sponsor is required to permit you to elect and purchase coverage which, as of the time coverage

is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months from the date employment terminated or hours were reduced if a second event entitling you to choose continuation coverage (such as death, divorce, legal separation, ceasing to be a dependent child, or Medicare entitlement) occurs within that 18 month period.

The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration (for purposes of Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act) to have been disabled at any time during the first 60 days of COBRA continuation coverage. This 11 month extension is available to all individuals who are qualified beneficiaries due to a termination in employment or reduction in hours. To benefit from this extension, the qualified beneficiary must notify ABC of the Social Security Administration's determination within 60 days of such a determination and before the end of the original 18 month period of continuation coverage. The qualified beneficiary must also notify the Employer within 30 days of the date of any final determination by the Social Security Administration that the individual is no longer disabled.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary must pay the entire cost of continuation coverage. The amount a qualified beneficiary must pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to disability, 150 percent) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

When and How Must Payment for COBRA Continuation Coverage Be Made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the election notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA administrator at the address, phone number or e-mail address provided at the end of this section to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under COBRA, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or

before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

Grace period for periodic payments
Although periodic payments are due on the dates noted above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

Early Termination of COBRA

COBRA provides that your continuation coverage may be terminated before the end of the maximum coverage period for *any* of the following reasons:

- The Plan Sponsor no longer provides group medical coverage to any of its employees;
- Any required premium for continuation coverage is not paid in full on time;
- A qualified beneficiary becomes covered -- after electing COBRA continuation coverage -- under another group medical plan (as an employee or otherwise) that does not impose any pre-existing condition limitation for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage;
- A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group medical plans may impose preexisting condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule (in the third bullet above) with these new limits as follows:

If you become covered by another group medical plan and that plan contains a preexisting limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the Plan Sponsor may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, as discussed above, you will have to pay all the required premiums for your continuation coverage. The law also says that, at the end of the 18 month, 29 month or 36 month continuation coverage period, you must be allowed to enroll in an individual conversion medical plan *if* such an individual conversion medical plan is otherwise generally available under the Plan.

Continuation coverage under COBRA is provided subject to the qualified beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible.

COBRA continuation coverage may also be terminated for any reason if the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

More complete information regarding your COBRA continuation coverage rights is available from the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group medical and dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at: www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Wellesley Informed of Address Changes

In order to protect your family's rights, you should keep the Human Resources Office informed of any changes in the addresses of family members. We keep a copy, for your records, of any notices you send to the plan administrator.

Plan Contact Information (Plan Administrator)

Benefits Manager
106 Central Street
Wellesley, MA 02481
781-283-2215

Family and Medical Leave Act (FMLA)

All participants in Wellesley College's Employee Welfare Benefits Plan are covered by this act. Under FMLA, you are eligible for at least 12 weeks of unpaid leave for any of the following reasons:

- The birth or adoption of your child, or the placement of a child with you for foster care (you must take the leave within one year of the birth, adoption, or placement)
- A serious health condition of your child, spouse, or parent
- Your own serious health condition that prevents you from performing the duties of your job (this condition must require inpatient care or continuing treatment by a health care provider)

If you take a leave of absence under FMLA, you may continue your medical and dental coverage during the leave by continuing to pay the required premiums. If you choose not to continue coverage while on an FMLA leave, you are not reimbursed for any medical and/or dental claims

incurred while you are on the FMLA leave. You are eligible to apply for COBRA coverage while on leave. On return from FMLA leave, the medical and/or dental coverage that was discontinued or terminated is reinstated only on reapplication for coverage. If you do not return to work after your FMLA leave ends, you may be eligible to continue coverage under COBRA.

- FMLA at the Department of Labor: **http://www.dol.gov/esa/whd/fmla/**

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)

Under this act group health care insurers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Plans and insurance issuers may not, under Federal law, require that a provider of services, a doctor or hospital, obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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 at all states of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under your coverage under this Plan. If you would like more information on WHCRA benefits, contact the Plan Administrator at the address and phone number listed in this Summary Plan Description.

Qualified Medical Child Support Orders (QMCSOs)

As required by ERISA, the Plan recognizes qualified medical child support orders (QMCSOs). A QMCSO is a court order or an order issued by a state administrative agency in accordance with federal and state laws that require an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant's group medical coverage and/or dental coverage.

The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the Plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid.

A QMCSO must be provided to the Plan Sponsor to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and is enrolled as a dependent of the employee participant. If the Plan Sponsor receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified and will be provided with a copy of the Plan's QMCSO procedures.

Mental Health Parity and Addiction Equity Act of 2008 (MHPA)

Effective for plan years beginning on and after October 4, 2009, if any group medical coverage feature (1) provides for both medical and surgical mental health or substance use disorder benefits and (2) is not subject to an increased cost exemption (within the meaning of the MHPA):

- The group medical coverage feature may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The group medical coverage feature may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any group medical coverage feature with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the MHPA) to any current or potential participant upon request.
- The reason for any denial under the Plan or reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or as otherwise required under the MHPA, be made available by the Plan Administrator to the Participant in accordance with the claims procedures applicable to the group medical coverage feature.
- The Plan shall be operated and construed in all respects in compliance with the MHPA.

"Mental health benefits" and "substance use disorder benefits" shall be defined in the contract applicable to the group medical coverage feature, pursuant to applicable state and Federal law, and consistent with generally recognized standards of current medical practice.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Under this act, you and your dependents have the right to continue your group health care coverage if you are on a military leave of absence. You and your dependents must pay for this coverage. For more information about filing for coverage under this act, contact the Plan Sponsor.

- USERRA at the Department of Labor: **http://www.dol.gov/compliance/laws/comp-userra.htm**

Grandfathered Plan Notice

Wellesley College believes its heath plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefit Manager at Wellesley College at 781-283-2215. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov.ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

How to File Claims and Appeals

Claims for Fully Insured Benefits

All claims and appeals of denied claims involving a benefit under the Plan that is fully insured shall be submitted to the applicable insurance carrier, which shall be solely responsible for administering all such claims in accordance with ERISA (including the Department of Labor Regulations thereunder) and state law, as applicable. The final determination of the insurance carrier on review shall in all cases be final, and the Plan Sponsor shall not have any authority to

overrule any determination of the insurance carrier of a fully insured benefit under the Plan. See the appropriate claims contact information below:

Medical and Dental Benefit and Reimbursement Plan Claim Procedure and Appeals

The subscriber certificates provided to you separately, at the time of your enrollment in coverage, explains how to claim benefits under the Plan, summarized below. If benefits to which you believe you are entitled under the Plan or the Reimbursement Plans are not paid, you must make a claim for benefits under the Plan or the Reimbursement Plans in writing to the applicable claims administrator.

Benefits are administered according to the terms of the applicable insurance policies, administrative contracts, and plan documents. See the charts below for specific administration, claim contact, and funding information**.**

MEDICAL CLAIMS

Contact For Medical Claims Administration	**Funding Status**	**Group Contract Number**
Harvard Pilgrim Health Care Member Services 1600 Crown Colony Drive Quincy, MA 02169 1-888-333-4742	**Fully Insured**	**HMO** #060020
Harvard Pilgrim Health Care Member Services 1600 Crown Colony Drive Quincy, MA 02169 1-888-333-4742	**Fully Insured**	**PPO** #069860

DENTAL CLAIMS

Contact For Dental Claims Administration	**Funding Status**	**Group Contract Number**

Delta Dental of Massachusetts Claims Department P.O. Box 9695 Boston, MA 02114 1-800-872-0500	**Fully Insured**	**Delta Premier #7816**
Delta Dental of Massachusetts Claims Department P.O. Box 9695 Boston, MA 02114 1-800-327-6277	**Fully Insured**	**DeltaCare #7816**

LONG TERM DISABILITY CLAIM REVIEW

Contact for Disability Claim Review	**Funding Status**	**Policy Number**
Standard Insurance Company Claims Department 900 SW Fifth Avenue Portland, Oregon 97204 503-321-7000	**Fully Insured**	**137951-D**

SHORT TERM DISABILITY CLAIM REVIEW

Contact for Disability Claim Review	**Funding Status**	**Policy Number**
Standard Insurance Company Claims Department 900 SW Fifth Avenue Portland, Oregon 97204 503-321-7000	**Fully Insured**	**137951-A**

LIFE INSURANCE CLAIM REVIEW

Contact for Life Insurance Claim Review	**Funding Status**	**Policy Number**
Standard Insurance Company Claims Department 900 SW Fifth Avenue Portland, Oregon 97204 503-321-7000	**Fully Insured**	**137951-E**

HEALTH CARE AND DEPENDENT CARE FSA CLAIM REVIEW

Contact for FSA Claim Review	**Funding Status**	**Policy Number**
Crosby Benefit Systems, Inc. P.O. Box 929125 Needham, MA 02492 1-866-918-9711	**Self Insured**	N/A

Welfare Benefits Plan Administration

Authority of Plan Administrator

The Plan Administrator has complete discretionary authority with regard to the operation, administration and interpretation of the Plan and the Health Care Reimbursement Plan, and any determination by the Plan Administrator relating to the Plan and the Health Care Reimbursement Plan shall be final, binding and conclusive in the absence of clear and convincing evidence that the Plan Administrator acted arbitrarily and capriciously. The Plan Administrator may also delegate any of its responsibilities under the Plan and the Health Care Reimbursement Plan to any other person or entity.

Any insurance carrier from which benefits are purchased has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to

determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy.

Plan Administration

All benefits under the Plan and the Reimbursement Plans are administered by the insurance carriers from which the benefits are purchased, or in the case of certain self-funded benefits, by a third-party administrator. The name of each carrier or vendor is set out in the ***How to File Claims and Appeals*** section of this SPD. Unless otherwise indicated, all benefits furnished under the Plan are provided under the insurance policies, administrative contracts and/or subscriber certificates of the appropriate carrier or vendor identified in ***How to File Claims and Appeals*** and they provide all necessary administrative services. Please note that the Dependent Care Reimbursement Plan, while mentioned here for administrative purposes, is not subject to ERISA.

Plan Amendment or Termination

The Plan Sponsor hopes to continue the Plan and the Reimbursement Plans indefinitely but they may be changed or discontinued by the Plan Sponsor with respect to all or any class of employees (to the extent permitted by applicable law), at any time and for any reason, without notice. Any amendment or termination shall be effected by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate. No vested rights of any nature are provided under the Plan or the Reimbursement Plans.

Plan Documents

The documents constituting the Plan and the Reimbursement Plans may be reviewed in the offices of the Plan Administrator. Except as otherwise noted, the information below is the same for both the Plan and the Reimbursement Plans:

Name of Plans:	*Wellesley College Employee Welfare Benefits Plan* (the "Plan") Wellesley College Health Care Reimbursement Plan
Plan Sponsor:	*Wellesley College* 106 Central Street Wellesley, MA 02481 781-283-3202
Plan Administrator:	The Plan Sponsor is also the Plan Administrator. The Plan Administrator's address and telephone number is the same as that of the Plan Sponsor listed above.

Agent for Service of Legal Process:	The Plan Administrator, as listed above
Plan Sponsor's EIN:	04-2103637
Plan Numbers:	502 (the Plan) 514 (the Health Care Reimbursement Plan)
Type of Plans:	The Plan is a health and welfare plan providing medical and prescription drug, dental and life insurance, short term disability and long term disability coverage, long term care insurance and an employee assistance plan, as described in the corresponding Benefits Summaries and Subscriber Certificates. The Health Care Reimbursement Plan is a health and welfare plan providing for health care flexible spending account deferrals, as described in the corresponding Benefits Summaries and Subscriber Certificates. The Dependent Care Reimbursement Plan is a health and welfare plan providing for dependent care flexible spending account deferrals, as described in the corresponding Benefits Summaries and Subscriber Certificates.
Sources of Plan Contributions:	The Plan: The medical and dental coverage requires joint contributions from participating employees and the Plan Sponsor. The Plan Sponsor determines the amount participating employees must contribute. Employees pay Contributory Life Insurance, Spouse Life Insurance and health and dependent care FSA deferrals without contributions from the Plan Sponsor. Wellesley College Health Care Reimbursement Plan and Dependent Care Reimbursement Plan: Employees pay health care and dependent care FSA deferrals without contributions from the Plan Sponsor.

Plan Year:	The plan year is the 12 month period of January 1 to December 31.

OTHER WELLESLEY COLLEGE BENEFIT PROGRAMS

Retirement Benefits for the College

This section outlines the eligibility requirements for early retiree benefits, and provides you with information on enrollment, coverage, and cost. If you are considering retirement, you should contact the Wellesley College Human Resources Office at least 3 months prior to your prospective retirement date to determine your eligibility for retiree medical benefits

Turning Age 65 While Actively Employed

If you turn age 65 while actively working (and do not retire), your coverage remains the same as it was prior to age 65. Employees who are 65 should register with Social Security. If you are enrolled in Wellesley College sponsored medical coverage, however, it is not necessary for you to enroll in Medicare B until you retire or end your employment.

Early Retiree Medical and Dental Benefits

Eligibility Rules for Early Retiree Medical & Dental Benefits

To be eligible:

- You must be at least age 60,
- You must be under age 65,
- You must have at least 10 years of service (benefits eligible employment at Wellesley College), *and*
- You must be enrolled in the plan(s) at the time of retirement

Coverage Type and Cost of Early Retiree Medical

If you meet the eligibility rules above, the College will pay the portion of medical premiums it pays for all employees up to the first of the month in which you turn age 65, provided such is permitted under applicable law and the College's medical insurance plan is in effect. This means that you continue to pay the medical premium that you would pay as if you were an active employee, up to the first of the month in which you turn 65. At that time, you become enrolled in Medicare.

Spouses and eligible dependents are also covered (spouses are covered until age 65). If you are over age 65 at the time of retirement, however, there is no coverage for you, your spouse or dependents.

Coverage Type and Cost of Retiree Dental

If you meet the eligibility rules above, you may continue your dental coverage until the first of the month in which you turn age 65. You are responsible for the full group cost of your dental coverage as Wellesley College no longer subsidizes the premium. This means that you will pay the dental premium that you would pay if you were an active employee *plus* the rest of the group premium that Wellesley College subsidizes for active employees.

Spouses and eligible dependents are also covered (spouses are covered until age 65). If you are over age 65 at the time of retirement, however, there is no coverage for you, your spouse or dependents.

Retiree Life Insurance Benefit

Eligibility Rules for Retiree Life Insurance Benefits

To be eligible:

- You must be at least age 65,
- You must have been hired before January 1, 1995, *and*
- You must have at least 10 years of service

Coverage Type and Cost of Retiree Life Insurance

Insurance Amount at Retirement

Non-Exempt Employees:	$1,000 benefit
Exempt Employees:	$2,500 benefit

There is no cost to this benefit. Employees hired on or after January 1, 1995 are ineligible for this benefit.

Conversion Privilege

At the time of your retirement, you may exercise your "conversion privilege" and convert to an individual Life Insurance policy. You must apply within 31 days of retirement, and you do not have to submit evidence of insurability. Should you die during this 31-day period, the amount of your Life Insurance will be paid whether or not you have used the "conversion privilege." This would apply to the full Life Insurance coverage while employed, not the death benefit.

Other Benefits at Retirement

Long Term Disability at Retirement

Your LTD coverage ends when you retire.

Short Term Disability at Retirement

Your STD coverage ends when you retire.

Flexible Spending Accounts at Retirement

If you are enrolled in a Health Care FSA at the time of your retirement, you may continue post-tax contributions to your FSA on COBRA. If you are participating in a Dependent Care FSA, it stops at retirement. See **COBRA,** under ***Your Rights as a Participant***.

Long Term Care Coverage at Retirement

You may continue your long term care coverage directly with CNA. To contact CNA, see **Benefits Contact Information** in this SPD.

EAP at Retirement

Your EAP coverage terminates when you retire.

Where to Find Benefits Information

Benefits Information Online

Websites and telephone numbers for benefit plan providers are listed below for your interest and for further information about these benefit plan offerings:

Plan Provider	Website	Telephone
Crosby Benefit Systems **(Health and Dependent Care Spending Accounts)** and COBRA	www.crosbybenefits.com	1-800-462-2235
Delta Dental of Massachusetts		
- Premier Plan	www.deltamass.com	1-800-872-0500
- DeltaCare	www.deltamass.com	1-800-327-6277
Harvard Pilgrim Healthcare HMO & PPO	www.harvardpilgrim.org	1-800-789-2925
Long Term Care Insurance (CNA)	www.ltcbenefits.com	1-877-777-9072
The Standard Insurance Company **(Life Insurance and Long Term Disability)**	www.standard.com	1-503-321-7000
The Wellness Corporation **(Emplyee Assistance Program)**	www.WellnessWorkLife.com	1-800-828-6025

Benefits Contact Information

Wellesley College Human Resources Office

106 Central Street
Wellesley, MA 02481
781-283-3202

Benefits Manager
781-283-2215

Benefits Coordinator
781-283-2212