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**Health Reimbursement Arrangement**

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INTRODUCTION

We sponsor this Health Reimbursement Arrangement to provide you with additional health coverage benefits. The benefits available under this Plan are outlined in this summary plan description. We will also tell you about other important information concerning the Plan, such as the rules you must satisfy before you become eligible and the laws that protect your rights.

Read this summary plan description carefully so that you understand the provisions of our Plan and the benefits you will receive. You should direct any questions you have to the Administrator. There is a plan document on file, which you may review if you desire. In the event there is a conflict between this summary plan description and the plan document, the plan document will control.

I
ELIGIBILITY

1. What Are the Eligibility Requirements for Our Plan?
   You will be eligible to join the Plan once you have satisfied the conditions for coverage under our group medical plan.

2. When is My Entry Date?
   Once you have met the eligibility requirements, your entry date will be the date you become covered under Bay Path College’s medical plan.

3. Are There Any Employees Who Are Not Eligible?
   Yes, there are certain employees who are not eligible to join the Plan. They are:

   Employees who are not enrolled in the plan sponsor group medical plan.

II
BENEFITS

1. What Benefits Are Available?
   The plan allows you to be reimbursed for any deductible expenses, which you have to meet under the Employer’s group medial plan, which are incurred by you or your dependents.

   ➢ The eligible reimbursement amount will be indicated in your Summary of Benefits which is provided to you annually or when first employed.

   Expenses are considered “incurred” when the service is performed, not necessarily when it is paid for. Any amounts reimbursed to you under the Plan may not be claimed as a deduction on your personal income tax return nor reimbursed by any other health plan coverage including a health flexible spending account and a health savings account.
You may submit expenses for yourself, your spouse or your dependents or any other dependent as outlined in the sponsors medical plan policy. You may be reimbursed for expenses for any child until that child reaches age 26. A child is a natural child, stepchild, foster child, adopted child, or a child placed with you for adoption.

Women's Health and Cancer Rights Act: This plan, as required by the Women's Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Contact your Plan Administrator for more information.

2. **When Must Expenses Be Incurred?**
   You may submit expenses that you incur each “Coverage Period.” A new “Coverage Period” begins each July 1 and ends the following June 30.

   Expenses under this Plan are treated as being "incurred" when you are provided with the care that gives rise to the expenses, not when you are formally billed or charged, or you pay for the medical care.

3. **When Will I Receive Payments From the Plan?**
   During the course of the Coverage Period, you may submit requests for reimbursement of expenses you have incurred. However, you must make your requests for reimbursements no later than 75 days after the end of the Plan Year. You must submit to the Administrator proof of the expenses (a copy of the Explanation of Benefits from your insurance carrier is acceptable documentation) you have incurred and that they have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, reimbursements made from the Plan are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes.

4. **What Happens If I Terminate Employment?**
   If your employment is terminated during the Plan Year for any reason, your participation in the Plan will cease and any unused amounts are forfeited.

5. **Family and Medical Leave Act (FMLA)**
   If you take leave under the Family and Medical Leave Act, you may revoke or change your existing elections for health insurance. If your coverage in these benefits terminates, due to your revocation of the benefit while on leave, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return.

   If you continue your coverage during your unpaid leave, you may pre-pay for the coverage, you may pay for your coverage on an after-tax basis while you are on leave, or you and your Employer may arrange a schedule for you to “catch up” your payments when you return.
6. **Uniformed Services Employment and Reemployment Rights Act (USERRA)**
If you are going into or returning from military service, you may have special rights to
health care coverage under your Health Reimbursement Arrangement under the Uniformed
Services Employment and Reemployment Rights Act of 1994. These rights can include
extended health care coverage. If you may be affected by this law, ask your Administrator
for further details.

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

8. **Qualified Medical Child Support Order**
A medical child support order is a judgment, decree or order (including approval of a
property settlement) made under state law that provides for child support or health
coverage for the child of a participant. The child becomes an "alternate recipient" and can
receive benefits under the health plans of the Employer, if the order is determined to be
“qualified.” You may obtain, without charge, a copy of the procedures governing the
determination of qualified medical child support orders from the Plan Administrator.

### III

**GENERAL INFORMATION ABOUT OUR PLAN**

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

1. **General Plan Information**
Bay Path College Health Reimbursement Account is the name of the Plan.

Your Employer has assigned Plan Number 501 to your Plan.

The provisions of your Plan become effective on July 1, 2007.

2. **Employer Information**
Your Employer’s name, address, and identification number are:

Bay Path College
588 Longmeadow St.
Longmeadow, MA 01106
04-2103865

The Plan allows other employers to adopt its provisions. You or your beneficiaries may
examine or obtain a complete list of employers, if any, who have adopted your Plan by
making a written request to the Administrator.
3. **Plan Administrator Information**  
The name, address and business telephone number of your Plan’s Administrator are:

Bay Path College  
588 Longmeadow St.  
Longmeadow, MA 01106  
413.565.1252

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about our Plan. The Plan Administrator has the exclusive right to interpret the appropriate plan provisions. Decisions of the Administrator are conclusive and binding. You may contact the Administrator for any further information about the Plan.

4. **Third Party Claims Administrator Information**  
The name, address and telephone number of the Third Party Claims Administrator are:

BFP Associates, Inc.  
110 Elm Street  
West Springfield, MA 01090-0478  
413.739.2352  
800.426.4695

The Third Party Claims Administrator is responsible for the actual processing of claims on behalf of the Plan Administrator.

5. **Service of Legal Process**  
The Employer is the Plan’s agent for service of legal process.

6. **Type of Administration**  
The Plan is a health reimbursement arrangement and the administration is provided through a Third Party Claims Administrator. The Plan is not funded or insured. Benefits are paid from the general assets of the Employer.

**IV**  
**ADDITIONAL PLAN INFORMATION**

1. **Your Rights Under ERISA**  
Plan Participants, eligible employees and all other employees of the Employer may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code. These laws provide that Participants, eligible employees and all other employees are entitled to:

   (a) Examine, without charge, at the Administrator’s office, all Plan documents, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S.
Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain copies of all Plan documents and other Plan information upon written request to the Administrator. The Administrator may charge a reasonable fee for the copies.

(c) Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(d) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

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

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may request the 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, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if a Plan Participant disagrees with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

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 legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.
If you have any questions about the Plan, you should contact the Administrator. If you have any questions about this statement, or about your rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

2. How to Submit a Claim
When you have a Claim to submit for payment, you must fax, email or mail a copy of the medical insurance explanation of benefits to the claims administrator for reimbursement.

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan’s reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. “Days” means calendar days.

<table>
<thead>
<tr>
<th>Description</th>
<th>Time Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of whether Claim is accepted or denied</td>
<td>30 days</td>
</tr>
<tr>
<td>Extension due to matters beyond the control of the Plan</td>
<td>15 days</td>
</tr>
<tr>
<td>Insufficient information on the Claim:</td>
<td></td>
</tr>
<tr>
<td>Notification of</td>
<td>15 days</td>
</tr>
<tr>
<td>Response by Participant</td>
<td>45 days</td>
</tr>
<tr>
<td>Review of Claim denial</td>
<td>60 days</td>
</tr>
</tbody>
</table>

The Plan Administrator will provide written or electronic notification of any Claim denial. The notice will state:

(1) The specific reason or reasons for the denial.
(2) Reference to the specific Plan provisions on which the denial was based.
(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
(4) A description of the Plan’s review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502 of ERISA following a denial on review.
(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and
(6) If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to the claimant upon request.
When you receive a denial, you will have 180 days following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the Claim determination;
2. was submitted, considered, or generated in the course of making the Claim determination, without regard to whether it was relied upon in making the Claim determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants;
4. or constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.
(1) **General.** This is a Summary of Material Modifications regarding the Bay Path University Health Reimbursement Account (“Plan”). This Summary of Material Modifications supplements and amends the Summary Plan Description (“SPD”) dated July 1, 2013. You should retain this document with your copy of the SPD.

(2) **Identification of Employer.** The legal name, address and Federal employer identification number of the Employer are:

Bay Path University    EIN: 04-2103865
588 Longmeadow Street
Longmeadow, MA 01106

(3) **Description of Modifications.** The Employer has amended the Plan to make the following changes, which are in effect on the date indicated above.

A. Section III #1, page 4, General Plan Information:
   Plan Name is now Bay Path University Health Reimbursement Account

B. Section III #2, Page 4, Employer Information
   Bay Path University
   588 Longmeadow St.
   Longmeadow, MA 01106
   04-2103865

C. Section III #3, Page 5, Plan Administrator
   Bay Path University

(4) **Effect on Summary Plan Description.** This Summary amends and updates the SPD as follows:

A. Section III, page 4, item 1 will read as follows:
   Bay Path University Health Reimbursement Account is the name of the plan.

B. Section III, page 4, item 2, will read as follows:
   Bay Path University
   588 Longmeadow St.
   Longmeadow, MA 01106
   04-2103865

C. Section III, page 5, item 3, will read as follows:
   Bay Path University
   588 Longmeadow St.
   Longmeadow, MA 01106