THIS DOCUMENT IS THE AMENDED AND RESTATED
EMPLOYER-FUNDED
MEDICAL REIMBURSEMENT PLAN
FOR
KALAMAZOO COLLEGE

Effective Date of Amended and Restated Plan:
January 1, 2019

Group Number: G-1013
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ARTICLE I: ESTABLISHMENT OF THE PLAN

KALAMAZOO COLLEGE establishes the Kalamazoo College Employer-Funded Medical Reimbursement Plan as of January 1, 2019, for the purpose of providing eligible Employees with tax-free medical reimbursement benefits. The Plan is intended to qualify as a medical reimbursement plan under Section 105(h) of the Code and is to be interpreted in a manner consistent with the requirements of that Section.

ARTICLE II: BASIC INFORMATION ABOUT THE PLAN

1. **Plan Name:**
   Kalamazoo College Employer-Funded Medical Reimbursement Plan

2. **Employer/Plan Sponsor/Plan Administrator:**
   Kalamazoo College
   1200 Academy Street
   Kalamazoo, Michigan 49006
   (269) 337-7284

3. **Taxpayer Identification No.:**
   38-1358014

4. **ERISA Plan Number:**
   525

5. **Group Number:**
   G-1013

6. **Type of Plan:**
   Welfare Benefit Plan

7. **Claim Administrator:**
   Administration Systems Research Corporation International (ASR)
   P.O. Box 6392
   Grand Rapids, Michigan 49516-6392
   (616) 957-1751 or (800) 968-2449

8. **Type of Administration:**
   The Claim Administrator administers claims for benefits pursuant to a contract with the Plan Administrator.

9. **Agent for Service of Legal Process:**
   Director of Human Resources
   Kalamazoo College
   1200 Academy Street
   Kalamazoo, Michigan 49006
   Service of process may be made upon the Plan Administrator.

10. **Effective Date of Amended and Restated Plan:**
    January 1, 2019

11. **Benefit Year:**
    January 1 through December 31
ARTICLE III: FILING A CLAIM

Any eligible expenses not covered under the Employer’s group health Black Plan will automatically be paid to the health-care provider from the Employer-Funded Medical Reimbursement Plan. The Participant does not need to take action to obtain reimbursement nor send the EOB from the Employer’s group health Black Plan back to ASR.

All claims for reimbursement must be filed with the Claim Administrator no later than 12 months from the date of service. If a claim is not timely filed, it shall be denied. Eligible claims shall be paid up to the limit described in the Limit on Benefits section.

The Plan Administrator reserves the right to establish additional procedures for the submission of claims for reimbursement.

The Participant should keep a copy of the EOB statement(s) for each reimbursement request for the Participant’s own records. Any questions can be directed to the Employer or ASR.

ARTICLE IV: BENEFITS

4.1 Covered Medical Expenses

For each Benefit Year, the Plan Administrator shall reimburse a Participant for Medical Expenses incurred by the Participant or the Participant’s Dependent during the Benefit Year that are applied to the in-network deductible. For purposes of the Plan, such a Medical Expense shall be incurred on the date the service or supply is provided and is eligible for reimbursement only if all of the following circumstances apply:

(a) The Medical Expense was incurred as the result of a Participant’s or the Participant’s Dependent’s treatment by an individual or entity designated as a participating (in-network) provider under the Employer’s group health Black Plan.

(b) The Medical Expense was eligible for payment under the Employer’s group health Black Plan on behalf of the Participant or one of the Participant’s enrolled Dependents but for the application of that plan’s in-network deductible provisions.

(c) The Medical Expense is ineligible to be paid or reimbursed by health insurance or any other source. However, if the Participant has health plan coverage other than through the Employer, this Plan shall pay before the other coverage.

(d) The Medical Expense was incurred while the Employee or former Employee was a Participant.

(e) The Medical Expense is not a premium paid to obtain health insurance.
4.2 Limit on Benefits

The maximum amount per Benefit Year that may be reimbursed to a Participant for Medical Expenses incurred under the Employer’s group health Black Plan is 75 percent of each claim applied toward the in-network deductible of the Participant and the Participant’s enrolled Dependents under the Black Plan (up to $750 per Covered Person and $1,500 per family). The Participant must pay the other 25 percent of each claim applied toward the in-network deductible under the Black Plan (up to $250 per Covered Person and $500 per family).

Example: A Covered Person is enrolled in single coverage under the Employer’s group health Black Plan and incurs three claims toward the $1,000 in-network deductible under the Black Plan within the same Benefit Year. The Plan will reimburse 75% of each claim, up to the $750 maximum Plan benefit. The Covered Person is responsible for the balance of each claim until the deductible is satisfied.

If a Participant has a change in status during the Benefit Year and adds or drops Dependents, causing the Participant to go from single to family coverage or vice versa under the Employer’s group health Black Plan, the Participant’s maximum benefit for that Benefit Year shall be adjusted accordingly.

### ARTICLE V: PARTICIPATION

5.1 Eligibility

Each Employee of the Employer who is eligible for and has elected coverage under the Employer’s group health Black Plan shall be eligible to participate in this Plan.

5.2 Participation

An Employee eligible under the Eligibility section on the effective date of the Plan is deemed to be a Participant as of that date. Any other eligible Employee shall be deemed to be a Participant on the date on which the Employee becomes a Participant in the Employer’s group health Black Plan. The Employer’s group health Black Plan complies with the special enrollment rights requirements of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). As a result, because the participation provisions of this Plan are tied to the participation requirements of the Employer’s group health Black Plan, this Plan shall comply with the special enrollment rights requirements of HIPAA.

5.3 Termination of Participation

An individual who stops participating in the Employer’s group health Black Plan shall be considered to have terminated participation in this Plan as of that date. The individual shall be ineligible to receive reimbursement under the Plan for Medical Expenses incurred after the date the individual’s participation in the Plan terminated, except to the extent the individual continues to participate in the Plan as described in the Continuation Coverage section.

5.4 Continuation Coverage

During any time period in which the Plan is subject to COBRA, an individual whose participation in the Plan terminates under the Termination of Participation section has the option of continuing to participate in the Plan to the extent required by the continuation coverage
provisions of COBRA. This Plan shall be considered a part of the Employer’s group health Black Plan for purposes of COBRA.

If an individual is eligible to elect COBRA, the individual may continue participation by making after-tax contributions on a monthly basis in an amount equal to 102% of the cost of identical coverage for similarly situated enrollees. This option of continuing to participate is generally available for the 18-month period immediately following the date when the individual’s participation terminated and shall continue for any longer period as may be required by COBRA. However, the continuation coverage provided under this section shall terminate immediately upon the occurrence of any of the following events:

(a) The Plan Sponsor and its related employers within the meaning of Section 414 of the Code no longer offer any group health coverage for its Employees.

(b) The individual fails to timely make the required payments for the continuation coverage.

(c) The individual becomes covered under another group health plan after the date of election of COBRA continuation coverage.

(d) The individual becomes entitled to Medicare benefits (Part A or Part B) after the date of election of COBRA continuation coverage.

(e) The individual’s continuation coverage is terminated for cause on the same basis that the Plan terminates for cause the coverage of active Employees (e.g., for fraud or misrepresentation in a claim for benefits).

Further, if an Employee ceases to be eligible to participate in the Plan because of service in the U.S. Military, the Plan shall comply with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 with respect to the Plan. However, these requirements shall only apply to the extent they provide the Employee with more favorable coverage than under COBRA.

ARTICLE VI: HIPAA PRIVACY AND SECURITY RULES

The provisions of this Article shall apply to the extent the Plan Sponsor is subject to HIPAA’s privacy rules. For any time period where the Employer has fewer than 50 employees who are eligible to participate in the Plan and the Plan Sponsor administers the Plan without the assistance of a third-party administrator, the provisions of this Article shall not apply.

6.1 Permitted and Required Uses and Disclosure of Protected Health Information (PHI)

Subject to the Certification of Plan Sponsor section, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such PHI except for the following purposes:

(a) To perform Plan Administrative Functions that the Plan Sponsor does for the Plan.

(b) To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.
(c) To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

6.2 Conditions of Disclosure

The Plan Sponsor agrees to the following stipulations with respect to any PHI:

(a) To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

(b) To ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) To report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for which it becomes aware.

(e) To make a Participant’s or the Participant’s Dependent’s PHI available when access is requested in accordance with 45 CFR §164.524.

(f) To make a Participant’s or the Participant’s Dependent’s PHI available when an amendment is requested and incorporate any amendments to that PHI in accordance with 45 CFR §164.526.

(g) To make available the information required to provide an accounting of disclosures of PHI to a Participant or the Participant’s Dependent upon request in accordance with 45 CFR §164.528.

(h) To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.

(i) To return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, if feasible, and retain no copies of such information when no longer needed for the purpose for which the disclosure was made; if such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR §164.504(f)(2)(iii), is satisfied and that the terms set forth in the Adequate Separation between Plan and Plan Sponsor section below are followed.

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, the Plan Sponsor shall implement
administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. The Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

6.3 Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in the Conditions of Disclosure section.

6.4 Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only for the following purposes:

(a) To obtain premium bids from health plan providers to provide health coverage under the Plan.

(b) To modify, amend, or terminate the Plan.

6.5 Adequate Separation between Plan and Plan Sponsor

The Plan Sponsor will provide access to PHI to the Employees or classes of Employees listed in its HIPAA privacy policies and procedures for its group health plans. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule on the required effective date, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

6.6 Disclosure of Certain Enrollment Information to Plan Sponsor

Pursuant to 45 CFR §164.504(f)(1)(iii), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in, or has terminated from, any health insurance issuer or health maintenance organization offered by the Plan.

6.7 Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.
Participant Notification

Participants shall be notified of the provisions of this Article in a Notice of Privacy Practices.

ARTICLE VII: ADMINISTRATION

7.1 Powers of Plan Administrator

The Plan Administrator shall have the discretionary authority and power necessary to administer and meet its obligations under the Plan, including, without limitation, the following:

(a) Interpret the terms and provisions of the Plan.

(b) Decide all questions of eligibility for participation in the Plan.

(c) Make and enforce rules and regulations it deems necessary for the efficient administration of the Plan.

(d) Establish procedures by which Participants may apply for reimbursement under the Plan.

(e) Determine the rights under the Plan of any Participant applying for or receiving reimbursement.

(f) Reimburse all Participants entitled to reimbursement under the Plan in a timely manner.

(g) Administer the claim procedures provided for in this Article.

(h) Delegate specific responsibilities for the operation and administration of the Plan to any Employees or agents as it deems advisable.

(i) Maintain records pertaining to the Plan.

(j) Perform all acts necessary to meet the reporting and disclosure obligations imposed by Sections 101 through 111 of ERISA and the reporting obligations imposed by Section 6039D of the Code, to the extent applicable.

(k) Correct administrative and operational errors and omissions.

7.2 Administrative Services

The Plan Administrator shall enter into an administration agreement with the Claim Administrator, under which the Claim Administrator shall be given broad authority by the Plan Administrator to administer claims for reimbursement under the Plan and to render other administrative services on behalf of the Plan. The Claim Administrator shall review, interpret, and evaluate all claims for reimbursement under the Plan. However, the Claim Administrator shall have no power to modify any terms of the Plan or any benefit provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan. The Plan Administrator shall have the sole and final discretion regarding whether any expense is eligible for reimbursement under the Plan.
To the extent that these administrative responsibilities are assumed by the Claim Administrator under an administration agreement, the Employer and the Plan Administrator shall have no responsibility for these functions. The Plan Administrator may periodically amend the administration agreement or enter into similar agreements with any other Claim Administrator as the Plan Administrator shall in its discretion select.

7.3 Claim for Reimbursement

The Claim Administrator shall evaluate a claim for reimbursement and notify the claimant of the approval or disapproval, in accordance with the provisions of the Plan.

(a) Claims Evaluation. Any claimant whose claim for reimbursement under the Plan is denied, in whole or in part, shall be given notice of the denial within 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided the Plan Administrator both determines that such an extension is necessary owing to matters beyond the control of the Plan Administrator and notifies the claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected to be made. If such an extension is necessary owing to the failure of the claimant to submit the information required to decide the claim, the notice of extension shall describe the information still needed, and the claimant shall be granted 45 days from the receipt of the notice to provide the additional information. The Plan’s period for making the benefit determination shall be the 15-day period beginning on the date the claimant furnishes the additional information. If the claimant does not provide the additional information within 45 days from the receipt of the extension notice, the Plan Administrator may issue a denial of the claim within 15 days after the end of the 45-day period.

(b) Approval of Claim. Except as may be provided in the Plan, if a claim is approved, payment shall be made as soon as administratively feasible.

(c) Denial of Claim. If a claim is denied in whole or in part, the Plan Administrator shall provide the claimant with a written or electronic notification of the denial. The notice shall set forth the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, and describe any additional material or information necessary for the claimant to perfect the claim. The notice shall also describe the Plan’s review procedures and related time limits and will include a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following a denial on review. If the denial was based upon an internal rule, guideline, protocol, or other similar criterion, a copy shall be provided free of charge to the claimant upon request.

7.4 Special Rules for Non-Grandfathered Plans

This Plan is not a grandfathered plan under Health Care Reform. Accordingly, Participants must be provided with the following additional rights with respect to claims and appeals:

(a) A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this
As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

(b) In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale for the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

(c) The Plan cannot base decisions regarding the hiring, compensation, termination, or promotion of a claims adjudicator, medical expert, or similar individual upon the likelihood that the individual will support the Plan’s denial of benefits.

(d) Certain benefit determination notices and appeal notices may be required to be provided in a non-English language where a minimum number of Participants are literate only in the same non-English language. Further, the notices must include additional information such as information sufficient to identify the claim involved; the denial code, its corresponding meaning, and any standard used in denying the claim; and a description of the available internal appeals and external review processes.

(e) No court action may be brought by a claimant until exhausting the claim procedure provisions of the Plan. If the Plan fails to strictly adhere to the internal claim and appeal procedures prescribed by Health Care Reform, the claimant is deemed to have exhausted the internal claim and appeal procedures. As a result, the claimant may initiate an external review or file a legal proceeding.

(f) A Plan must offer an external review process. If the Plan is not subject to ERISA, the Plan may be subject to the applicable state external review processes for fully insured health plans and non-ERISA self-funded health plans. If the Plan is subject to ERISA, the applicable state external review processes may also be used if the state offers access to the processes for ERISA self-funded health plans. Otherwise, the Plan will offer an external review procedure that satisfies U.S. Department of Labor regulations.

7.5 Review of Claim Denial

If a claim for reimbursement is denied, in whole or in part, the claimant shall have the right to request that the Plan Administrator review the denial.

(a) Claimant’s Request for Review (or Appeal). To request review (or appeal), the claimant must file a written request for review with the Plan Administrator within 180 days following the denial of the claim. The claimant (or the claimant’s duly authorized representative) may submit written comments, documents, records, and other information relating to the claim to the Plan Administrator. The information shall be considered without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the claimant shall be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant’s claim for benefits.
(b) **Administrative Review.** The review shall not defer to the initial denial. The review shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial denial nor a subordinate of that individual.

(c) **Administrative Decision.** The Plan Administrator shall notify the claimant of the Plan’s determination on review within 60 days after the Plan’s receipt of the claimant’s request for a review of a denial. The Plan Administrator shall provide a claimant with a written or electronic notification of the Plan’s determination on review. The notice shall include the same information that must be included in the notification of the initial decision. The decision of the Plan Administrator on appeal shall be final and binding.

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**ARTICLE VIII: AMENDMENT AND TERMINATION**

8.1 **Amendment of the Plan**

The Plan Sponsor may amend the Plan at any time. No amendment shall reduce or eliminate a Participant’s right to receive reimbursement in accordance with the provisions of the Plan for Medical Expenses incurred before the date of amendment. Further, any amendment may be made retroactively to the extent permitted by the Code.

8.2 **Termination of the Plan**

Although the Plan Sponsor intends to continue the Plan indefinitely, the Plan Sponsor reserves the right to terminate or partially terminate the Plan at any time by action of its Board of Directors. If the Plan is terminated or partially terminated for any reason, this act shall not reduce or eliminate a Participant’s right to receive reimbursement in accordance with the provisions of the Plan for Medical Expenses incurred before the date of termination.

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**ARTICLE IX: MISCELLANEOUS PROVISIONS**

9.1 **Standard of Care**

The Plan Administrator shall administer the Plan in accordance with the terms of the Plan solely in the interest of the Participants and for the exclusive purpose of providing benefits to Participants and defraying the reasonable expenses of administration of the Plan. The Plan Administrator shall administer the Plan with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims.

The Plan Administrator shall not be liable for any act or omission relating to its duties under the Plan, unless the act or omission violates the standard of care described in this section. The Plan Administrator shall not be liable for any act or omission by another relating to the Plan.

9.2 **Uniformity of Treatment**

Any discretionary action taken under the Plan by the Plan Administrator shall be uniform in its application to similarly situated persons and shall be based upon the objective criteria set forth in the Plan.
9.3 **Nondiscrimination Rules**

If the Plan Administrator determines at any time that the Plan may not satisfy a nondiscrimination rule in the Code, the Plan Administrator may take whatever action it deems appropriate to assure compliance with the rule. Any action shall be taken uniformly with respect to similarly situated enrollees.

9.4 **Funding of Benefits**

Benefits under the Plan shall be paid from the Employer’s general assets. Nothing in the Plan shall be construed to require the Employer or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant.

9.5 **Governing Law**

This Plan shall be construed in accordance with ERISA, the Code, and, where not pre-empted, the laws of the state of Michigan.

9.6 **Form 5500**

Although the Plan has a separate Plan document, this Plan and the Employer’s group health Black Plan shall be considered a single plan for purposes of satisfying any obligation to file an IRS Form 5500. A single IRS Form 5500 is intended to be filed with regard to both plans.

9.7 **Summary Plan Description**

Each Participant shall be provided with a copy of the Plan document. The Plan document and the information in the “Participant’s Rights under ERISA” and “Basic Information about the Plan” sections are intended to serve as the Summary Plan Description.

9.8 **Patient Protection and Affordable Care Act**

Pursuant to IRS Notice 2013-54, the Plan shall be an “integrated” medical reimbursement plan under the “minimum value required” method. As a result, the market reforms of the Patient Protection and Affordable Care Act shall not apply to the Plan. Accordingly, the Plan shall maintain the following rules:

(a) Plan Sponsor shall offer a group health plan to the Participant that provides minimum value pursuant to Section 36B(c)(2)(C)(ii) of the Code.

(b) The Participant must be enrolled in a group health plan that provides minimum value as defined in subsection (a), regardless of whether Plan Sponsor maintains the plan or the plan is maintained by another employer (such as the employer of the Participant’s spouse).

(c) Only Employees who are enrolled in a group health plan described in subsection (b) may participate in the Plan.

(d) The Participant may permanently opt out of and waive future reimbursements once each Benefit Year. Upon termination of employment, the Participant shall forfeit any future reimbursements.
The terms of the Plan are intended to be consistent with IRS Notice 2015-87, which indicates that if a claim for reimbursement is for expenses regarding the Participant’s Dependent, the Dependent must also be enrolled in the group health plan as described in subsection (b) in order for the claim to be a Medical Expense under the Plan. That is, the Participant may not be enrolled in Employee-only (single) coverage under the group health plan.

ARTICLE X: DEFINITIONS

Certain words and phrases used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where these terms are used elsewhere in the Plan with the meanings assigned to them below, the terms usually will be capitalized, and where these terms are used with their common, non-technical meanings, the terms usually will not be capitalized (except when necessary for proper grammar).

10.1 Benefit Year

The term “Benefit Year” means each 12-consecutive-month period beginning January 1 and ending December 31.

10.2 Board of Directors

The term “Board of Directors” means the governing body of the Employer.

10.3 Business Associate

The term “Business Associate” means a person or entity that does the following:

(a) Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).

(b) Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

10.4 Claim Administrator

The term “Claim Administrator” means ADMINISTRATION SYSTEMS RESEARCH CORPORATION INTERNATIONAL (ASR), the firm retained by the Plan Administrator to handle the processing, payment, and settlement of benefit claims and other duties specified in a written administration agreement. ASR is not a fiduciary and does not insure that any medical expenses of Participants will be paid. If there is no Claim Administrator (including circumstances owing to the termination or expiration of the administration agreement with ASR, or if the term is used in connection with a duty not expressly assumed by ASR in a signed writing) the term shall mean the Plan Administrator.

10.5 COBRA

10.6 Code


10.7 Consolidated Omnibus Budget Reconciliation Act of 1985

The term “Consolidated Omnibus Budget Reconciliation Act of 1985” means a federal law that gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. See COBRA.

10.8 Covered Person

The term “Covered Person” means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan. This term includes Participants and their eligible Dependents.

10.9 Dependent

The term “Dependent” means an individual who is a spouse of an Employee or a dependent of an Employee as defined in Section 152 of the Code—determined without regard to Section 152(b)(1), (b)(2), and (d)(1)(B) of the Code—and who is enrolled in the Employer’s group health Black Plan. Further, the term “Dependent” also includes an Employee’s child as defined under Code Section 152(f)(1) who has not attained age 27 as of the end of the month or end of the calendar year (whichever time period is consistent with the Employer’s group health Black Plan), as provided by Code Section 105(b), as amended by the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010.

10.10 Employee

The term “Employee” means any person who, for tax purposes, is considered by the Employer to be a common-law employee of the Employer. If an independent contractor or a leased employee is subsequently characterized as a common-law employee of the Employer, that person shall not be eligible to participate in the Plan for any time period before the date on which the determination is made that that person is a common law employee of the Employer.

10.11 Employee Retirement Income Security Act of 1974

The term “Employee Retirement Income Security Act of 1974” means a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. See ERISA.

10.12 Employer

The term “Employer” means KALAMAZOO COLLEGE. It also means any related employers to the Plan Sponsor (within the meaning of Section 414 of the Code, or where there is at least a 25% common-ownership interest) who participate in the Employer’s group health Black Plan.

10.13 ERISA

10.14 **Health Insurance Portability and Accountability Act of 1996**

The term “Health Insurance Portability and Accountability Act of 1996” means a federal law that limits the use of waiting periods and health status exclusions; eliminates certain discriminatory exclusions, such as for self-inflicted injuries; and promulgates administrative simplification provisions. See HIPAA.

10.15 **HIPAA**


10.16 **Medical Expenses**

The term “Medical Expenses” means any expenses incurred by a Participant or the Participant’s Dependent for medical care that would be deductible under Section 213 of the Code (without regard for the 7.5% of adjusted gross income limitation).

10.17 **Participant**

The term “Participant” means an Employee who has satisfied the participation requirements under Article V and is enrolled in the Plan.

10.18 **PHI**

The term “PHI” means Protected Health Information. See Protected Health Information.

10.19 **Plan**

The term “Plan” means Kalamazoo College Employer-Funded Medical Reimbursement Plan, as periodically amended.

10.20 **Plan Administrative Functions**

The term “Plan Administrative Functions” means activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan. Plan Administrative Functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-plans such as vision and dental.

PHI for these purposes may not be used by or between the Plan or Business Associates of the Plan in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Plan Administrative Functions specifically do not include any employment-related functions.

10.21 **Plan Administrator**

The term “Plan Administrator” means KALAMAZOO COLLEGE, the named fiduciary responsible for the day-to-day operation and administration of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

10.22 **Plan Sponsor**

The term “Plan Sponsor” means KALAMAZOO COLLEGE.
10.23  **Protected Health Information**

The term “Protected Health Information” means information that is created or received by the Plan or a Business Associate of the Plan, and relates to the past, present, or future physical or mental health or condition of a Participant or the Participant’s Dependent; the provision of health care to a Participant or the Participant’s Dependent; or the past, present, or future payment for the provision of health care to a Participant or the Participant’s Dependent; and that identifies the Participant or the Participant’s Dependent or for which there is a reasonable basis to believe the information can be used to identify the Participant or the Participant’s Dependent (whether living or deceased). The following components of a Participant’s or the Participant’s Dependent’s information are considered to enable identification:

- Names
- Street address, city, county, precinct, or zip code
- Dates directly related to a Participant’s or the Participant’s Dependent’s receipt of health care treatment, including birth date, health facility admission and discharge dates, and date of death
- Telephone numbers, fax numbers, and electronic mail addresses
- Social Security numbers
- Medical record numbers
- Health plan beneficiary numbers
- Account numbers
- Certificate/license numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Device identifiers and serial numbers
- Web Universal Resource Locators (URLs)
- Biometric identifiers, including finger and voice prints
- Full face photographic images and any comparable images
- Any other unique identifying number, characteristic, or code

See PHI.

10.24  **Summary Health Information**

The term “Summary Health Information” means information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under a health plan. The information described in 45 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

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**ARTICLE XI: PARTICIPANT'S RIGHTS UNDER ERISA**

Participants in the Plan are entitled to certain rights and protections under ERISA.

11.1  **Plan Information and Benefits**

(a) Participants may examine without charge, at the Plan Administrator’s office, all documents governing the Plan, including summary plan descriptions and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the
Participants may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may charge a reasonable fee for these copies.

11.2 Continued Group Health Coverage

A Participant may continue health care coverage if there is a loss of coverage under the Plan as the result of a qualifying event. The Participant may have to pay for such coverage. The Continuation Coverage section contains the rules governing COBRA continuation coverage rights.

11.3 Plan Fiduciaries

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

11.4 Enforcement of Rights

If a Participant’s claim for reimbursement under the Plan is denied or ignored, in whole or in part, the Participant has a right to know why, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See the “Review of Claim Denial” section for more information.

Under ERISA, there are steps that a Participant can take to enforce the above rights. For instance, if a Participant requests materials from the Plan Administrator and does not receive them within 30 days, the Participant may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Participant up to $110 a day until the Participant receives the materials, unless the Plan Administrator could not send the materials owing to reasons beyond its control. If a Participant has a claim for benefits that is denied or ignored, in whole or in part, the Participant may file suit in a state or federal court. In addition, if the Participant disagrees with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, the Participant may file suit in federal court. If Plan fiduciaries misuse the Plan’s money, or if a Participant is discriminated against for asserting rights, the Participant may seek assistance from the U.S. Department of Labor, or may file suit in federal court. The court shall decide which party will pay court costs and legal fees. If the Participant is successful, the court may order the person being sued to pay these costs and fees, but if the Participant loses, the court may order the Participant to pay them (for example, if it finds that the claim is frivolous).

11.5 Assistance with Questions

The Participant should contact the Plan Administrator with any questions about the Plan. If a Participant has any questions about this statement (Your Rights Under ERISA) or about rights under ERISA, or if a Participant needs assistance in obtaining materials from the Plan Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration.
Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. A Participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272 or by viewing its Website at www.dol.gov/ebsa.
The use of the singular includes the plural where applicable and vice versa. The headings do not limit or extend the provisions of the Plan. Capitalized terms, except where capitalized solely for grammar, have the meaning provided in the Plan. Errors cannot cause the Plan to provide a benefit that a Participant or the Participant’s Dependent is not otherwise entitled to under the Plan. If a provision is unenforceable in a legal proceeding, the provision shall be severed solely for purposes of that proceeding and the remaining provisions of the Plan shall remain in full force.

Kalamazoo College has caused this amended and restated Plan to be effective as of 12:01 a.m. local time, January 1, 2019.

KALAMAZOO COLLEGE

[Signature]

Authorized Representative

[Signature]
Witness

3-20-19
Date

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ASR Health Benefits