Plan Document and
Summary Plan Description for the
Noble and Greenough School Health and Welfare
Benefit Wrap

- Your Health Care Benefits
- Your Health Reimbursement Arrangement ("HRA")
- Your Life Insurance and AD&D Benefits
- Your Disability Benefits
- Employee Assistance Program ("EAP")
- Other Insurance Benefits

EFFECTIVE DATE: 01/01/2014
Introduction

Noble and Greenough School (the “Employer” or “Company”) is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet provides information about your medical/prescription drug, dental, Health Reimbursement Arrangement, long-term disability benefits, basic group term life and accidental death and dismemberment benefits, Employee Assistance Program Benefit Programs. It serves as the Plan document and the Summary Plan Description (“SPD”) for the Noble and Greenough School Health and Welfare Benefit Wrap (“the Plan”).

Note: A separate SPD has been issued that describes information for the following Benefit Program(s):
403(b) Health Care and Dependent Care FSA.

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with the written plan document and disclosure requirements under the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended.

The “Benefit Programs” covered by this SPD are shown in Appendix A. For fully insured Benefit Programs, the insurance contracts or policies (including amendments and riders), plan descriptions, benefit summaries, schedule of benefits, the Certificate of Insurance or Certificate of Coverage and other descriptive documents relating to each Benefit Program (collectively, the “insurance certificates”) are incorporated herein by reference only to the extent they are the source of eligibility, benefits, claims procedures, or other substantive provisions of the Benefit Programs.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.
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Plan Overview

The Plan provides benefits to eligible employees and their dependents through each Benefit Program listed in Appendix A. Fully insured benefits are payable solely by the Insurer listed for the respective Benefit Program.

Your Eligibility

You are eligible for the Benefit Program(s) shown in Appendix A if you are a full-time active employee or a part-time employee who is normally scheduled to work 17.5 or more hours per week. Retirement DC plan: can join after 6 months from date of hire, unless coming from employment with 403(b) then can join right away. Need to work minimum of 17.5 hours per week. Life, LTD on contract salary, Life to include housing benefit.

The following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, persons hired on a seasonal or temporary basis, and other individuals who are not on the Employer payroll, as determined by the Employer, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

The definition of eligible dependents and other provisions, such as whether you may enroll your eligible dependents in a Benefit Program, are defined in the insurance certificates for each Benefit Program. Those provisions, and the definition of a dependent for each Benefit Program, are incorporated by reference herein.

Unless otherwise defined by the insurance certificate for a Benefit Program, your eligible dependents include:

- your legal spouse;
- your Domestic Partner of the same sex;
- your Domestic Partner of the opposite sex;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan;
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support);
- a step child as long as you are married to the child’s natural parent;
- a foster child residing in your household;
- a grandchild for whom you are in a parent-child relationship who resides with you;
• a child for whom you are the court-appointed legal guardian;
• your Domestic Partner’s child who resides with you;
• an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

In addition, an eligible dependent who lives outside the U.S. may be restricted from coverage unless the dependent has established his or her primary residence with you. If you have any questions regarding dependent coverage under a Benefit Program, check with the Insurer or Claims Administrator.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, the enrollment will be considered a late enrollment.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Employer, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other’s coverage, but only one of you may cover your dependent children. It is your responsibility to notify the Employer if your dependent becomes ineligible for coverage.

**When Coverage Begins**

To be eligible for a Benefit Program, you must satisfy the eligibility requirements described for that Benefit Program in the applicable insurance certificates and other materials provided for that Benefit Program. Unless otherwise stated in those materials, your coverage begins on the first day of employment. Coverage for your eligible dependents begins on the same day as your initial eligibility provided you enroll your dependents within 31 days of eligibility. Certain benefits, such as disability or life insurance, may require you to be actively at work in order to be initially eligible for a Benefit Program and for any change in coverage to take effect. See the materials provided by your Insurer to determine when this applies to you.

If you terminate employment and are subsequently rehired, you will need to satisfy any eligibility requirements to be covered under the Plan.

**Proof of Dependent Eligibility**

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent’s eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

**Your Contribution for Coverage**

Each year, the Employer will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Any required contribution amount will be provided to you by the
Employer in your enrollment materials. You may also request a copy of any required contribution amounts from the Plan Administrator.

For most benefits you pay the employee cost of Plan premiums through pre-tax payroll deductions each pay period; however, some Benefit Programs may require premiums to be paid with after-tax dollars. You must elect coverage for yourself in order to cover your eligible dependents. Your coverage for certain Benefit Programs may also be subject to deductibles, copayments, coinsurance, or other fees as described in the materials for the coverage you select.

**Enrolling for Coverage**

**New Hire Enrollment**

As a newly eligible employee, you will receive an Election Form and enrollment information when you first become eligible for benefits. For each Benefit Program, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Employer to deduct any required premiums from your pay through salary reduction.

The elections you make will remain in effect until the next December 31, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will be deemed to have elected no coverage or the default coverage designated by the Employer for a Benefit Program.

**Late Entrant**

An enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after cancelling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period to enroll in coverage.

**Annual Open Enrollment Period**

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your enrollment materials and Election Form will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on January 1 and stay in effect through December 31, the Plan Year, unless you have a qualifying change in status. The Plan Year may differ from the policy year of an insured benefit, with deductible and out-of-pocket expenses based on the policy year. You should refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies.

**Effect of Section 125 Tax Regulations on this Plan**

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those...
regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Employer nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the following:

- The date you have a qualifying change in status as described below; or
- The date you meet the Special Enrollment Rights criteria described below.

**Qualifying Change in Status**

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by Internal Revenue Code Section 125, or the regulations thereunder, the following events may be considered a change in status:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child’s eligibility;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Employer work location or home address that changes your overall benefit options and/or prices;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent’s coverage under this or another plan; or
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes in your election must be consistent with your change in status event. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change to the Plan Administrator as soon as possible, but no later than 31 days after the event occurs.

**Special Enrollment Rights**

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents’ other coverage). However, you must request
enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This “special enrollment right” exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Except as otherwise provided in the insurance certificate, your coverage under this Plan ends 1. termination ON or AFTER the 20th of the month, coverage will continue through the end of the month
2. termination PRIOR to the 20th of the month, coverage will end on day of termination.

Coverage may be extended under certain circumstances, such as when you take an approved leave of absence.

Coverage for your covered dependents ends on the date your coverage ends, or, if earlier, on the date your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Employer terminates this Plan or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

If your coverage under the Plan ends for reasons other than the Employer’s termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under a Benefit Program, coverage for you and your covered dependents will be canceled for that Benefit Program and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by
you or your covered dependent. You will receive 30 days advance written notice of any
cancellation of coverage to be made on a prospective basis.
The Plan reserves the right to recover from you and/or your covered dependents any benefits
paid as a result of the wrongful activity that are in excess of the contributions paid. In the event
the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation
coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work
In certain situations, coverage may continue for you and your dependents when you are not at
work, so long as you continue to pay your share of the cost. If you take an unpaid leave of
absence, you will need to make payment arrangements prior to the start of your leave. Your
payments will be made on an after-tax basis, unless you are on paid leave, in which case your
premium payments will continue to be deducted on a pre-tax basis. You should discuss with
Human Resources or your supervisor what options are available for paying your share of costs
while you are absent from work.

If You Take a Leave of Absence (FMLA)
If you take an approved FMLA leave of absence, your coverage will continue for the duration of
your leave, as long as you continue to pay your share of the cost as required under the
Employer’s FMLA Policy. Coverage for other benefits can be found in the insurance certificates
for the respective Benefit Programs in which you have enrolled.

If You Take a Military Leave of Absence
If you are absent from work due to an approved military leave, coverage may continue for up to
24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994
(USERRA) starting on the date your military service begins.
Coverage for other benefits can be found in the insurance certificates furnished by the Insurer
for the respective Benefit Programs in which you have enrolled and will be governed by the
provisions of USERRA.
Your Health Care Coverage

You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

The following health care Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Medical/Prescription Drug
- Dental

Participation

To become a participant in the above Benefit Program(s), you must meet all eligibility requirements and enroll in coverage. You may also enroll your dependents if they are eligible dependents as defined in the Insurer’s benefits booklets. You will automatically receive identification cards for you and your enrolled dependents when your enrollment is processed.

Benefits Provided

The benefits provided under each Benefit Program are more fully described in the Certificate of Insurance/Coverage and other benefits booklets provided by the Insurer.

Your health care benefits are delivered through a network of participating physicians, hospitals, and other providers who have agreed to provide services at a negotiated cost.

You may choose from several types of medical plans or programs of benefits under this Plan, including:

- an HMO (Health Maintenance Organization)
- a PPO (Preferred Provider Organization).

When you use network providers, the Plan pays the negotiated amount of covered expenses (after meeting any deductible) to your provider and there are no claim forms to complete. Certain medical options, such as an EPO or HMO, require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network health care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.

Certain medical options, such as an HMO or POS, may require you to select a primary care physician (“PCP”) to coordinate your care. If so, you may designate any PCP who participates in the network and who is available to accept you or your family members. For dependent children, you may designate a pediatrician as the PCP. You do not need prior authorization from the Insurer or your PCP to obtain access to obstetrical or gynecological care from a network professional who specializes in obstetrics or gynecology. The network professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a PCP, and for a list of participating primary care physicians, contact the Insurer at the telephone number or website shown on your identification card.

You may choose from several types of dental plans or programs of benefits under this Plan, including:
• a Dental Indemnity Program

When you use network providers, the Plan pays the negotiated amount of covered expenses (subject to applicable deductible and coinsurance) to your provider and there are no claim forms to complete. The provider will not balance bill you for the discount provided on the claims. Certain dental options, such as a DMO, may require services to be received only from network providers in order to be covered. You must use network providers in order to receive the maximum benefit payable under the Plan if you are enrolled in this type of plan.

For a listing of current network dental care providers (at no cost to you), contact the Insurer at the telephone number or website shown on your identification card.

Source of Payments

Benefits for covered services and expenses under the Benefit Program(s) listed above are paid by the Insurer and are guaranteed under the insurance contracts. Any cost-sharing provisions, such as your deductible, co-payment, or coinsurance, are set forth in the materials furnished by the Insurer.

Any required premiums for coverage will be shown in your enrollment materials. Your premiums will be deducted from your pay on a pre-tax basis.

Limitations and Exclusions

The materials for each Benefit Program contain information about limitations on benefits, covered preventive care services, prescription drugs, pre-authorizations required, utilization reviews required, obtaining emergency care, exclusions and expenses not covered, medical tests and procedures covered, any limits or caps on certain coverage, and relative costs for in-network and out-of-network services.

Continuation of Health Care Coverage through COBRA

If your health care coverage under the Plan ends for reasons other than the Employer's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). Health care coverage may continue at your own expense for a specific length of time. See the section entitled “Your HIPAA/COBRA Rights” for additional information. Please note that if your Employer has less than 20 employees, Federal COBRA legislation may not apply to you, but you may instead be eligible for COBRA benefits available through your state. Contact your Insurer for additional information as these provisions vary from state to state.

For More Information

If you have a question about a covered service, or for more information about a specific procedure, coverage of new drugs, tests, or experimental or investigative treatments, you should consult the materials furnished by the Insurer for the coverage in which you are enrolled.
Your Health Reimbursement Arrangement (“HRA”)

An HRA is an arrangement funded entirely by the Employer. The purpose of the HRA is to reimburse you, up to certain limits, for you and your covered dependents’ eligible out-of-pocket health care expenses, as explained below. Reimbursements paid by the HRA generally are excluded from taxable income.

How the HRA Works

Once you enroll in coverage, the Employer will establish an “HRA Account” in your name to keep a record of the amounts available to you for reimbursement of eligible health care expenses. This account is merely a recordkeeping account; it is not funded nor does it accrue earnings or interest of any kind. Reimbursements are made from the general assets of the Employer.

Before the start of each Plan Year, the Employer will determine the amount that may be credited during that Plan Year to your HRA. This amount will be shown in your enrollment materials. You do not contribute any money to the HRA.

The total annual Employer contribution amount will be credited to your HRA Account on your first day of coverage. If you first enroll in coverage during annual enrollment, your HRA funds will be available for reimbursement the first day of the next Plan Year.

Your HRA will be reduced by any amount paid to you, or for your benefit, for eligible health care expenses. The amount available for reimbursement as of any given date will be the total amount credited to your HRA as of such date, reduced by any prior reimbursements made to you. You may submit eligible expenses that you incur during a coverage period. Expenses are incurred when the service is performed or received.

Your HRA may only be used to reimburse the annual deductible for you and your covered dependents under the Plan.

You receive a new Employer contribution each year you remain a participant in the HRA option. Any unreimbursed amount will be forfeited at the end of the coverage period.

How to File a Claim

When you (or your medical provider) submit eligible medical expenses incurred during a coverage period, reimbursement will automatically be made from your available HRA balance.

Claim forms are available from the Claims Administrator. Receipts submitted with a claim form should include the name and address of the provider, the date of service, the amounts being submitted for reimbursement, and any other supporting information such as an Explanation of Benefits (EOB) from your insurance carrier or provider. You will be advised of the cut-off date for submitting claims for a coverage period.

Benefit Payment

When you file a claim, the Claims Administrator will make payment directly to you. You can be reimbursed for eligible expenses as they are incurred, up to the maximum HRA amount available at the time your claim is submitted.

Maintaining Records

You should keep all receipts to document expenses reimbursed to you from the HRA. If a payment must be verified at a later date, the Claims Administrator may request receipts from
you to ensure that payment was made for a qualified expense. If a claim for benefits is denied, you have the right to appeal (see “Claims Procedure” for additional information) with the Claims Administrator.

**Ineligible Claims**

If the Claims Administrator determines that you have submitted an ineligible claim or you do not provide required documentation upon request, your transaction will be considered an overpayment. You will have 30 days from the date you receive notification of the overpayment to provide additional information or repay the full amount of the overpayment. Otherwise, any overpayment will be deducted from future claim reimbursements. If the overpayment remains at year-end, it must be reported as imputed income on your Federal tax return.

**When Participation Ends**

Your participation in the HRA ends when you terminate employment. You may continue to access your HRA balance as described below.

If you terminate employment, your available HRA balance can be used only for eligible expenses incurred before the date of your termination. Any remaining amounts will be forfeited.

If you enroll in COBRA continuation coverage and elect an HRA medical option, you can continue to use your remaining HRA balance to pay for eligible expenses. Additionally, if you enroll in the HRA under COBRA, you may also be assessed administrative fees as permitted by law. If you are eligible for COBRA continuation coverage and decline coverage or do not enroll in an HRA medical option, you will forfeit any unreimbursed HRA funds.

If you divorce, your HRA balance will stay with you. If your ex-spouse enrolls in COBRA coverage and elects an HRA medical option, a separate HRA contribution will be available to him or her. You will receive additional information from the Claims Administrator when you notify the Plan of your divorce.

In the event of your death, if your spouse is eligible for continued coverage and elects an HRA medical option under the Plan, your spouse may continue to use your remaining HRA balance for reimbursement of eligible expenses for the remainder of the coverage period following your death.

**Health Care Flexible Spending Account and HRA**

The HRA is different from a Health Care Flexible Spending Account even though both may reimburse similar expenses. If you participate in both a Health Care Flexible Spending Account and an HRA, eligible expenses will be first reimbursed as described in your enrollment materials.

**For More Information**

For additional information about your HRA, contact the Claims Administrator or refer to your enrollment materials.
Your Life and Accidental Death & Dismemberment ("AD&D") Coverage

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Group Term Life Insurance
- AD&D Insurance

Participation
You must meet all eligibility requirements for coverage in order to become a participant. Enrollment in basic coverage is automatic.

Benefits Provided
The benefits and amounts of coverage provided under each Benefit Program are more fully described in the materials provided to you by the Insurer. Life insurance benefits are paid in the event of the death of a covered participant. AD&D benefits are paid if a covered participant becomes dismembered or seriously injured as the result of a covered accident. You will need to designate a beneficiary to receive benefits in the event of your death.

Source of Payment
Group Term Life Insurance and AD&D benefits are paid by the Insurer and are guaranteed under the applicable insurance contracts. The Company pays the full cost of your basic coverage. You are not required to make any contributions.

Plan Limitations and Exclusions
You should refer to the materials provided by the Insurer for information concerning any limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, age reductions, or reductions for other benefits that may apply.

Coverage Continuation
If your Group Term Life Insurance coverage ends for any reason other than death, you may have a right to continue your insurance under an individual policy. You should consult your Certificate of Insurance for additional information about continuing your coverage as there may be time limits for making this decision once your coverage under the Plan ends.

For More Information
Consult your Certificate of Insurance or benefits booklets for additional questions about your coverage.
Your Disability Benefits

The following Benefit Programs are fully insured and administered by the Insurer(s) listed in Appendix A:

- Long-Term Disability (LTD) Benefits – ER Paid
- Mandatory Long-Term Disability (LTD) Benefits – EE Paid

Participation

Your LTD coverage begins after you satisfy all eligibility requirements for coverage. Enrollment is automatic - no action is required on your part other than completing an application where required. You must also satisfy any required elimination period defined in the Insurer's materials before LTD benefits are payable.

Your LTD coverage begins after you satisfy all eligibility requirements for coverage. You are required to enroll in coverage. You must also satisfy any required elimination period defined in the Insurer’s materials before LTD benefits are payable. The associated premium costs for coverage will be shown on your Election Form when you first enroll in the Plan. You pay the entire cost of this coverage.

Benefits Provided

Your Certificate of Insurance defines when you are considered disabled. Generally, you are considered disabled when you are unable to perform with reasonable continuity the material duties of your own occupation due to physical disease, injury, or similar disorders.

LTD benefits are payable following an elimination period of 180 days. The amount of your LTD benefit, determined by your employee classification, is shown in your Certificate of Insurance.

You must be under the direct and continuous care of a licensed physician throughout the period for which disability benefits are paid. In order to continue receiving benefits, you are required to submit evidence, as requested, to support your disability claim. You may also be required to apply for Social Security disability benefits during the fifth month of your disability and, if necessary, appeal a denied claim.

Source of Payment

All disability benefits described above are paid by the Insurer and are guaranteed under the applicable insurance contract(s) or policies.

Payment of Benefits

The Insurer is the Claims Administrator and is authorized to handle the day-to-day administrative tasks and pay claims. The Insurer may obtain the services of a licensed physician who will have the full authority and discretion to determine whether an absence is due to the same or related condition.

Offset of Other Benefits

If you become eligible for any disability benefits under state law or disability fund, Workers’ Compensation, the Jones Act or any similar laws, state or Federal government income benefits (excluding military pensions), any self-insured, group, or individual pension plan to which the Employer contributes, or if you become entitled to Social Security disability benefits, your
disability benefits may be reduced by the amount of benefits you receive, or are entitled to receive, as the result of your disability.

Limitations and Exclusions

No benefits will be payable for any period in which: 1) you engage in any occupation or perform any work for compensation or profit, except approved rehabilitative employment; 2) you are not under the continuous care of a licensed physician; or 3) you are determined not to be disabled.

You should refer to the materials provided by the Insurer for information concerning any additional limitations, waiting periods before coverage begins, maximum benefits payable, when coverage ends, exclusions, taxability of benefits, age reductions, or reductions for other benefits that may apply.

Claims and Appeals

If your claim for disability benefits is denied, you have the right to file an appeal with the Insurer, as described in your Certificate of Insurance and other materials provided by the Insurer. If your claim for benefits is denied, the Insurer will send you written notice of denial which will include the reasons for the decision and other supporting information used to make its decision. Any appeal of a denied claim must be filed within the required time frames specified in the group policy and your Certificate of Insurance.

For More Information

Consult your Certificate of Insurance or benefits booklets for additional questions about your disability coverage.
Your Employee Assistance Program ("EAP")

The EAP Benefit Program is fully insured and administered by the Insurer listed in Appendix A.

Participation
You are automatically enrolled in the EAP after you meet all eligibility requirements for coverage as described in the Insurer’s materials. No action is required on your part to participate.

Benefits Provided
The benefits provided under the EAP are more fully described in the materials provided to you by the Insurer. The EAP offers short-term counseling and referral services to you and your eligible dependents.

Source of Payment
Benefits under the EAP are paid by the Insurer and are guaranteed under the applicable insurance contract. The Employer pays the full cost of your coverage. You are not required to make any contributions.

Plan Limitations and Exclusions
You should refer to the materials provided by the Insurer for information concerning any limitations or exclusions that may apply to your coverage.

For More Information
If you have a question about the EAP, you should consult your Certificate of Insurance or other materials provided by the Insurer.
Flexible Spending Account

The following Benefit Program is fully insured and administered by the Insurer listed in Appendix A:

- Flexible Spending Account

Participation

To become a participant in the Flexible Spending Account Benefit Program, you must meet all eligibility requirements and enroll in coverage. Your eligible dependents are also automatically enrolled in coverage.

Benefits Provided

The benefits provided under the Flexible Spending Account Benefit Program are more fully described in the materials provided to you by the Insurer.

Source of Payment

Benefits under the program are paid by the Insurer and are guaranteed under the applicable insurance contract.

Any required premiums for coverage will be shown on your Election Form. Your premiums are deducted on a pre-tax basis.

Plan Limitations and Exclusions

You should refer to the materials provided by the Insurer for information concerning any limitations, exclusions, or reduction for other benefits that may apply to your coverage.

For More Information

If you have any questions about the Flexible Spending Account Benefit Program, you should consult your Certificate of Insurance or other materials provided by the Insurer.
Long Term Care
The following Benefit Program is fully insured and administered by the Insurer listed in Appendix A:

- Long Term Care

Participation
You are automatically enrolled in the Long Term Care Benefit Program after you meet all eligibility requirements for coverage as described in the Insurer’s materials. No action is required on your part to participate. You may also elect to enroll your eligible dependents.

Benefits Provided
The benefits provided under the Long Term Care Benefit Program are more fully described in the materials provided to you by the Insurer.

Source of Payment
Benefits under the program are paid by the Insurer and are guaranteed under the applicable insurance contract. The Employer pays the full cost of your coverage. You are not required to make any contributions.

Any required premiums for coverage will be shown on your Election Form. Your premiums are deducted on an after-tax basis.

Plan Limitations and Exclusions
You should refer to the materials provided by the Insurer for information concerning any limitations, exclusions, or reduction for other benefits that may apply to your coverage.

For More Information
If you have any questions about the Long Term Care Benefit Program, you should consult your Certificate of Insurance or other materials provided by the Insurer.
Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Insurer or Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is a Federal law. This Summary Plan Description is issued in accordance with ERISA and may not include language or certain mandated coverage required by state insurance laws. State mandated coverage may be addressed separately in the insurance certificates provided by the Insurer.

Plan Sponsor and Administrator

Noble and Greenough School is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

**Plan Administrator**
Noble and Greenough School
10 Campus Drive
Dedham, MA 02026
781-326-3700

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Employer. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Employer, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.
In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan.

For fully insured benefits, unless otherwise expressly provided in the insurance policy or contract governing a Benefit Program, the Insurer shall be the Plan Administrator and Named Fiduciary only with respect to the benefits provided through the insurance policy or contract. The Insurer shall be responsible for determining eligibility for and the amount of benefits payable under the Benefit Program, and for prescribing claims procedures to be followed by Participants. The Insurer shall also be responsible for paying claims.

**Plan Year**

The Plan Year is January 1 through December 31.

Note: An insured benefit may use a policy year that differs from the Plan Year, with deductible and out-of-pocket expenses based on the policy year. Please refer to the insurance certificate and other materials provided by the Insurer to determine if a different policy year applies to certain annualized benefits.

**Type of Plan**

This Plan is a called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

**Identification Numbers**

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 04-2104784   PLAN NUMBER: 501

**Plan Funding and Type of Administration**

Funding and administration of the Plan is as follows.

<table>
<thead>
<tr>
<th>Type of Administration</th>
<th>The Plan is administered by the Employer through an arrangement with Insurers and third-party (claims) administrators. Insured benefits will be payable solely by the Insurer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>The Employer and employees both contribute to the Plan. Premiums are paid to the Insurers for fully insured Benefit Programs and benefits will be paid by the Insurer in accordance with the applicable insurance contract/policy.</td>
</tr>
</tbody>
</table>

Funding for this Plan shall consist of an aggregation of the funding for all Benefit Programs. The Employer shall have the right to insure any benefits under this Plan, to establish any fund or trust for the payment of benefits under this Plan, or to do neither and pay benefits under this Plan from its general assets, either as mandated by law or as the Employer deems advisable. In addition, the Employer shall have the right to alter, modify, or terminate any method or methods used to fund the payment of benefits under this Plan, including, but not limited to, any trust or insurance policy.
If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the Insurer.

**Insurers/Claims Administrators**

For fully insured Benefit Programs, the Insurer is responsible for administering benefits and paying claims. They may contract with a separate Claims Administrator to process claims. You may contact the Insurer/Claims Administrator directly, using the information listed below.

While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan Documents always control, even if their terms conflict with information given to you by an Insurer or other service provider.

**Medical/Prescription Drug Benefits**

Blue Cross Blue Shield of Massachusetts
Landmark Center
401 Park Drive
Boston, MA 02215-3326
800-262-2583
www.bluecrossma.com

**HRA Benefits**

HRC Total Solutions
111 Charles Street
Manchester, NH 03101
603-647-1147
www.hrcts.com

**Dental Benefits**

Blue Cross Blue Shield of Massachusetts
Landmark Center
401 Park Drive
Boston, MA 02215-3326
800-262-2583
www.bluecrossma.com

**Group Term Life Insurance Benefits**

Assurant Employee Benefits
One Research Drive
Suite 305
Westborough, MA 01581
800-345-5705
www.assurant.com
Accidental Death & Dismemberment Benefits
Assurant Employee Benefits
One Research Drive
Suite 305
Westborough, MA 01581
800-345-5705
www.assurant.com

LTD Benefits
Assurant Employee Benefits
One Research Drive
Suite 305
Westborough, MA 01581
800-345-5705
www.assurant.com

Employee Assistance Program
ESI Employee Assistance Group
55 Chamberlain Street
Wellsville, NY 14895
800-225-2527
www.theEAP.com

Flexible Spending Account
HRC Total Solutions
111 Charles Street
Manchester, NH 03101
603-647-1147
www.hrcts.com

Long Term Care
UNUM Life Insurance Company of America
2211 Congress Street
Portland, ME 04122
800-635-5597
www.unum.com

Agent for Service of Legal Process
For disputes arising under any fully insured Benefit Program, Service of Legal Process may be made upon the Insurer listed above. Service of Legal Process may also be served upon:
Noble and Greenough School
10 Campus Drive
Dedham, MA 02026
781-326-3700
Service of Legal Process may also be served on the Plan Administrator.

**No Obligation to Continue Employment**
The Plan does not create an obligation for the Employer to continue your employment or interfere with the Employer's right to terminate your employment, with or without cause.

**Non-Alienation of Benefits**
With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator or, where applicable, the Insurer, has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator or Insurer.

**Severability**
If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

**Payment of Benefits to Others**
The Insurer/Claims Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

**Expenses**
All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

**Fraud**
No payments under the Plan will be made if you or a provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Insurer/Claims Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. If you or a covered dependent attempts or commits fraud upon the Plan, your coverage may be terminated and you may be subject to disciplinary action by the Employer, up to and including termination of employment.

**Indemnity**
To the full extent permitted by law, the Employer will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative (“Plan Administration Employee”) of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

**Compliance with State and Federal Mandates**
Each Benefit Program will comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA), the Women’s Health and Cancer Rights Act of
1998, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle’s Law (if applicable), and Title I of GINA (prohibiting the use of genetic information to discriminate with respect to health insurance premiums, contributions or other restricted purposes).

Refund of Premium Contributions
For fully insured Benefit Programs, the Plan will comply with DOL guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) of insurance premiums. Where any refund is determined to be a plan asset to the extent amounts are attributable to participant contributions, such assets will be: 1) distributed to current plan participants within 90 days of receipt, 2) used to reduce participants’ portion of future premiums under the Plan (e.g., premium holiday); or 3) used to enhance future benefits under the Plan. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Non-discrimination
In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan
The Employer expects that the Plan will continue indefinitely. However, the Employer has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time. The Employer may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.
Claims Procedures/Coordination of Benefits

This section describes what you must do to file or appeal a claim for services. It also describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Claims and Appeals

For fully insured Benefit Programs, the claims procedures, including issues related to payment, preauthorization approval, or utilization review, as well as the time frames for submitting claims, are set forth in the insurance certificates.

If your claim is denied and you disagree and want to pursue the matter, you must file a First Level Appeal with the respective Insurer. You or your authorized representative may appeal a denied claim within the time frame provided in the insurance certificates for that Benefit Program. Different time frames apply to healthcare claims and disability-related claims. You will have the right to submit for review, written comments, documents, records, and other information related to the claim; and to request, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The Insurer, acting on behalf of the Plan, has full and exclusive authority and discretion to construe and interpret the provisions of the Program, to determine questions of coverage, and entitlement to and termination of benefits, and to make factual findings. If the Insurer denies your claim (in whole or in part) during a First Level Appeal, you may file a Second Level Appeal. If after such review, the Insurer continues to deny the claim in full or in part, you will be notified of the decision in writing.

The Insurer’s decision will include specific reasons for the decision, written in a manner calculated to be easily understood, with specific references to the Benefit Program’s provision or provisions, including any internal rules, guidelines, protocol, or other similar criterion relied upon, on which the appeal decision is based. It will also include a statement of your right to access and receive copies of all documents, records, and other information relevant to your appeal. You will also be provided a statement advising that you are entitled to bring civil action in Federal court under Section 502(a) of ERISA.

Exhaustion Required

The decision of the Insurer for fully insured Benefit Programs shall be final and conclusive on all persons claiming benefits under the Benefit Program, subject to applicable law. No other actions may be brought by any person until an appeal for denied benefits has been brought and been denied (or deemed denied) as described above under the respective claims procedure. You must exhaust all remedies available to you before bringing legal action. You cannot take any other steps unless and until you have exhausted all appeals. For example, if your claim is denied and you do not use the appeals procedures, the denial of your claim will be conclusive and cannot be challenged, even in court.

Non-Duplication of Benefits / Coordination of Benefits

If you (or an eligible dependent) are covered by another employer’s plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.
The Insurer is responsible for ensuring that eligible expenses are coordinated with benefits from:

- other employers’ plans;
- certain government plans; and
- motor vehicle plans when required by law.

The Insurer may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

**Health Care Coverage Coordination with Medicare**

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first (“primary”) is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer’s plan to pay first and Medicare pays second (“secondary”). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer’s coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- **End-stage renal disease**—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.

- **Mandated coverage under another group plan**—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

**Subrogation and Reimbursement**

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer has a right to subrogation and reimbursement. Subrogation applies when the Insurer has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer of each fully insured Benefit Program. The Insurer shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer to facilitate enforcement of its rights and interests.

These provisions shall not apply where subrogation is specifically prohibited by enforceable law.
Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, 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 copies of the latest annual report (Form 5500 Series), if applicable, 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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free-of-charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request the certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it 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, after you exhaust your appeals, 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. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan’s decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.
Your HIPAA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights as they pertain to your health insurance benefits. You will receive a separate “Notice of Privacy Provisions” from the Insurer which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan Sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan Sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Insurer involved with the PHI in question. The Insurer will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Employer or Plan Sponsor with respect to such information. The Employer or Plan Sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan’s use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The
HIPAA Plan’s policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan Sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

Certificate of Creditable Coverage

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event (See Continuing Health Care Coverage through COBRA below.)

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate never will cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all covered persons in a family who are losing coverage at the same time.

If you need to establish creditable coverage to reduce any pre-existing exclusion imposed by any subsequent health plan for mental health/substance abuse treatment and/or prescription drugs, an alternative certificate also is available by request.

To request another copy of the standard certificate and/or the alternative certificate, contact the Insurer within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Insurer may provide this information by phone.
Your COBRA Continuation Coverage Rights

Continuing Health Care Coverage through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Employer is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same healthcare coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue healthcare benefits upon the occurrence of a qualifying event that would otherwise result in such person losing healthcare benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Healthcare coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

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

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of COBRA coverage in addition to the 18-month continuation period (for a total of 29 months of coverage from the date of the qualifying event). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period (including a child born or placed for adoption with you); and
• he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
• he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation
Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:
• death;
• divorce or legal separation;
• eligibility for Medicare coverage; or
• dependent child’s loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus 11 month extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications
If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation, or a dependent child’s loss of eligibility under the Plan, you or your dependent must notify the Employer within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage by completing and returning your COBRA enrollment form.

NOTE: If you have a new child during the COBRA continuation period by birth, adoption or placement for adoption, your new child is entitled to the status of a qualified beneficiary. As such, your new child is entitled to receive coverage upon his or her date of birth, date of adoption or date placement for adoption is made and you become legally obligated to provide
support for the child, provided you enroll the child within thirty (30) days of the child’s birth/adoption/placement.

Cost of COBRA Coverage
You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments
Each qualified beneficiary may make an independent COBRA coverage election. You elect coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month’s premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier’s check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA
If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage.

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends
COBRA coverage for a covered individual will end when any of the following occur:
The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).

The maximum period of COBRA coverage, as it applies to the qualifying event, expires.

The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plan’s pre-existing condition exclusion. If the individual does not have enough creditable coverage to meet the new plan’s requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage, or 36 months.

The individual becomes entitled to Medicare.

The Employer terminates its group health plan coverage for all employees.

Social Security determines that an individual is no longer disabled during the 11-month extension period.

**Additional COBRA Election Period.** The Trade Act of 2002 provides an additional COBRA election period for certain eligible Trade Adjustment Assistance (“TAA”) recipients. If you did not elect continuation coverage under the regular COBRA election period, described above, you may elect continuation coverage within the 60-day period that starts on the first day of the month when you are determined to have met the definition of an eligible TAA recipient. However, such election may not be made later than six (6) months after the date you lost coverage as a result of your separation from employment that resulted in you becoming an eligible TAA recipient.
Definitions

COBRA
The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of healthcare coverage in certain circumstances for Employers with 20 or more employees. Small Employers may be subject to individual state COBRA provisions.

Dependent
The definition of a dependent is defined in the insurance certificate and other materials provided by the Insurer. Under the PPACA, your dependent for health insurance coverage includes your child under age 26, regardless of financial dependency, residency with you, marital status, or student status.

Your “child” includes:

- Your biological child;
- Your legally adopted child (including any child under age 18 placed in the home during a probationary periods in anticipation of the adoption where there is a legal obligation for support;
- A child for whom you are the court-appointed legal guardian; or
- An eligible child for whom you are required to provide coverage under the terms of a QMCSO or NMSN, as defined below.

Certain states may impose a different definition of dependent that extends coverage beyond age 26. Your employer also may elect a more generous definition of dependent or apply the above definition to other Benefit Programs. For questions regarding dependent eligibility, refer to your insurance certificate.

Employee
A person who is a fulltime employee and who is regularly scheduled to work for the Employer in an employer-employee relationship. The definition of an eligible employee is defined in the Plan Overview.

Election Form
The form used by employees to elect to participate in a Benefit Program and to authorize payment of premiums for such Benefit Program, where applicable.

ERISA
The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Family and Medical Leave Act
The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant’s home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant’s own serious health condition; or
- any qualifying exigency arising from an employee’s spouse, son, daughter, or parent being a member of the military on “covered active duty”. Additional military caregiver
leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Employer for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Employer has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Employer. Various states also have enacted similar legislation for their residents. Covered employers must comply with the Federal or state provision that provides the greater benefit to their employees. If you have questions regarding your eligibility for FMLA coverage or your state’s family medical leave provisions, if applicable, contact your Employer.

GINA

HIPAA

HITECH
The Health Information Technology for Economic and Clinical Health Act, as amended.

Insurer
Any insurance company that fully insures (or partially insures) any benefit provided by this Plan or any Benefit Program.

Leased Employee
Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Medicare
The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

NMHPA
The Newborns’ and Mother’s Health Protection Act of 1996, as amended. Group health plans and health insurance issuers 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Participant
An eligible employee who elects to participate in the Plan by completing the necessary Election Form on a timely basis, as provided by the Plan Administrator.

PPACA
The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.
Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee’s child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994; a Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA

The Women’s Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.
Adoption of the Plan

The Noble and Greenough School Health and Welfare Benefit Wrap, as stated herein, is hereby adopted as of 01/01/2014. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this __________ day of _________________________________. 201.

BY: ________________________________

TITLE: ________________________________
APPENDIX A

BENEFIT PROGRAMS OFFERED: MEDICAL/PRESCRIPTION DRUG, DENTAL, LONG-TERM DISABILITY INSURANCE COVERAGE, GROUP TERM LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE COVERAGE, EMPLOYEE ASSISTANCE PROGRAM, HEALTH REIMBURSEMENT ARRANGEMENT, FLEXIBLE SPENDING ACCOUNT AND LONG TERM CARE.

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<th>NAME OF INSURER/ CLAIMS ADMINISTRATOR</th>
<th>POLICY OR CONTRACT NUMBER(S)</th>
<th>BENEFITS PROVIDED</th>
<th>ELIGIBILITY</th>
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Model General Notice Of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

**Introduction**

You’re getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

**What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren’t required to pay] for COBRA continuation coverage.

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your spouse dies;
• Your spouse’s hours of employment are reduced;
• Your spouse’s employment ends for any reason other than his or her gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.

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

• 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 parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a “dependent child.”

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

• The end of employment or reduction of hours of employment;
• Death of the employee;
• Death of the employee;[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer]; or
• The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all 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 within 60 days [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to: [Enter name of appropriate party]. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.]

How is COBRA continuation 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.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.]

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]
Commonwealth of Massachusetts
Department of Mental Health

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION* ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

*Protected Health Information (PHI)

PLEASE REVIEW IT CAREFULLY

Notice Effective Date: December 15, 2010
Version 6

Privacy
The Department of Mental Health (DMH) is required by state and federal law to maintain the privacy of your protected health information (PHI). PHI includes any identifiable information about your physical or mental health, the health care you receive, and the payment for your health care.

DMH is required by law to provide you with this notice to tell you how it may use and disclose your PHI and to inform you of your privacy rights. DMH must follow the privacy practices as set forth in its most current Notice of Privacy Practices.
This notice refers only to the use/disclosure of PHI. It does not change existing law, regulations and policies regarding informed consent for treatment.

Changes to this Notice
DMH may change its privacy practices and the terms of this notice at any time. Changes will apply to PHI that DMH already has as well as PHI that DMH receives in the future. The most current privacy notice will be posted in DMH facilities and programs, and on the DMH website (www.state.ma.us/dmh), and will be available on request. Every privacy notice will be dated.
How Does DMH Use and Disclose PHI?
DMH may use/disclose your PHI for treatment, payment and health care operations without your authorization. Otherwise, your written authorization is needed unless an exception listed in this notice applies.

Uses/Disclosures Relating to Treatment, Payment and Health Care Operations
The following examples describe some, but not all, of the uses/disclosures that are made for treatment, payment and health care operations.

For treatment - Consistent with its regulations and policies, DMH may use/disclose PHI to doctors, nurses, service providers and other personnel (e.g., interpreters), who are involved in delivering your health care and related services. Your PHI will be used to help make a determination on your application for DMH services, to assist in developing your treatment and/or service plan and to conduct periodic reviews and assessments. PHI may be shared with other health care professionals and providers to obtain prescriptions, lab work, consultations and other items needed for your care. PHI will be shared with DMH service providers for the purposes of referring you for DMH services and then for coordinating and providing the DMH services you receive.

To obtain payment - Consistent with the restrictions set forth in its regulations and policies, DMH may use/disclose your PHI to bill and collect payment for your health care services. DMH may release portions of your PHI to the Medicaid or Medicare program or a third party payor to determine if they will make payment, to get prior approval and to support any claim or bill.

For health care operations - DMH may use/disclose PHI to support activities such as program planning, management and administrative activities, quality assurance, receiving and responding to complaints, compliance programs (e.g., Medicare), audits, training and credentialing of health care professionals, and certification and accreditation (e.g., The Joint Commission).

Appointment Reminders
DMH may use PHI to remind you of an appointment or to provide you with information about treatment alternatives or other health related benefits and services that may be of interest to you.

Uses/Disclosures Requiring Authorization
DMH is required to have a written authorization from you or your personal representative with the legal authority to make health care decisions on your behalf for uses/disclosures beyond treatment, payment and health care operations unless an exception listed below applies. You may cancel an authorization at any time, if you do so in writing. A cancellation will stop future uses/disclosures except to the extent DMH has already acted based upon your authorization.
Exceptions

- For guardianship or commitment proceedings when DMH is a party
- For judicial proceedings if certain criteria are met
- For protection of victims of abuse or neglect
- For research purposes, following strict internal review
- If you agree, verbally or otherwise, DMH may disclose a limited amount of PHI for the following purposes:
  - **Clergy** – Your religious affiliation may be shared with clergy
  - **To Family and Friends** – DMH may share information directly related to their involvement in your care, or payment for your care
- To correctional institutions, if you are an inmate
- For federal and state oversight activities such as fraud investigations, usual incident reporting, and protection and advocacy activities
- If required by law, or for law enforcement or national security
- To EOHHS and/or its agencies, such as MassHealth, DCF, DDS, DYS, DTA and DPH for functions including service delivery, eligibility and program management.
- To avoid a serious and imminent threat to public health or safety
- For public health activities such as tracking diseases and reporting vital statistics
- Upon death, to funeral directors and certain organ procurement organizations

**Your Rights**

You, or a personal representative with legal authority to make health care decisions on your behalf, have the right to:

- Request that DMH use a specific address or telephone number to contact you. DMH is not required to comply with your request.
- Obtain, upon request, a paper copy of this notice or any revision of this notice, even if you agreed to receive it electronically.
- *Inspect and copy PHI that may be used to make decisions about your care. Access to your records may be restricted in limited circumstances. If you are denied access, in certain circumstances, you may request that the denial be reviewed. Fees may be charged for copying and mailing.
- *Request additions or corrections to your PHI. DMH is not required to comply with a request. If it does not comply with your request, you have certain rights.
- *Receive a list of individuals who received your PHI from DMH (excluding disclosures that you authorized or approved, disclosures made for treatment, payment and healthcare operations and some required disclosures).
- *Ask that DMH restrict how it uses or discloses your PHI. DMH is not required to agree to a restriction.

* These requests must be made in writing
Record Retention
Your individual records relating to DMH provided care and services will be retained at a minimum for 20 years from the date you are discharged from inpatient care and/or from the applicable community services. After that time, your records may be destroyed.

To Contact DMH or to File a Complaint

If you want to obtain further information about DMH's privacy practices, or if you want to exercise your rights, or you feel your privacy rights have been violated, or you want to file a complaint, you may contact: DMH Privacy Officer, Department of Mental Health, 25 Staniford Street, Boston, MA 02114, Phone: 617-626-8160, Fax: 617-626-8131, E-mail: PrivacyOfficer@dmh.state.ma.us. A complaint must be made in writing.

You also may contact a DMH facility's medical records office (for that facility’s records), a DMH program director (for that program’s records), your site office (for case management records), or the human rights officer at your facility or program, for more information or assistance.

No one may retaliate against you for filing a complaint or for exercising your rights as described in this notice.

You also may file a complaint with the Secretary of Health and Human Services, Office for Civil Rights, U.S. Department of Health and Human Services, JFK Federal Building, Room 1875, Boston, MA. 02203.