

**Wellesley College  
Employee Welfare Benefits Plan  
Summary Plan Description (SPD)**

**Effective January 1, 2016**

**This SPD includes the following programs:**

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

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

# WELLESLEY COLLEGE EMPLOYEE WELFARE BENEFITS PLAN

## SUMMARY PLAN DESCRIPTION

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# **WELLESLEY COLLEGE EMPLOYEE WELFARE BENEFITS PLAN (“PLAN”) SUMMARY PLAN DESCRIPTION**

## **Summary Plan Description Notice**

This document, together with any separate benefit plan certificates or booklets for the benefits you have selected, constitute the Summary Plan Description (“SPD”) for your health and welfare benefits, and is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA). You should use these materials to understand the health and welfare benefits that Wellesley College (“the College”) offers to you and your family.

This SPD does not serve as a guarantee of continued employment or benefits. The College policies on hiring, discharge, layoff and discipline are in no way affected by the programs described here.

This document presents basic information about the health and welfare benefits provided by the Plan, as of January 1, 2016, and your rights to benefits as a plan participant. This document, together with any separate benefit plan certificate, summary, or booklet for the health and welfare benefits you have selected, constitute the SPD for your health and welfare benefits. You and any of your dependents covered under the Plan should review this entire document and the applicable insurance certificates, summaries, or booklets for the benefits you have selected. The term “employee” refers to faculty, administrative and union employees unless otherwise noted.

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

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

# I. PARTICIPATION IN THE PLAN

## Employee Eligibility

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

- Medical, Dental and Vision Coverage
- Flexible Spending Accounts (FSAs) and/or Health Savings Account (HSA)
- Life Insurance (Basic, Contributory, Spouse)
- Short Term Disability (STD) Insurance – Union only\*
- Long Term Disability (LTD) Insurance
- Employee Assistance Plan (EAP)

**\*Note:** The Short Term Disability program for administrative employees is a payroll practice. Please refer to the **Administrative Handbook** for more information. Faculty are not eligible for STD coverage.

The tables below list the eligibility and effective date of coverage for each benefit program.

### FACULTY

<b>Eligibility Criteria</b>	<b>Effective Date of Coverage</b>
You must work at least half-time to enroll in: Medical, Dental, Vision, FSAs and Life Insurance.	Medical, Dental, Vision, FSAs, Life Insurance and Long Term Disability: the 1 <sup>st</sup> of the month coincident with or following your date of hire, if elected/eligible
You must work full-time to be covered by Long Term Disability.	

### ADMINISTRATIVE EMPLOYEES

<b>Eligibility Criteria</b>	<b>Effective Date of Coverage</b>
You must work at least 17.5 hours per week to enroll in: Medical, Dental, Vision, FSAs and Life Insurance or to be eligible for Short Term Disability (via payroll).	Medical, Dental, Vision, FSAs, Life Insurance, Short Term Disability (via payroll) and Long Term Disability: the 1 <sup>st</sup> of the month coincident with or following your date of hire, if elected/eligible
You must work at least 35 hours per week to be covered by Long Term Disability.	

## UNION EMPLOYEES

Eligibility Criteria	Effective Date of Coverage
You must be scheduled to work at least 20 hours per week to enroll in: Medical, Dental, Vision and the FSAs.	Medical, Dental, Vision and the FSAs: the 1 <sup>st</sup> of the month coincident with or following your date of hire, if elected
You must work at least 40 hours per week to enroll in Life Insurance or to be covered by Short Term Disability or Long Term Disability.	Basic Life Insurance, Short Term Disability and Long Term Disability: after 12 consecutive months of being actively at work

There is no waiting period for the Employee Assistance Program. All employees are eligible on their date of hire.

### Union Short Term Disability (STD) Eligibility

STD for union employees is provided through the Employee Welfare Benefits Plan and coverage is outlined in this SPD. Employees do not need to enroll in STD coverage, nor pay for this coverage; it is provided automatically once you are eligible.

## Dependent Eligibility

If you are enrolled for Medical, Dental and/or Vision under the Plan, you may enroll your spouse and eligible dependents for coverage to the extent that coverage is available. Your dependents must be enrolled in the same Medical, Dental and/or Vision coverage in which you enroll. If you enroll a dependent, you may be asked to provide proof of the dependent's eligibility.

### Eligible Dependents

Your eligible dependents can include your spouse and children up to age 26 (regardless of tax dependent status). Eligible dependent children include:

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

Proof of dependent eligibility includes a valid marriage certificate for spousal coverage and a birth certificate or adoption paperwork for eligible children. Copies of documents are acceptable.

## **Children Who Are Incapacitated**

Your unmarried children who are physically or mentally disabled and incapable of self-support are eligible for benefits regardless of age, as long as your own coverage remains in effect. Continued coverage for your disabled dependents will not be effective until it is approved by the health plan.

## **How to Enroll**

### **You Must Complete and Return the Enrollment Paperwork**

When you are hired or become newly eligible for benefits at the College, you receive a New Employee Packet. This packet contains enrollment forms for Medical, Dental, Vision and Flexible Spending Account benefits, which **you must complete and return to the Human Resources Office within 30 days of your hire date.**

**You must also complete an Acknowledgement of Medical Plan Offer of Coverage and return it to the Human Resources Office within 30 days of your hire date.**

If you are enrolling in Contributory Life Insurance and/or Spouse Life Insurance, you may be required to complete additional forms. Please contact Human Resources if you are interested in these benefits.

Enrollment in Basic Life Insurance, Short Term and Long Term disability (LTD) coverage is automatic if you are eligible, with no enrollment paperwork.

### **Coverage Level Options**

You may elect Medical and/or Dental coverage for yourself only (“individual”) or for yourself and your eligible dependents (“family”). For Vision coverage, you have a choice of: employee only, employee plus spouse, employee plus child(ren) or family coverage.

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

See the **Life Insurance** section for coverage options.

### **Enrollment Constraints**

**If you do not return your paperwork within 30 days of your date of hire, or the date of benefits eligibility if you are not a new hire, you will not be allowed to enroll in Medical, Dental, Vision, Flexible Spending Accounts, Contributory or Spouse Life Insurance until the next Open Enrollment period. Open Enrollment is held each fall, with coverage to begin the following January 1.**

Because your Medical, Dental, Vision and FSA deductions are taken on a pre-tax basis, you will only be able to make a benefit election change outside of this 30-day enrollment period if you experience a qualified change in family or employment status. (See the **Changing Your Benefit Elections** section.)

Should you decide to elect Contributory Life Insurance or Spouse Life Insurance after the 30-day enrollment period, you will be subject to certain restrictions and may be asked to submit evidence of insurability before being approved for such coverage.

## **Paying for Your Benefits**

When you enroll, you begin to pay for the benefits you have elected as of the effective date of your coverage. Automatic payroll deductions occur each time you are paid throughout the course of the year. The amount you pay per pay period depends on which benefits you elect, your coverage level, and how often you are paid.

**For More Information.** Please refer to the fall issue of the Illuminator for the current per pay period costs. You may also access this information on the Human Resources website.

### **Pre-Tax Deduction of Premiums from Your Salary**

Medical, Dental and Vision premiums, along with Flexible Spending Account or Health Savings Account contributions, are deducted from your gross salary before certain taxes (e.g., federal, state and FICA taxes depending on the benefit or account) are applied to your pay. If you elect Contributory and/or Spouse Life Insurance, your premium is deducted from your post-tax pay.

Any tax deductions for benefits do not lower your compensation for the purposes of computing salary increases, pension contributions, Life Insurance amounts, or Disability benefits, which are based on your total, actual salary before benefit deductions are taken from your pay. Your future Social Security benefits are, however, based on your reduced salary. In most cases, any reduction in future Social Security benefits is offset by current tax savings. If you have any questions regarding this, consult your tax advisor to determine your personal tax consequences.

### **Sharing the Cost of Your Benefits**

In many cases, the College pays some or all of the cost of your benefits. The chart below provides more information. Also refer to the fall issue of the Illuminator or the latest Open Enrollment materials for cost information.

	<b>How costs are shared...</b>	<b>Your share is paid...</b>
<b>Medical*</b>	You and the College share the cost	On a pre-tax basis
<b>Health Savings Account (HSA)</b>	You and the College can contribute	On a pre-tax basis
<b>Dental</b>	You and the College share the cost	On a pre-tax basis
<b>Vision</b>	You pay the full cost	On a pre-tax basis
<b>Flexible Spending Accounts (FSAs)</b>	You decide whether and how much to contribute	On a pre-tax basis
<b>Life Insurance</b>	The College pays the full cost of Basic coverage; you pay the full cost of any Contributory or Spouse coverage you elect	On a post-tax basis
<b>Disability</b>	The College pays the full cost if you are eligible	Not applicable
<b>Employee Assistance Program (EAP)</b>	The College pays the full cost	Not applicable

\*In 2016, you are eligible for an opt-out credit if you decline Medical coverage through Wellesley College.

### **Deductions for Summer Months for Academic Year Employees**

If you do not work in June, July and August, your payroll deductions for Medical, Dental, Vision and Contributory and Spouse Life Insurance for those months will be taken from your paycheck when you return to work in the fall. Contributions to the Flexible Spending Accounts and/or the Health Savings Account resume when you have a paycheck.

### **Life Insurance Imputed Income**

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

## **Changing Your Benefit Elections**

### **Changes to Medical, Dental, or Vision and Flexible Spending Account Participation**

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

### **Changes to Health Savings Account Contributions**

You may start, stop or change the contributions you are making to the Health Savings Account once each month.

### **Changes to Contributory and Spouse Life Insurance**

Because you pay for Contributory and Spouse Life Insurance on a post-tax basis, you may enroll in or make changes to Contributory and Spouse Life Insurance coverage outside the 30-day enrollment window and throughout the calendar year. Evidence of insurability may be required if you elect or increase the amount of your coverage at a future date.

### **Benefit Changes Are Allowed During the Open Enrollment Period**

During the Open Enrollment period, held each fall, you are allowed to make changes to your benefit elections. You may elect to:

- Enroll in any benefit program,
- Change your coverage level for a benefit (e.g., individual to family coverage),
- Add an eligible dependent to your coverage,
- Drop a dependent from your coverage, or
- Stop your participation in any benefit program.

Any changes you make become effective as of January 1 of the new calendar year, and remain effective for the duration of the calendar year, unless you make changes as a result of a qualified change in family or employment status. If you do not make any changes or new elections during the annual Open Enrollment period, you will keep the same Medical, Dental and Vision coverage for the new calendar year that you had in the previous calendar year.

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

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

### **Benefit Changes May Be Allowed for a Qualified Change in Status**

Outside of the Open Enrollment period, federal law only allows you to change certain benefit elections if you experience a change in status. Any change in benefit elections must be consistent with your change in status. That is, you can only change your elections if the change in status affected your eligibility for the benefits you wish to add or drop. A change in status includes, but is not limited to, the following types of life events:

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

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

In addition to the qualified status changes noted above, you may be permitted to change your Dependent Care FSA election amount if the cost of child care with your current provider changes significantly.

### **How to Request a Change in Your Benefit Elections**

Any requested change in coverage must be consistent with your change in status. **You must notify the Human Resources Office within 30 days of the date of your life event.** If you do not request a change to your benefit elections within 30 days of your life event, you must wait until the next Open Enrollment period, or until you experience another life event recognized as a qualified change in status, to make a change. You will need to provide the following information to request a change:

- The type of family or employment status change you have,
- Proof of the change (documentation showing the change),
- The effective date of the change, and
- The benefit coverage you want to drop, add or change.

The change in coverage will take effect on the date of birth/adoption for a newborn or adopted child. Otherwise, the change takes effect as soon as possible after the change. Any resulting change in the cost of your coverage (for example, going from individual coverage to family coverage) is effective on the first pay period following the date of your requested change in coverage as a result of a change in status. There may, however, be additional or pro-rated amounts due to payroll timing.

### **Special Enrollment Relating to Medicaid or CHIP Coverage**

If you or your dependent is eligible but not enrolled for Medical coverage under this Plan, the College must allow enrollment for Medical coverage under the Plan if either of the following conditions is met:

- The employee's or dependent's Medicaid or State Children's Health Insurance Plan (SCHIP) coverage is terminated due to a loss of eligibility or
- The employee or dependent becomes eligible for a premium subsidy under Medicaid or SCHIP.

**For More Information.** To request special enrollment or obtain more information about Medicaid or CHIP, contact the Human Resources Office. For CHIP information, also see the latest notice on the Human Resources website.

## When Your Participation Ends

You may elect to end your coverage in a particular benefit program during the Open Enrollment period, or if you experience a change in family or employment status which is consistent with dropping your coverage.

Other circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits are described in the appropriate Subscriber Certificate (the benefit contract between the College and the insurance carrier of a specific benefit program). You should review the applicable Subscriber Certificate(s) to acquaint yourself with these provisions.

The College also reserves the right to amend or terminate benefits under the Plan at any time. You may lose coverage if the College terminates the Plan or amends it to reduce or eliminate your coverage.

Otherwise, your coverage under this Plan generally ends when you terminate employment with the College or otherwise cease to be an eligible employee. For example, your coverage typically ends on the earliest date that:

- You no longer meet the eligibility requirements to participate,
- You fail to make the required premium contributions,
- Your employment with the College ends, or
- The College cancels the Plan or a particular benefit program.

You may have rights to continue coverage as outlined in the sections below.

### **If You (or a Dependent) Lose Benefit Eligibility**

Except as noted below, Medical, Dental and Vision benefits end the last day of the month in which you (or any dependent under your coverage) no longer meet the eligibility requirements to participate in the Plan. You (and any affected dependents) may elect to continue coverage under COBRA. (See the **COBRA** section for more information.)

**Note:** When a dependent ages off Medical, Dental or Vision coverage, he or she is removed from the Plan as of that date. His or her benefits do not continue to the end of the month.

If you are participating in the Health Care and/or Dependent Care FSA, your contributions end when you no longer meet the eligibility requirements. You may submit claims for reimbursement of Health Care FSA expenses incurred through your last day of eligibility. You may submit claims for reimbursement of Dependent Care FSA expenses incurred through the end of the calendar year in which your coverage terminates.

If you elect to continue participation in the Health Care FSA under COBRA, you must continue contributing to your Health Care FSA under COBRA on a post-tax basis. You may then continue to submit claims through the end of the calendar year in which your eligibility ends or until you cease making your monthly contributions, whichever occurs first. There is no COBRA continuation for the Dependent Care FSA.

Your Basic Life, Contributory and Spouse Life Insurance, Disability and Employee Assistance Plan coverage end the day after you (or any dependent under your coverage) no longer meet the eligibility requirements to participate in the Plan. Note that you may be able to continue Life Insurance (including Contributory and Spouse coverage) under the conversion or portability options.

### **If You Divorce**

Should you divorce, your former spouse, and his or her dependent children, may continue Medical, Dental and Vision coverages to the extent that federal law would usually apply. (See the **COBRA** section for more information.)

### **If You Die As an Active Employee**

The College allows surviving family members of deceased employees to continue Medical, Dental and Vision coverages at the employee cost for the five months immediately following your death. After five months, the surviving family members may maintain these coverages under COBRA for up to 36 months from the date of your death, but the College does not contribute to the premium cost under COBRA after this five-month period ends.

### **Receiving/Requesting the Paperwork**

If you or a covered dependent should become ineligible for a benefit program, WageWorks will mail a packet to your address of record explaining your rights and eligibility for COBRA continuation coverage. If you do not receive this package, contact WageWorks at [www.WageWorks.com](http://www.WageWorks.com) or at 1-877-924-3967.

You should contact Sun Life (1-800-247-6875) if you are interested in continuing your Life Insurance coverage(s).

## II. YOUR BENEFIT OPTIONS

Wellesley College offers a range of benefit programs designed to provide employees with comprehensive coverage and quality care. The content provided in this section can help you make informed enrollment decisions and allow you to take full advantage of the benefits available to you, including:

- Medical Coverage (Harvard Pilgrim)
- Dental Coverage (Delta Dental)
- Vision Coverage (EyeMed)
- Flexible Spending Accounts (FSAs) and/or Health Savings Account (HSA)
- Life Insurance (Basic, Contributory, Spouse)
- Short Term Disability (STD) Insurance – Union only
- Long Term Disability (LTD) Insurance
- Employee Assistance Plan (EAP)

### Medical Coverage

The College offers Medical coverage through Harvard Pilgrim Health Care (“HPHC”), providing employees with comprehensive coverage for a range of medical needs – from preventive and emergency care to prescription drug coverage. To have Medical coverage, you must be eligible and actively enroll. (See the **Employee Eligibility** section for information about eligibility and enrollment.) You may choose from the HPHC HMO and the HPHC PPO Plus HSA Plan. As of January 1, 2015, the HPHC PPO Plan is not available unless you were already a participant.

**Opt-out Credit.** For 2016, you are eligible for a \$1,000 credit if you choose to waive medical coverage from the College.

**For More Information.** This section provides a basic overview of your medical benefits. You should refer to the HPHC website ([www.harvardpilgrim.org](http://www.harvardpilgrim.org)) or call 1-888-333-4742 for details.

### HMO Option

An HMO is comprised of a network of health care providers who deliver managed care at a center or as part of a network. HMOs require you to select a primary care physician (PCP) who coordinates your care and authorizes visits to specialists or other providers. Your covered family members also select a PCP to coordinate their care. Each family member can choose his/her own PCP and location.

You have the right to designate any primary care provider who participates in the HPHC HMO network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You can change your PCP at any time. PCP directories and practice locations are available by going to [www.harvardpilgrim.org](http://www.harvardpilgrim.org). Paper copies will be made available upon request to HPHC or through the Human Resources Office, free of charge.

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

### **PPO Plus HSA Option**

The PPO Plus HSA Plan is a “preferred provider organization” that gives you the same in-network providers as the HMO as well as access to a national provider network for you and your dependents who are outside the HPHC service area. The plan also allows you to visit doctors and providers outside the HMO network without a referral from a PCP. This can be a valuable feature if you want the flexibility to choose a doctor outside of the network.

With the PPO Plus HSA Plan, you pay the full cost of services, including prescription drugs, until you meet the annual deductible (currently \$1,500 for individual coverage and \$3,000 for family coverage). Once you meet the deductible, most in-network services are covered in full for the rest of the calendar year. You pay 20% of the cost of any out-of-network services you choose during the year.

The PPO Plus HSA Plan also includes a Health Savings Account (“HSA”). An HSA allows you to contribute pre-tax dollars to your account (similar to a Flexible Spending Account) and use these dollars to cover your deductible, any copayments plus other eligible health care expenses such as dental and vision services. With an HSA, you do not lose your contributions at the end of the year. In fact, your account is always available to you for health care expenses – even if you leave the College or retire. You also have the option of investing your HSA and earning more for future expenses.

**Note:** Our Medical coverage meets the Massachusetts minimum creditable coverage requirements and it qualifies as Minimum Essential Coverage under the Affordable Care Act. See the most recent Minimum Creditable Coverage Notice on the Human Resources website.

**For More Information.** *The Schedule of Benefits* along with the *Member Handbook* provide more detailed coverage information, plan limits for preventive services, prescription drugs, medical tests, devices and procedures, the use of and access to in-network and out-of-network providers, any conditions or limits on the selection of primary care or specialty care providers, any restrictions on emergency medical care, and any pre-authorization and utilization review procedures. These documents are incorporated by reference and are available through the Human Resources website or from [www.harvardpilgrim.org](http://www.harvardpilgrim.org).

**If You Turn Age 65 While Actively Employed**

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

**Note:** You should **not** elect Medicare Part A if you participate in the PPO Plus HSA Plan and wish to continue to contribute to your HSA. Please contact the Human Resources Office for more information before you reach age 65.

**Health Advocate**

Health Advocate is a medical advocacy and assistance company available to all benefit-eligible non-union faculty and administrative employees and their families. This benefit is paid for by the College and all eligible employees are automatically enrolled. For more information and to contact Health Advocate, go to <http://www.healthadvocate.com/members> or call 1-866-695-8622.

**If You Move Out of the HMO Service Area**

If you move out of the HPHC HMO network service area, you will be removed from HMO coverage. You have 30 days from the date of your move to change your coverage. You may re-enroll when you move back into the service area or during the next Open Enrollment period.

**If You Receive Payment of Medical Benefits from Another Source**

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

**HIPAA: Maintenance and Confidentiality of Medical Records**

In accordance with the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), medical information is only disclosed for treatment, payment and health care operations purposes. It will not be disclosed for any other purpose without your authorization, unless permitted or required by law.

Your enrollment paperwork for College-sponsored Medical coverage is kept on file in the Human Resources Office. Your medical information is retained by Harvard Pilgrim Health Care or your provider and is kept confidential. Medical information is not maintained at Wellesley College.

For more information about your rights under HIPAA, please refer to the Plan's Notice of Privacy Practices, which is available at on the Human Resources website.

## Dental Coverage

The College offers dental benefits to eligible employees and their dependents through Delta Dental of Massachusetts. You must enroll to participate in Dental coverage. To determine if you are eligible to enroll, see the **Employee Eligibility** section. You may choose from the Delta Dental PPO Plus Premier option or the DeltaCare option.

### Delta Dental PPO Plus Premier Option

When you enroll in Delta Dental PPO Plus Premier, you have access to both the Delta Dental PPO and Delta Dental Premier provider networks, the most extensive dental network in Massachusetts. You may choose your dentist from among 7,000 practices (go to [www.deltadentalma.com](http://www.deltadentalma.com)). Diagnostic and preventive services are fully covered at 100%. After an annual individual deductible of \$50, or a family deductible of \$100, basic restorative services are covered at 80% and major restorative services are covered at 50%. Orthodontic services are covered at 50% up to a maximum of \$2,500 per lifetime. Fees for services are generally discounted when you see a dentist in the Delta Dental PPO and Premier networks. Therefore, seeing an in-network dentist allows your annual \$2,500 benefit to go further.

**Note:** Delta Dental PPO Plus Premier also includes a rollover benefit. If your claims do not exceed \$800 in a calendar year and you received at least one cleaning or oral exam during that year, you may roll over \$600 of your unused benefit amount to the next calendar year, increasing your maximum benefit amount for that year. This feature allows you to plan for more expensive procedures such as bridges, crowns and root canals. Any accumulated total rollover amount is capped at \$1,500.

### DeltaCare Option

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

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

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

**For More Information.** To select or change your PCD (under DeltaCare), go to the Directory of Participating Dentists at [www.deltadentalma.com](http://www.deltadentalma.com). For coverage and cost information, call Customer Service at 1-800-872-0500.

Refer to your Delta Dental PPO Plus Premier and DeltaCare Summary of Benefits, which are incorporated by reference and can also be found online at the URL above or in the Human Resources Office.

### **If You Turn Age 65 While Actively Employed**

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

### **If You Receive Payment of Dental Benefits from Another Source**

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

## **Vision Coverage**

You may elect Vision coverage for yourself and your eligible dependents through EyeMed. This plan provides benefits and allowances on exams, frames, lenses and contact lenses.

**For More Information.** For plan information or to contact EyeMed, go to [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com) or call 1-866-9-EYEMED.

## **Flexible Spending Accounts (FSAs)**

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

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

See the **Employee Eligibility** section for information about eligibility and enrollment. To participate, you must enroll within 30 days of your hire date or the date you have a qualifying change in status or during the Open Enrollment period.

You make a separate election for each FSA. That is, deductions to your Health Care FSA cannot be transferred to pay for expenses under your Dependent Care FSA or vice-versa.

**Your FSA elections do not carry over from one calendar year to the next. You must make an active election each fall during the Open Enrollment period to continue your participation for the next year.**

### **Health Care Flexible Spending Account**

The Health Care FSA allows you to be reimbursed with tax-free dollars for eligible expenses, as defined by the IRS, and not covered under your medical, dental or vision insurance. These expenses can include copayments, deductibles or coinsurance for medical, dental, orthodontic and vision services incurred by you, your spouse or your eligible dependents whether or not covered under a College plan.

If you participate in a Limited Purpose Health Care FSA (because you also participate in the Health Savings Account under the PPO Plus HSA Plan), you may only use the FSA for dental, orthodontic and vision expenses – until you have met your medical deductible. At that point, you may use your Limited Purpose Health Care FSA for any other eligible medical expenses as well.

**Eligible Dependents.** For the Health Care FSA, an eligible dependent means any person who is your dependent within the meaning of section 152 of the IRC Code, determined without regard to Code section 152(b)(1), (b)(2), and (d)(1)(B), including any child (as defined in section 152(f) of yours who, as of the end of the plan year, has not reached age 27. For this purpose, any child to whom section 152(e) of the Code applies shall be treated as a dependent of both parents. To determine if your dependent is a tax dependent, see IRS Publication 502 at [www.irs.gov/publications/p502/](http://www.irs.gov/publications/p502/).

**Contribution Limits for the Health Care FSA.** If you choose to participate in the Health Care FSA, you decide how much to contribute for the year (up to the limit allowed by the Plan) based on what you expect your eligible expenses will be for the year.

For 2016, you may choose to contribute up to \$2,550 (in whole dollar amounts) to the Health Care FSA. If you are married and you and your spouse are both employed at Wellesley College, you may each elect to contribute to the Health Care FSA. However, you both may not contribute more than a total of \$5,000 for the year. (Note that these limits may change each year.) Your contributions will be deducted from your paycheck in equal amounts during the year.

Beginning in 2016, participants will be able to carry over up to \$500 in their Health Care FSA from one year to the next.

**Examples of Eligible Health Care Expenses.** To be reimbursable, services and/or supplies must generally be performed and/or prescribed by a licensed practitioner. Allowable expenses are generally those that the IRS allows as itemized deductions on a federal income tax return with some notable exceptions. (For example, insurance premiums are considered deductible for income tax purposes but are not eligible for reimbursement through the FSA.)

Note that you cannot take a federal tax deduction or credit on your income taxes for expenses reimbursed through an FSA. Only allowable expenses that are adequately documented (see the **How to Request a Reimbursement** section), not covered by insurance and necessary for medical, dental or vision treatment are reimbursable. Eligible expenses can include:

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

**Examples of Ineligible Health Care Expenses.** Ineligible expenses include:

- Insurance premiums for any medical (including Medicare), dental or vision coverage, including premiums or expenses for long term care coverage,
- Any expenses reimbursable by health or dental insurance, workers' compensation, or any other expenses for which you were or can be reimbursed under any insurance or by other means,
- Cosmetic procedures,
- Toiletries or cosmetics, such as toothpaste, deodorant or face creams, and
- Dietary supplements for general good health.

The eligibility of non-prescription medications and other medical supplies is based upon IRS regulations. These regulations state that the items must be used to treat a specific medical condition and not for general wellness. For example, an over-the-counter dietary supplement would be eligible for reimbursement if it were purchased to treat a specific condition (as verified by a doctor's note), but not if it were purchased to promote the general health of the individual. In addition, expenses incurred by a qualified domestic partner are not eligible for reimbursement through the FSA, unless you can claim your domestic partner as a federal tax dependent.

**For More Information.** The above eligible and ineligible expenses are suggestive, not exhaustive. For a more extensive list, go to [www.WageWorks.com](http://www.WageWorks.com) or call 1-877-924-3967.

Also see IRS Publication 502, Medical and Dental Expenses. This publication is available online at [www.irs.gov/publications/p502/](http://www.irs.gov/publications/p502/). Please note that Publication 502 states as allowable some expenses which are not reimbursable under a Health Care FSA (for example, insurance premiums).

**Estimating Your Health Care FSA Contribution.** Because unused FSA dollars do not roll over and, if not used, are forfeited, it is important to estimate your health care expenses carefully. Visit the online FSA calculator available at <https://www.wageworks.com/employees/support-center/fsa-savings-calculator>. The Health Care FSA calculator will help you determine your annual contribution by asking you to estimate your out-of-pocket expenses and other expenses. It also shows an estimate of your potential tax savings.

### **Dependent Care Flexible Spending Account**

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

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

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

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

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

**Contribution Limits for the Dependent Care FSA.** For 2016, you may choose to contribute up to \$5,000 (in whole dollar amounts) for the year, unless one of the following IRS guidelines applies to you:

- If you are married and file separate tax returns, the most you and your spouse can each contribute to a Dependent Care FSA is \$2,500. If your spouse contributes less than \$2,500, you cannot make up the difference.
- If you are married and your spouse also contributes to a Dependent Care FSA through his or her employer, the \$5,000 annual maximum is the total amount that you and your spouse may contribute to both accounts combined.
- If you or your spouse earns less than \$5,000 a year, the most you can contribute is the lower of your two earned incomes.
- A spouse who is either a full-time student or not able to care for him/herself is treated as having earned income of \$250/month if there is one qualifying dependent in your home or at least \$500/month if there are two or more qualifying dependents in your home.
- If you are single, you may contribute up to the lesser of \$5,000 or 50% of your income if less than \$5,000.

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

**Examples of Eligible Dependent Care Expenses.** Eligible expenses can include:

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

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

**Examples of Ineligible Dependent Care Expenses.** Ineligible expenses include:

- Education, including tuition for private schools,
- Babysitting for reasons other than to enable you to work,
- Cleaning and cooking services,
- After-school specialty or educational programs,
- Summer or day camp providing overnight stays,
- Transportation between your home and dependent care services (if transportation is not provided by the care provider),
- Child support payments,
- Food, clothing, and diapers,
- Expenses for which a dependent care tax credit is taken,
- Activity fees and late payment fees for services,
- Liability insurance premiums, and
- Kindergarten expenses itemized as educational expenses.

**For More Information.** If you have a question about the eligibility of a dependent care expense, contact WageWorks at 1-877-924-3967 or go online at [www.WageWorks.com](http://www.WageWorks.com).

Also see IRS Publication 503, Child and Dependent Care Expenses. This publication is available online at [www.irs.gov/publications/p503/](http://www.irs.gov/publications/p503/).

**How to Look Up Your Account Balance.** You may check your Health Care or Dependent Care FSA balance online through [www.WageWorks.com](http://www.WageWorks.com).

**How to Request a Reimbursement**

You may submit claims via the WageWorks mobile application, online at [www.WageWorks.com](http://www.WageWorks.com) or by obtaining a form on the WageWorks or Human Resources website and mailing or faxing it to WageWorks.

- **Health Care FSA.** Your full annual contribution is available as of January 1. To be reimbursed for eligible health care expenses you have incurred, you must submit a Health Care FSA Reimbursement Request along with original receipts to WageWorks.
- **Dependent Care FSA.** Your contributions are available as they are deposited to your account. That is, you can be reimbursed only for expenses incurred up to the current balance in your Dependent Care FSA at the time you file your claim. To be reimbursed for eligible dependent day care expenses, you must submit a Dependent Care FSA Reimbursement Request along with original receipts, dates of service, the name of the dependent receiving the care and the name of the provider to WageWorks.

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

**Note:** To be reimbursed, Health Care and/or Dependent Care FSA expenses must be incurred on or before December 31 of the current year. However, you have until March 31 of the following year to **submit** expenses that were incurred in the prior year.

**Frequency of Reimbursements.** Reimbursements for the Health Care FSA and the Dependent Care FSA are made upon receipt of reimbursement requests throughout the year.

**Direct Deposit.** You can choose to have your reimbursements directly deposited at your bank. Sign up for direct deposit by going to [www.WageWorks.com](http://www.WageWorks.com).

### **Special Carryover for the Health Care FSA**

Beginning in 2016, there is a special carryover provision for the Health Care FSA. This means that you may carry over up to \$500 of your remaining Health Care FSA contributions from one year into the next and use them for eligible health care expenses in that year. The IRS does not allow this feature under the Dependent Care FSA.

### **Changing or Stopping Your Contributions**

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

If you do experience a qualified change, you have 30 days from the date of the event to make the change. See the **Changing Your Benefit Elections** section for examples of what would allow you to make a change to your FSA contributions.

### **Flexible Spending Accounts and Federal Tax Law**

The IRS will not allow two tax breaks on the same expense, so you cannot take a federal tax deduction or credit on your income taxes for expenses reimbursed through an FSA.

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

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

**Dependent Care FSA.** The federal government allows you to take a tax credit for eligible dependent care expenses. Under the Internal Revenue Code, the tax credit is a percentage of your dependent care expenses. This amount may change from year to year, and you should consult with a tax advisor to determine if the tax credit is more advantageous than using the Dependent Care FSA.

## Life Insurance

Our Life Insurance program is underwritten by Sun Life Financial and includes Basic, Contributory and Spouse coverage. (See the **Employee Eligibility** section for information about eligibility and enrollment.)

### Basic Life

Eligible employees are automatically covered for Basic Life Insurance. You remain covered as long as you remain eligible.

Your coverage is one times your basic annual earnings, rounded to the next higher \$1,000, to a maximum of \$450,000.

### Contributory Life

Eligible employees must apply to enroll in Contributory Life Insurance. You can purchase one, two, three or four times your basic annual earnings, rounded to the next higher \$1,000, to a maximum of \$900,000, when combined with your Basic Life Insurance. The guaranteed issue amount is the lesser of: two times the employee's basic annual earnings or \$300,000. Otherwise, you will be required to provide evidence of insurability.

### Spouse Life

Eligible employees must apply to elect Spouse Life Insurance. (You may elect an amount equal to 50% of your Contributory Life Insurance coverage. If you were hired on or after January 1, 2013, the guaranteed issue amount for Spouse Life Insurance is \$15,000. The guaranteed issue amount for employees insured for Spouse Life on December 31, 2012 is the amount of Spouse Life Insurance the employee had in force on that date.)

### Evidence of Insurability

For Basic and Contributory Life Insurance, evidence of insurability will be required, when:

- An employee elects an increase in his/her amount of Contributory Life Insurance\* or
- An employee is electing an amount of Life Insurance in excess of the guaranteed issue amount or
- Any increase in Contributory Life Insurance during annual enrollment exceeds the lesser of: two times basic annual earnings or \$300,000.

For Spouse Life Insurance, evidence of insurability, satisfactory to Sun Life, will be required for any of the following reasons:

- An employee does not elect Spouse Life Insurance initially and wants to elect it later or
- An employee has Basic Life Insurance only and subsequently elects Contributory Life Insurance and Spouse Life Insurance or

- An employee is electing an increase in the amount of Spouse Life Insurance\* or
- An employee is electing an amount of Spouse Life Insurance in excess of the guaranteed issue amount.

\*Evidence of insurability will not be required if the employee elects to increase his/her amount of Contributory Life Insurance within 31 days following a family status change such as the employee's marriage or the birth/adoption of the employee's child.

### **Designating Beneficiaries**

You must designate a beneficiary for your Basic Life and any Contributory Life Insurance you elect. You complete the beneficiary form online through the Sun Life website ([www.sunlife.com/us](http://www.sunlife.com/us)). Your beneficiary may be any person or persons, including your estate, but not Wellesley College. You may change your beneficiary at any time by completing a new beneficiary form.

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

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

### **No Age Reductions**

The amount of your insurance will not be reduced because of your age unless your insurance is subject to termination under the waiver of premium provision (see below). Spouse Life Insurance is never reduced due to age.

### **Disability and Waiver of Premium**

If you become disabled (as defined by the College's Long Term Disability coverage) prior to age 75 and are no longer able to work, your premium payments may be waived after a period of 180 days of consecutive total disability.

### **Accelerated Benefit**

If you become terminally ill and are not expected to live more than 12 months, you may request up to 75% of your Life Insurance amount (up to \$500,000), without fees or present value adjustments. A doctor must certify your condition to qualify for this benefit. Upon your death, any remaining benefit will be paid to your designated beneficiary(ies). You must be approved for a waiver of premium to be eligible for the accelerated benefit.

### **Travel Insurance Component**

Sun Life has partnered with MEDEX Assistance Corporation to provide you with a comprehensive program of information, referral, assistance, transportation and evacuation services while traveling. Whether your travel is for business or pleasure, if an unexpected emergency occurs, you may call any time of the day or night and you, your spouse and dependent children can get immediate assistance anywhere in the world.

Travel assistance is available to you when you travel to any foreign country, including neighboring Canada or Mexico. It is also available anywhere in the United States for those traveling more than 100 miles from home. Your spouse and dependent children do not have to be traveling with you to be eligible. However, a spouse traveling on business for his/her employer is not covered by this program.

### **Converting or Porting Your Life Insurance**

**Portability Option.** If, prior to age 70, you terminate your employment with the College, you may apply to “port” your Basic and Contributory Life Insurance up to the amount of coverage you had, to a maximum of \$500,000. If your coverage equaled \$10,000 or more, the minimum amount of coverage you can port must be \$10,000.

If you elect to apply for portable coverage of any amount of Life Insurance, you may also apply to port any amount of Spouse Life Insurance that ended due to your termination of employment.

If your coverage has been continued on the waiver of premium provision or if you are converting your coverage (see below), you are not eligible to apply for portable coverage.

**Conversion Option.** If your Basic Life Insurance ends because your employment ends or you are no longer eligible for coverage, you have a 31-day period in which to convert your coverage to “individual whole Life Insurance” coverage. You may convert all of coverage that you had in effect and you do not have to submit evidence of insurability. There are no rate increases as you age. Should you die during this 31-day period, the current amount of your Basic Life Insurance will be paid whether or not you have elected the conversion option.

**For More Information.** Contact the Human Resources Office or see your Sun Life contract for more about life insurance and/or to port or convert your coverage. Sun Life is available through [www.sunlife.com/us](http://www.sunlife.com/us) or at 1-800-786-5433.

## **Short Term Disability (STD)**

### **Union Eligibility and Coverage**

Union employees who work at least 40 hours per week are eligible for Short Term Disability after 12 consecutive months of being actively at work. Benefits only begin once you have exhausted any sick time you have accumulated.

STD coverage is paid for by the College. Short Term Disability pays 60% of your weekly earnings up to a maximum of \$1,000 per week for up to 26 weeks, or to the date Long Term Disability benefits become payable, whichever is earlier.

Your STD disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include amounts you receive or are entitled to receive under: workers' compensation or similar occupational benefit laws, state compulsory benefit laws, and other group or association disability programs or insurance.

### **Definition of Disability and When Benefits are Paid**

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

- If your disability is caused by an accident, medical necessity or mental disorder, your waiting period is seven days.
- If you are confined in a hospital for at least four hours during a benefit waiting period, the remainder of the waiting period will be waived. STD benefits will become payable on the 1<sup>st</sup> day of hospital confinement. Your maximum benefit period will begin on the date STD benefits become payable. You must be under the ongoing care of a doctor during your hospital confinement.

### **How to File a Claim**

To file an STD claim, please contact the Human Resources Office.

**Note for Faculty and Administrative Employees:** Faculty are not eligible for Short Term Disability. Short Term Disability benefits for administrative employees are provided through a payroll practice and are not covered by this Plan. Please refer to the **Administrative Handbook** for further information.

## **Long Term Disability (LTD)**

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

If you are eligible, LTD coverage is automatic and the College pays the full cost of coverage. You will pay taxes on any LTD benefits you actually receive. To determine your eligibility and effective date of coverage, see the **Employee Eligibility** section.

### **Monthly LTD Benefit Amount**

The program pays 60% of your pre-disability pay at the time you become disabled up to a monthly maximum of \$3,000 for union employees and \$15,000 for faculty and administrative employees.

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

### **Benefit Waiting Period**

The benefit waiting period is the period you must be continuously disabled before LTD benefits become payable. LTD benefits would begin after 180 days of disability. During your benefit waiting period, you will be considered disabled if you are unable to perform the day-to-day work and duties of your own occupation, and you are under the regular care of a physician.

### **Definition of Disability**

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

### **Own Occupation Definition of Disability**

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

### **Any Occupation Definition of Disability**

You are considered disabled from all occupations if, as a result of disease, injury, pregnancy or mental disorder, you are unable to perform the day-to-day work and duties of any occupation. Any occupation means any occupation or employment which you are able to perform, whether due to education, training, or experience, which is available at one or more locations in the national economy and in which you can be expected to earn at least 60% of your indexed pre-disability earnings within 12 months following your return to work, regardless of whether you are working in that or any other occupation.

### Maximum Benefit Period

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

If Your Disability Occurs at Age...	Benefits Could Be Paid for...
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

### Rehabilitation Plan

While you are disabled, you may qualify to participate in a formal rehabilitation plan, consisting of a program or course of vocational training or education that is intended to prepare you to return to work. An approved rehabilitation plan may include payment of some or all of the expenses you incur in connection with the rehabilitation plan, including:

- Training and education expenses,
- Family care expenses,
- Job-related expenses, and
- Job search expenses.

### Survivor Benefit

If you die while LTD benefits are payable and, on the date you die, you have been continuously disabled for at least 180 days, your beneficiary is entitled to a survivor benefit. The survivor benefit is a lump sum payment equal to three times your last gross monthly benefit. The survivor benefit will be paid to one of the following:

- Your spouse (if living),
- Your unmarried children under the age of 25, or
- If there are no eligible survivors, your estate.

### Reasonable Accommodation Benefit

If you would be able to return to part-time or full-time work with a modification to your workplace, Sun Life may reimburse the College (if appropriate) for the reasonable expenses to modify the workplace to a maximum of \$2,000 unless Sun Life approves a different amount in writing. The reasonable accommodation expense benefit is payable only if approved by Sun Life in writing prior to its implementation.

### **Pre-Existing Condition Exclusion**

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

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

### **Disabilities Subject to Limited Pay Periods**

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

- Mental disorders,
- Substance abuse, or
- Other limited conditions. (See your Sun Life LTD Certificate for definitions.)

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

### **Additional Benefits While on LTD**

While you are on Long Term Disability, your current Medical, Dental and/or Vision coverages continue automatically and you are billed for them at the active employee rate. These coverages end on the earlier of the date you retire or six months after the date you become eligible for Medicare. Please contact Human Resources for more information..

If you are eligible for a College contribution to the Wellesley College 403(b) retirement program, this contribution will continue to be made while you are on LTD. The contribution will equal 9% of your pre-disability earnings up to one-half of the Social Security Wage Base, plus 12% of pre-disability earnings above one-half the Social Security Wage base while you are disabled. (Employees may not make contributions to this program while on LTD.)

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

### **How to File a Claim**

To file an LTD claim, please contact the Human Resources Office.

## Employee Assistance Program (EAP)

The College offers an Employee Assistance Program to eligible employees and members of their households through AllOne Health. Eligible employees are automatically enrolled in the EAP and the College pays 100% of the cost. The EAP provides services to help you and your family members with the stresses of life and work including personal and family issues, drug or alcohol problems and job-related tensions. The program provides counseling, consultation, and education.

**For More Information.** Call 1-800-451-1834 or go to [www.allonehealthcorp.com](http://www.allonehealthcorp.com). (Username: wellesley and Password: employee)

### **III. YOUR RIGHTS AS A PARTICIPANT**

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

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

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

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

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

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Protheses and treatment of physical complications at all states of the mastectomy, including lymphedemas.

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

#### **Qualified Medical Child Support Orders (QMCSOs)**

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

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

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

## **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)**

### **Medical, Dental and Vision COBRA Continuation**

Under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you may be eligible to continue coverage after group Medical, Dental or Vision coverage ends if you were enrolled in coverage and you experience a qualifying event which would cause you to lose group Medical, Dental or Vision coverage.

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

If you are enrolled in the Medical, Dental and/or Vision coverage offered by this Plan, you will become a qualified beneficiary if you lose your group health coverage because either one of the following qualifying events happens:

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

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

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

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

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

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

### **Health Care FSA COBRA Continuation**

You may elect to continue your Health Care FSA under COBRA, up to the end of the calendar year in which you enrolled in COBRA. You cannot continue your Dependent Care FSA under the COBRA rules.

COBRA coverage need not be offered to qualified beneficiaries who have already used their entire account as of the date of COBRA eligibility. For those with remaining balances in their accounts, COBRA must be offered but will be terminated at the end of the year in which the qualifying event that allows COBRA eligibility occurs.

If you still have an account balance, enrolling in COBRA will allow you to incur and be reimbursed for expenses after that date. If you do not elect to continue your contributions under COBRA and you do not have sufficient claims at the time you lose eligibility to take your balance to zero, you will forfeit your FSA account balance.

It only makes sense to continue your Health Care FSA contributions under COBRA if you have an unused balance in your FSA. This is because you must continue to make the same contributions to your FSA account while on COBRA that you were making as an active employee. Your contributions are made on a post-tax basis and you will lose them if you do not submit expenses against your account.

### **When COBRA Coverage Is 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 for the employee: the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

### **You Must Give Notice of Some Qualifying Events**

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs and provide documentation substantiating the divorce, legal separation or loss of dependent status and the effective date of the event.

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

### **How COBRA Coverage Is Provided**

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

Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want to elect continuation coverage. If you do not elect continuation coverage, your coverage under the Plan will end, *as of the date of the qualifying event*. If you elect continuation coverage, the Plan Sponsor is required to permit you to elect and purchase coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce, legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months from the date of the event. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

### **Disability Extension of 18-month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled (for purposes of Title II (OASDI) or Title XVI (SSI) of the Social Security Act) and you notify the Plan Administrator in a timely fashion as described below, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of the COBRA continuation coverage period and must last at least until the end of the 18-month period of continuation coverage. To benefit from this extension, the qualified beneficiary must notify the Plan Administrator of the Social Security Administration's determination within 60 days of such a determination and before the end of the original 18-month period of continuation coverage.

The qualified beneficiary must also notify the Plan Administrator within 30 days of the date of any final determination by the Social Security Administration that he or she is no longer disabled. You must provide these notices to the COBRA Administrator listed at the end of this summary, along with copies of correspondence from the Social Security Administration substantiating the disability/loss of disability and the effective date of the applicable Social Security Administration determination. Furthermore, during the period after the 18<sup>th</sup> month through the 29<sup>th</sup> month of continuation coverage, the monthly premium cost will be increased to 150% of the applicable premium relating to continuation coverage.

### **Second Qualifying Event Extension of 18-month Period of Continuation Coverage**

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan Administrator. You must provide this notice to the COBRA Administrator listed at the end of this summary, along with copies of documentation substantiating the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

### **The Cost of COBRA Continuation Coverage**

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

### **When and How Payment for COBRA Continuation Coverage Is Made**

**First payment for continuation coverage.** If you elect continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the election notice is postmarked, if mailed.)

If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Crosby Benefit Systems, a division of WageWorks, Inc. to confirm the correct amount of your first payment.

**Periodic payments for continuation coverage.** After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made on a monthly basis. Under COBRA, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break.

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

### **Early Termination of COBRA**

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

- The Plan Sponsor no longer provides health coverage to any of its employees,
- Any required premium for continuation coverage is not paid in full on time,
- A qualified beneficiary becomes entitled to Medicare (under Part A, Part B, or both) after electing COBRA continuation coverage, or
- A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

### **Another Option: Marketplace Coverage**

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and reduces your out-of-pocket costs for deductibles, coinsurance, and copayments) right away. You can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **COBRA Administrator**

More complete information regarding your COBRA continuation coverage rights is available from Crosby Benefit Systems, a division of WageWorks, Inc.

### **Keep the College Informed of Address Changes**

To protect your family’s rights, you should keep the Human Resources Office informed of any changes in the addresses of family members:

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

## **Family and Medical Leave Act (FMLA)**

All participants in the Plan are covered by this Act. Under FMLA, you are eligible for at least 12 weeks of unpaid leave for any of the following reasons:

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

If you take a leave of absence under FMLA, you may continue your Medical, Dental or Vision coverage during the leave by continuing to pay the required premiums. If you choose not to continue coverage while on an FMLA leave, you are not reimbursed for any Medical, Dental and/or Vision claims incurred while you are on the FMLA leave. You are eligible to apply for COBRA coverage while on leave.

On return from FMLA leave, the coverage that was discontinued or terminated is reinstated only on reapplication for coverage. If you do not return to work after your FMLA leave ends, you may be eligible to continue coverage under COBRA.

**For More Information.** For more information about FMLA, contact the Department of Labor at: <http://www.dol.gov/esa/whd/fmla/>.

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

Under this Act, you and your dependents have the right to continue your group health care coverage if you are on a military leave of absence. You and your dependents must pay for this coverage.

**For More Information.** To file for coverage under this Act, contact the Plan Sponsor or the Department of Labor at: <http://www.dol.gov/compliance/laws/comp-userra.htm>.

## **Claims and Appeals**

The Subscriber Certificates provided to you separately, at the time of your enrollment in coverage, explain how to claim benefits under the Plan. The Subscriber Certificates and the claims and appeal procedures described therein are incorporated by reference into this SPD. If benefits to which you believe you are entitled under the Plan are not paid, you must make a claim for benefits under the Plan in writing to the applicable Claims Administrator.

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

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

## MEDICAL CLAIMS

<b>Claims Administrator</b>	<b>Funding</b>	<b>Group Contract Number</b>
Harvard Pilgrim Health Care Member Services 1600 Crown Colony Drive Quincy, MA 02169 1-888-333-4742	Self-insured	<b>HMO</b> #060020 Policy #082439 <b>PPO</b> <b>(closed to new participants)</b> #069860 Policy #082440  <b>PPO Plus HSA</b> #040928 Policy #040928

## DENTAL CLAIMS

<b>Claims Administrator</b>	<b>Funding</b>	<b>Group Contract Number</b>
Delta Dental of Massachusetts Claims Department P.O. Box 9695 Boston, MA 02114 1-800-872-0500	Self-insured	<b>#7816</b>

## VISION CLAIMS

<b>Claims Administrator</b>	<b>Funding</b>	<b>Policy Number</b>
EyeMed, OON Claims 4000 Luxotica Place Mason, OH 45040	Fully insured	<b>#9858390</b>

## HEALTH CARE FSA CLAIMS

<b>Claims Administrator</b>	<b>Funding</b>	<b>Policy Number</b>
WageWorks P.O. Box 14053 Lexington, KY 40512 Fax: 1-877-353-9236	N/A	N/A

## **LIFE INSURANCE, SHORT TERM DISABILITY (UNION ONLY), AND LONG TERM DISABILITY CLAIMS**

<b>Claims Administrator</b>	<b>Funding</b>	<b>Policy Number</b>
Sun Life 1 Sun Life Executive Park Wellesley Hills, MA 02481 1- 800-247-6874	Fully insured	#224991

## **Employee Retirement Income Security Act of 1974 (ERISA)**

As a participant in the Wellesley College Employee Welfare Benefits 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 shall be entitled to:

### **Receive Benefits Plan and Program Information**

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continuation of Group Health Care Coverage**

You may 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 this coverage. Review this Summary Plan Description and the documents governing the Employee Welfare Benefits Plan for the rules governing your COBRA continuation coverage rights.

### **Prudent Actions by Plan Fiduciaries**

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

## **Enforce Your Rights**

If your claim for a plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the right described above. For instance:

- If you request a copy of the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Domestic Relations Order or a Medical Child Support Order, you may file suit in a federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance With Your Questions**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about the ERISA information provided here or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by going online at the Employee Benefits Security Administration at <http://www.dol.gov/ebsa/> or at the Department of Labor: <http://www.dol.gov/dol/topic/health-plans/erisa.htm>.

## **Plan Administration**

### **Authority of Plan Administrator**

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

Any insurance carrier from which benefits are purchased has discretionary authority to construe any and all terms of the group insurance policy it has issued, and the power and discretion to determine questions of fact and law arising in connection with the administration, interpretation and application of the group insurance policy.

### **Plan Administration**

All benefits under the Plan are administered by the insurance carriers from which the benefits are purchased, or in the case of certain self-funded benefits, by a third-party administrator. The name of each carrier or vendor is set out in the **Claims and Appeals** section of this SPD.

Unless otherwise indicated, all benefits furnished under the Plan are provided under the insurance policies, administrative contracts and/or Subscriber Certificates of the appropriate carrier or vendor identified in the **Claims and Appeals** section and they provide all necessary administrative services.

### **Plan Amendment or Termination**

The Plan Sponsor hopes to continue the Plan indefinitely but may change or discontinue the Plan with respect to all or any class of employees, at any time and for any reason, without notice. Any amendment or termination shall be effected by a written instrument signed by an officer of the Plan Sponsor, or his or her authorized delegate. No vested rights of any nature are provided under the Plan.

### **Plan Documents**

The documents constituting the Plan may be reviewed in the Human Resources Office.

## Important Plan Information

<b>Name of Plan:</b>	Wellesley College Employee Welfare Benefits Plan (the "Plan")
<b>Plan Sponsor, Administrator and Agent for Service of Legal Process:</b>	Wellesley College 106 Central Street Wellesley, MA 02481 781-283-3202
<b>Plan Sponsor's Employer Identification Number (EIN):</b>	04-2103637
<b>Plan Number:</b>	502
<b>Type of Plan:</b>	The Plan is a health and welfare plan providing Medical (including Prescription Drug benefits), Dental, and Vision coverage, Flexible Spending Account participation, Life Insurance, Short Term Disability (as eligible) and Long Term Disability (as eligible) as well as Employee Assistance Program benefits, as described in the corresponding Benefits Summaries and Subscriber Certificates.
<b>Sources of Plan Contributions:</b>	<p>The Medical and Dental coverage requires joint contributions from participating employees and the Plan Sponsor. The Plan Sponsor determines the amount participating employees must contribute.</p> <p>Employees pay the full cost of Vision, Contributory Life Insurance, Spouse Life Insurance and FSA deferrals without contributions from the Plan Sponsor.</p>
<b>Plan Year:</b>	The plan year is the 12-month calendar year from January 1 to December 31.

## IV. SPECIAL SITUATIONS

### Leave of Absence/Sabbatical Coverage

Benefits continue while you are on a leave of absence or sabbatical unless you inform the Human Resources Office otherwise. The length of time that benefits continue varies by the benefit and type of leave. If you want to stop or change your coverage, you have 30 days from the start of your leave to request this change in writing. Please contact the Human Resources Office with any questions.

### Medical, Dental and Vision Coverage

Your Medical, Dental and Vision coverage automatically continues while you are on a leave or sabbatical. If you want coverage to stop, you must submit this request in writing to the Human Resources Office. If you cancel coverage, you can re-enroll when you return from leave or at the next Open Enrollment period.

### Billing and Payment

**Paid Leave/Sabbatical.** If you are on a paid leave or sabbatical, you will continue to pay the employee portion of the premium through payroll deduction.

**Unpaid Medical Leave.** If you are on an unpaid, medical leave, you will be billed for the employee portion of the premium on a post-tax basis.

**Long Term Disability.** If you are on Long Term Disability, you will be billed for the employee portion of your Medical, Dental and Vision premiums (at the active employee rate and on a post-tax basis) for as long as you are covered under any of these plans.

**Unpaid Personal Leave.** If you are on an unpaid, personal leave, you will be billed for continued coverage at 100% of the cost of coverage (employee and employer cost) on a post-tax basis.

You have the option to pay your premiums on a monthly basis via check or in one lump sum payment. If premium payments are not made, your participation in any benefits you have elected will end. Once these benefits end, you will have to wait until the next Open Enrollment period to re-enroll or you may be able to re-enroll upon your return to work if you are on an unpaid leave (if permitted by law).

### Flexible Spending Account Participation

**Paid Leave/Sabbatical.** If you are on a paid leave or sabbatical, any Flexible Spending Account contributions you are making will continue.

**Unpaid Leave.** If you go on an unpaid leave of absence, your FSA contributions will stop because you have no paycheck from which to deduct your contributions:

- Claims incurred under the Health Care FSA during your leave will not be eligible for reimbursement unless you elect to continue participation through COBRA. If you elect COBRA coverage, you may be reimbursed for expenses during your leave of absence (and before the end of the calendar year, if your leave extends beyond that). You can stop COBRA once you have used your balance.
- Claims incurred under the Dependent Care FSA during your leave are eligible for reimbursement through the end of the calendar year of the leave. There is no COBRA for the Dependent Care FSA.

**Returning from Leave.** If you elected to continue your contributions to the Health Care FSA under COBRA, and you return to work during the same calendar year, your deductions will begin again based on your remaining pay periods and your total election for that calendar year (minus what you had contributed post-tax while on COBRA). If you did not elect COBRA, and you return to work in the same calendar year, your deductions for either FSA will begin again based on your remaining pay periods and your total election for that calendar year.

If you return in another calendar year, you must make a new FSA election to participate. Coming back from an unpaid leave of absence in another calendar year is considered a qualifying event and allows you to elect to participate in an FSA.

### **Continued Life Insurance and Disability Coverage**

For more information about whether and how your Life Insurance, Short Term Disability and/or Long Term Disability continues while you are on a leave or sabbatical, please contact Human Resources.

## Retiree Benefits

You may be eligible for retiree benefits from the College if you meet certain requirements. If you are considering retirement, you should contact the Human Resources Office at least three months prior to your prospective retirement date to determine your eligibility for retiree benefits.

**Important:** As noted in the Summary Plan Description Notice, the College reserves its right to amend or terminate any benefits offered under the Plan, including any retiree benefits, subject to applicable law and the terms of any collective bargaining agreements.

### Eligibility for Retiree Benefits

You are eligible for the benefits outlined below if you retire and are:

- At least age 60 and
- Have at least 10 years of benefit-eligible service and
- Are under age 65 (or your spouse is under age 65).

### Medical, Dental and Vision Coverages

If you meet the eligibility rules above and are enrolled in the Medical and Dental plan(s) at the time you retire, the College will pay the portion of medical and dental premiums it pays for all employees up to the first of the month in which you turn age 65, provided this is permitted under applicable law and the College's plans. You continue to pay the medical and dental premiums that you would pay as if you were an active employee, up to the first of the month in which you turn 65.

Retiree Medical and Dental coverage is available to retiree spouses until the earlier of five years or when he/she reaches age 65 as long as your spouse does not have access to group coverage elsewhere. Eligible dependents remain on the plan until you or your spouse ages out.

You will automatically be offered COBRA continuation coverage if you have Vision coverage when you retire. COBRA coverage can continue for up to 18 months; you pay 102% of the cost.

### Flexible Spending Account Participation

If you are enrolled in a Health Care FSA at the time of your retirement, you may continue post-tax contributions to your FSA through COBRA. If you are participating in a Dependent Care FSA, your participation ends when you retire. See the **COBRA** section for more information.

### **Life Insurance Benefits**

You may convert your current life insurance coverage – without providing medical evidence – if you contact Sun Life within 31 days of retiring. You receive an additional life insurance benefit (\$2,500 for faculty or exempt employees or \$1,000 for non-exempt employees) if you:

- Are at least age 65 and
- Were hired before January 1, 1995 and
- Have at least 10 years of service.

### **Other Benefits at Retirement**

Your Short Term Disability, Long Term Disability and Employee Assistance Program benefits end when you retire.

### **ExtendHealth**

Wellesley College offers a benefit service for retiring employees age 65 and over. Extend Health is available to retiring employees age 65 and over to give you personalized support when choosing a Medicare supplement plan. ExtendHealth is not an insurance company. Their trained and licensed benefit advisors educate you about Medicare and will do the legwork to determine which plans meet your individual needs and budget. Together, you evaluate the plans and choose the best one for you. Once you are ready to enroll, ExtendHealth will walk you through the enrollment process.

**For More Information.** Contact ExtendHealth at <https://www.extendhealth.com/retireebenefits> or call 1-888-724-3001.

## V. Contact Information

### Provider Information

Websites and telephone numbers for our benefit plan providers are listed below so that you can obtain more information about these benefits.

Plan Provider	Website	Telephone
Medical (Harvard Pilgrim Health Care)	<a href="http://www.harvardpilgrim.org">www.harvardpilgrim.org</a>	1-888-333-HPHC
Health Advocate	<a href="http://www.healthadvocate.com/members">http://www.healthadvocate.com/members</a>	1-866-695-8622
Dental (Delta Dental)	<a href="http://www.deltadentalma.com">www.deltadentalma.com</a>	1-800-872-0500
Vision (EyeMed)	<a href="http://www.eyemedvisioncare.com">www.eyemedvisioncare.com</a>	1-866-9-EYEMED
Flexible Spending Accounts and Health Savings Account (WageWorks)	<a href="http://www.WageWorks.com">www.WageWorks.com</a>	1-877-924-3967
Life and Disability Insurance (Sun Life)	<a href="http://www.sunlife.com/us">www.sunlife.com/us</a>	1-800-247-6875
Employee Assistance Program (EAP)	<a href="http://www.allonehealthcap.com">www.allonehealthcap.com</a> Username: wellesley Password: employee	1-800-451-1834

### Human Resources Information

Human Resources Office  
Wellesley College  
106 Central Street  
Wellesley, MA 02481  
781-283-3202

Benefits Manager: 781-283-2215

Benefits Coordinator: 781-283-2212