Skidmore College Flexible Benefits Program

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Skidmore College Flexible Benefits Program

INTRODUCTION

This benefit brochure is a description of Skidmore College's Flexible Benefits Program. This brochure, in combination with handbooks and certificates from the insurance companies and vendors, constitutes your summary plan description. This brochure will:

- □ Provide a comprehensive source of information about Skidmore benefit plans and programs.
- □ Make your Skidmore benefits plans easier to access and understand when you need them most.
- □ Help you with personal benefits and cost planning.

Please retain this brochure for future reference and share it with your family.

Reviewing the information contained here will help you make the benefit choices that best protect you and your family. Although Skidmore cannot directly advise you or provide individual counseling on which benefit plans you should select, Human Resources can provide you with in-depth information on each of the plans to help you reach an informed decision. This booklet is not meant to interpret, extend, or change the plans in any way. The provisions of the plans can only be determined by consulting the plan documents. A copy of each plan is on file with Human Resources, Barrett Center, and may be reviewed by an employee at any reasonable time. In the event of a discrepancy between this booklet and the actual provisions of each plan, the plan document from the insurance company/vendor shall govern.

Skidmore College offers a cafeteria plan to eligible employees called the "Skidmore College Flexible Benefits Program." This cafeteria plan allows employees to choose from a "menu" of one or more qualified benefits. You will have the opportunity to pay for employee contributions, if any, with tax-free dollars. Additionally, the program allows you to have a portion of your pay set aside before any taxes have been calculated to be applied to "Flexible Spending Accounts" to pay for certain health care expenses and dependent day care costs not covered elsewhere in the Program.

Enrollment and Effective Dates

As a newly hired benefit eligible employee, you are covered under this Program the first of the month following date of hire. If hired on the first of the month, benefits begin immediately. You will have the opportunity to attend a detailed benefits orientation shortly after you begin employment to choose benefits for the remainder of the benefit year (calendar year). An initial benefit package, along with pertinent applications, will be given to you prior to or on your employment date. Included in this package will be Human Resources' web address for you to review your benefits prior to your benefits orientation. You will be given a personalized Benefits Election Form during your benefits orientation to select your benefits. Continuing employees have the opportunity to change their benefits during open enrollment each November to be effective the following January 1 by logging in to *My Employment Information, My Benefits* at the following link: https://apps.skidmore.edu

Skidmore College Flexible Benefits Program

GENERAL INFORMATION

Why Flexible Benefits?

There are three reasons why Skidmore College offers its employees the Flexible Benefits Program:

- To allow you to tailor certain benefits to your specific needs;
- To provide a variety of benefit options and let you pay for certain expenses with tax-free dollars;
- To help Skidmore better manage future increases in benefit costs while offering you the opportunity to choose the benefits you consider most appropriate for you.

What Plans Are Included?

- The plans that are included in the Flexible Benefits package are:
- Three health care plans plus the choice to waive coverage if you have health care coverage elsewhere;
- Dental coverage;
- Life insurance for yourself;
- Two separate Flexible Spending Accounts (FSA); one that reimburses you for certain health care related expenses, including dental and vision expenses; and another that reimburses you for dependent day care expenses.

Benefits Election Form

Human Resources will contact you and schedule your benefits orientation following employment. At that time, you will be given a personalized Benefits Election Form for benefit selection. Your completed Benefits Election form and enrollment applications (if applicable) should be forwarded to Human Resources by the deadline indicated on your form.

You will be able to print a Confirmation Statement from the online benefits enrollment system for your records. It is important that you verify the accuracy of each entry since your benefit elections are based on this information. The benefits listed on your Confirmation Statement will be deemed correct unless we hear from you prior to the following pay date, and they will remain in effect until the following benefit year (January 1 of the following year).

A *Navigation Guide for Online Benefit Enrollment* is located at the link: http://cms.skidmore.edu/hr/benefits/benefitsprograminfo.cfm. You may wish to print this out prior to your login. To log on to the Benefits Enrollment System, go to https://apps.skidmore.edu. Once you logon, select *My Employment Information*, then *My Benefits*. You will also use this system to change or elect benefits during each open enrollment period.

Special Enrollment Periods

You normally may enroll for health care benefits during either your initial enrollment period or the annual open enrollment period. For medical coverage (but not dental, vision care or health care flexible spending accounts), you also may have a special enrollment period based on rules enacted by the Health Insurance Portability and Accountability Act (HIPAA). These rules are summarized below. (The term "dependent" includes a spouse or domestic partner.)

Special Enrollment Following Loss of Other Medical Coverage

Enrollment of Employee
You may enroll during a special enrollment period if you had other medical coverage when you previously declined medical coverage under this plan and:

- □ COBRA Coverage: If the other coverage was COBRA coverage, and that coverage has since been exhausted; or
- □ Non-COBRA Coverage: If the other coverage was not COBRA coverage, and either: (A) the other employer's contributions toward the other coverage have been terminated; or (B) the other coverage has been terminated due to loss of eligibility – for reasons including legal separation, divorce, death, termination of employment, or reduction in hours of employment.

A "loss of eligibility" does not include loss due to nonpayment of premiums on a timely basis, or termination of the other coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Therefore, these circumstances do not give rise to a special enrollment period.

Enrollment of dependent
A dependent who previously was not enrolled because of having other coverage also may be enrolled if that coverage is lost (see above).

Enrollment of employee and dependent
You may enroll both yourself and your dependent if either of you had other coverage when you declined coverage under this Plan, and that coverage later is lost as explained earlier in this section.

Special enrollment period following loss of other coverage

Coverage under the special enrollment rules must be elected within the 30-day period after the other coverage ends. The application must be made under the same application rules that apply to other enrollments. If elected, coverage begins on the first day of the calendar month that begins after the date that the completed request is received by the Plan.

Special enrollment with respect to certain dependents

Enrollment of dependents (and yourself)
You may enroll dependents in the health insurance plans – and yourself if you are not already enrolled – by complying with the Plan's procedures for other enrollments, if an individual becomes your dependent through marriage (the spouse and any eligible stepchildren), birth, adoption or

placement for adoption. In the case where a child is born, adopted or placed for adoption, your spouse also may be enrolled during such a special enrollment period. You may also change from one healthcare coverage option to another when you add a dependent under a special enrollment.

Time of enrollment after acquiring a dependent
The special enrollment period for dependents is the 30-day period that begins on the date of the marriage, birth, adoption or placement for adoption, as applicable. The coverage is effective (i) in the case of marriage, the date the completed request for enrollment is received by the Plan; (ii) in the case of a dependent's birth, the date of the birth; and (iii) in the case of adoption or placement for adoption, the date of such adoption or placement.

Who is Eligible?

You are eligible to participate in Skidmore's Flexible Benefits Program if you are a non-union, regular, full-time employee, or a part-time U.S. employee hired to work in a 12-month position for at least 1,365 hours per year; Faculty appointed in temporary positions for the full academic year; or Administrative/Professional and Support Staff hired in full-time temporary positions for at least 9 consecutive months; Faculty, Administrative/Professional and Support Staff appointed to an approved shared position. Your participation will begin on the first of the month following date of hire. If hired on the first of the month, benefits begin immediately.

You may cover your dependent(s) under the Program at the time of enrollment or within 30 days of acquiring a new eligible dependent. ***Skidmore must approve the documentation provided to determine dependent status.*** Your eligible dependents are your:

- Spouse
  Same-sex parties to marriages validly performed outside of New York must be treated as "spouses" for purposes of the New York Insurance Law, including all provisions governing health insurance.

- A "Dependent" for purposes of group health plan coverage is typically defined by reference to section 152 of the Internal Revenue Code ("Code"), which describes dependent status based on whether an individual is a "qualifying child" or a "qualifying relative." Effective January 1, 2009, the Fostering Connections to Successful and Increasing Adoptions Act of 2008 changed the definition of "qualifying child" under Code Section 152(c). This information applies to the other following categories of children.

  Two new requirements are added to the definition of "qualifying child:"

  1. The child must be younger than the taxpayer claiming the individual as a dependent;

  and

  2. The child must not have filed a joint return (other than only for a refund claim) with the child's spouse for the taxable year in question.

  The new law also allows a non-parent to claim the child as a dependent, as long as the parents do not, and the nonparent's adjusted gross income is higher than the highest adjusted gross income of any of the parents.

□ Unmarried Children up to 19 years of age (or up to 25 years of age if still your dependent, and a registered full-time student in an accredited college or university), as follows:

- biological children
- stepchildren dependent upon you
- children supported by you through legal guardianship through court order and living at your home
- children legally adopted by or placed for adoption with you or your spouse
- children for whom you are the proposed adoptive parent and who is dependent upon you during the waiting period prior to the adoption becoming final

□ Unmarried Children up 25 years of age and a full-time college student as above, on a certified medical leave of absence of up to 12 months (under Michelle's Law, Public Law No. 110-381 effective plan years beginning on or after October 9, 2009. Generally, the law provides that the plan cannot terminate coverage prior to the earlier of the date that is one year after the first day of the medically necessary leave of absences or the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence must commence while the child is suffering from a serious illness or injury, be medically necessary and cause the child to lose student status as defined by the plan.

□ Unmarried Children of any age incapable of self-support because of a mental or physical disability, who become disabled before reaching the limiting age (plan requires periodic medical documentation)

□ domestic partner who is

- age 18 or older, and
- unmarried, and
- not related to you by marriage or blood in any way that would bar marriage, and
- residing with you, and
- financially interdependent with you, and
- involved in the domestic partnership for a period of not less than 6 months, and
- someone with whom you have made a lifetime commitment to each other and
- be each other's sole domestic partner.

Please read the Domestic Partnership Benefits Policy and Affidavit for required documentation. http://cms.skidmore.edu/hr/benefits/index.cfm

□ Children of Domestic Partners

To be eligible for coverage under your benefit plans, children of domestic partners must meet the plans' eligibility requirements, must reside in your household, and must receive 51 percent or more of their support from you.

Please read the Domestic Partnership Benefits Policy and Affidavit for further requirements. http://cms.skidmore.edu/hr/benefits/index.cfm

When Coverage Ends

Your coverage under Skidmore's Flexible Benefits Program will terminate on the earliest of the following dates:

- The date you or your dependents no longer satisfy the eligibility requirements of the Program;

  or

- The end of the month in which you terminate employment. If your coverage is terminated, you may be eligible to continue health care and dental benefits (please refer to the section of the booklet entitled "Continuation of Coverage Required by Federal Law"). If you change to a non-eligible status, you are eligible to purchase coverage and continue your Flexible Spending Accounts on a taxable basis.

If you change employment status, your participation may be affected. The regulations pertaining to mid-year employment changes are outlined below:

Employment Changes	Rules and Regulations
From non-eligible part-time status to regular full-time status	Entry into Flexible Benefits Program on first of month following change of status
From non-eligible temporary status to regular full-time status	Entry into Flexible Benefits Program on first of month following change of status
From regular status to non-eligible temporary or part-time status	Stop participation in Flexible Benefits Program the first of month following change in status

Changing Your Elections

You will have an opportunity to change your benefit elections once every year to be effective January 1. Annual election forms are normally distributed in November. After the designated deadline for benefit selection for the coming plan year (January 1 through December 31), you may change your elections during the plan year only if you have a change in status as defined below:

- Legal marital status;
- Number of dependents;
- Employment status of employee, spouse or dependent;
- Work schedule of employee, spouse or dependent, including a strike or lock-out;
- A dependent's eligibility status;
- Change in residence or worksite;
- Commencement or termination of adoption proceedings;
- Significant or insignificant change in cost to your benefits or dependent care expenses;

- ☐ Significant curtailment of coverage of your benefits;
- ☐ Addition or elimination of benefit options;
- ☐ Change in coverage of spouse or dependent under other employer's plan;
- ☐ FMLA leave;
- ☐ COBRA event;
- ☐ Judgment, decree, or court order;
- ☐ Medicare or Medicaid entitlement.

HEALTH CARE COVERAGE

Electing Coverage

You can cover yourself (employee only), yourself and one dependent (employee plus one), or yourself and two or more dependents (family) under any of the health care plan options offered by Skidmore College. Qualified Domestic Partners and their dependent children may also be eligible for coverage under your health care plan (not all health care plans cover children of domestic partners). You can also choose to waive coverage if you have health care coverage elsewhere.

If you do not enroll yourself or your dependents in a health care plan when you are first eligible for participation in the Flexible Benefits Program, you can not enroll until the following plan year (January 1) unless you incur a family status change (see *Changing Your Elections* on page 8).

The cost of a health care plan to you will vary depending on the level of coverage needed (i.e. employee only, employee plus one, or family), the health care plan chosen, and your annual base salary. Your employee contribution will be deducted from your paycheck, prorated over the remainder of the calendar year (for continuing employees prorated over the entire calendar year) before state, federal and FICA taxes are calculated. An *Employee Health Care Cost Sharing* sheet is located at http://cms.skidmore.edu/hr/benefits/benefitsprograminfo.cfm. Once you select a health care plan, you will be asked to indicate the plan and your annual cost on your benefits election form.

Employees in approved shared positions are normally required to pay for half of the annual cost, plus half of the designated cost sharing in their salary band for their elected health care plan. More detailed information is located in the policy on Shared Appointments.

Health Care Issues

If you enroll in health care coverage, you must choose a coverage category that will determine how many people are covered for your health care benefits. In choosing a coverage category you should know:

- ☐ You must cover yourself if you are electing health care benefits;
- ☐ You may choose individual coverage regardless of family status;
- ☐ You may choose different coverage categories in health care and dental care benefits.

Health Care Plan Options

You have three health care plan options from which to choose: The Skidmore College PPO Plan, also known as Traditional Blue PPO through Blue Shield of Northeastern New York, which utilizes a preferred provider organization (PPO), and two health maintenance organizations (HMOs), MVP Health Plan and Capital District Physicians' Plan (CDPHP). A PPO allows you the choice of utilizing in-network physicians and providers for the least out-of-pocket cost to you, or out-of-network providers to maintain your choice of physicians and other health care providers for treatment. Utilizing out-of-network providers will normally result in higher cost to you. An HMO is a specified organization of participating health care providers that offers a certain range of health care in return for a set fee, normally in one geographic location.

A health care plan comparison summary is outlined on the following pages; however, please refer to the actual individual plan booklets for more detailed coverage.

Health Care Plan Options and Highlights

To assist you in making informed decisions, the following is a summary of the health care plans Skidmore College offers.

The Skidmore College PPO Plan (also know as Traditional Blue PPO through Blue Shield of NENY) This Plan is a self-insured Plan and allows choice of designated physicians and other health care providers in the Blue Shield PPO network for local services and the Blue Cross Blue Shield national network of providers for services out of the area. In choosing a participating provider (in-network), the Plan offers the opportunity for the least out-of-pocket expense to you. Please refer to the actual Plan document or the *Health Care Plans Comparison* on page 12 and 13 for the co-pay when utilizing in-network providers. Participating providers have agreed to accept your Plan co-pay (if any), submit their bill for service, and accept payment directly from Blue Shield of NENY as payment in full.

You have the right to continue to use an out-of-network provider. However, the cost for services in the calendar year will be subject to an annual deductible and will be paid at 80% of reasonable and customary fees. You will be responsible for 20% co-insurance. Pre-notification on certain services is required; however, it is the responsibility of the treating physician or health care provider to notify Blue Shield of NENY.

Prescription Coverage for PPO

Prescription coverage, as well as prescriptions by mail order, is offered under this Plan through informRx (previously NMHCRx). **Please note that prescription coverage is not administered by Blue Shield of NENY.** The prescription coverage is a mandatory generic fill program with three (3) levels of co-pays depending on the type/brand of drug purchased.

MVP Health Plan: This Plan is a health maintenance organization (HMO) which requires employees to choose a participating primary care physician when enrolling in the Plan. To utilize a participating specialist, a referral from the designated primary care physician is

required. Participating physicians are normally located in the capital district. The Plan also includes preventive dental services for children under the age of 19. Prescription coverage is included, as well as prescriptions by mail order. The Plan is a mandatory generic fill program with three (3) levels of co-pays depending on the type/brand of drug purchased.

Capital District Physicians' Health Plan: This Plan is a health maintenance organization (HMO) which requires employees to choose a participating primary care physician when enrolling in the plan. To utilize a participating specialist, a referral from the designated primary care physician is required. Participating physicians are located in the capital district. Prescription coverage is included, as well as prescriptions by mail order. The Plan is a mandatory generic fill program with three (3) levels of co-pays depending on the type/brand of drug purchased.

Skidmore College Flexible Benefits Program

Health Care Plans Comparison

Available Plan Options:	Skidmore College PPO Plan Traditional Blue PPO through Blue Shield of NENY http://www.bsneny.com/		MVP Health Plan (HMO) http://www.mvphealthplan.com	Capital District Physicians' Health Plan (HMO) http://cdphp.com
	In-Network Coverage	**Out-of-Network Coverage**		
Plan Services:	Choice of participating physicians in Traditional Blue PPO network for local services and Blue Cross Blue Shield national network for out-of-area services Pre-Certification required for designated health care services Provides for certain health and wellness services	Choice of physicians Pre-Certification required for designated health care services Provides for certain health and wellness services Annual deductible ($200 individual/$500 family) and coinsurance applies (20%)	Choice of participating primary care physicians and specialists in service area Designation of Primary Care Physician required Pre-Certification required for certain health care services Provides for health and wellness services Provides a preventive dental program for children	Choice of participating primary care physicians and specialists in service area Designation of Primary Care Physician required Referral to specialists required Pre-Certification required for certain health care services Provides for health and
Alternative Health Care Benefit: o Acupuncture o Fitness Center Membership o Fitness Classes o Homeopathic o Hypnotherapy for weight control or o smoking cessation o Massage Therapy o Nutritional Counsel o Weight Control Programs	Plan pays 100% up to a limit of $300 per family per calendar year Products purchased through these programs are not covered benefits	Plan pays 100% up to a limit of $300 per family per calendar year Products purchased through these programs are not covered benefits	Some discounts available for health and wellness programs	Some discounts available for health and wellness programs
Routine Physical	$15 employee co-pay; Plan covers one per year	Not Covered	$15 employee co-pay	No Charge
Office Visits	$15 employee co-pay per visit	Deductible and Coinsurance	$15 employee co-pay per visit	$15 employee co-pay per visit
In-patient (IP) Hospitalization - Room, Board & Ancillary Service	$200 individual; $500 family aggregate co-pay	Deductible and Coinsurance	100% coverage	100% coverage
Prescription Drugs Automatic Generic Fill Programs	**informedRx **** (not a Blue Shield plan) http://nmhcrx.com *$5 employee co-pay for generic; $20 or $35 employee co-pay for brand name; Mail Order Program 90 day supply available at 2x employee co-pay; Mandatory Mail Order for Maintenance Drugs	**informedRx**** (not a Blue Shield plan) Out-of-network pharmacy will charge employee full cost of drug; Employee may not be reimbursed full cost of prescription if a participating pharmacy was available	*$5 employee co-pay for generic; $20 or $40 employee co-pay for brand name; Some drugs excluded; Mail Order Program 90 day supply available at 2½ x employee co-pay	$10 employee co-pay for generic; $25 or $40 employee co-pay for brand name; Some drugs excluded; Mail Order Program 90 day supply available at 2 ½ x employee co-pay

Health Care Plans Comparison …cont'd

Available Plan Options:	Skidmore College PPO Plan Traditional Blue PPO through Blue Shield of NENY http://www.bsneny.com/		MVP Health Plan (HMO) http://www.mvphealthplan.com	Capital DistrictPhysicians' Health Plan (HMO) http://cdphp.com
Plan Services	**In-Network Coverage**	**Out-of-Network Coverage**		
In-patient Mental Health Services and Substance Abuse Detox/Rehab	100% coverage after IP copay 100% coverage after IP copay	Deductible and Coinsurance Deductible and Coinsurance	100% coverage 100% coverage	100% coverage 100% coverage
Diagnostic X-rays, Lab & MRIs	100% Coverage (MRIs need prior authorization)	Deductible and Coinsurance (MRIs need prior authorization)	$15 employee co-pay for x-rays No employee co-pay on Laboratory Testing	No co-pay at participating Facilities; $15 employee co-pay at non-participating facilities
Mental Health Services and Substance Abuse Services Outpatient Care	$15 employee co-pay per visit	Deductible and Coinsurance	$15 co-pay per visit	$15 co-pay per visit
Routine Vision Care	$15 employee co-pay for eye exam; Plan pays up to $150 for frames, lenses or contacts; benefit payable every 24 mo.	Deductible and Coinsurance for eye exam; Plan pays up to $150 for frames, lenses or contacts; benefit payable every 24 mo.	$15 employee co-pay for eye exam; Plan pays 50% up to $75 for frames and lenses or contacts; benefit payable every 24 months	None
Chiropractors	$15 employee co-pay; Plan pays up to $1,500 per year	Deductible and Coinsurance; Plan pays up to $1,500 per year	$15 employee co-pay with referral from primary care physician	$15 employee co-pay with referral from primary care physician
Adult Immunizations over age 19	100% coverage	Deductible and Coinsurance	$15 employee co-pay	$15 employee co-pay
Colonoscopy Screening age 50+	100% coverage	Deductible and Coinsurance	$15 employee co-pay	$75 employee co-pay

- Skidmore College PPO Plan out-of-network:
  Services subject to annual deductible of $200 individual and $500 family aggregate
  Services subject to the deductible and coinsurance are paid according to usual and customary fees
  Employee pays 20% of charge for services (coinsurance) after annual deductible is met; Plan pays 80%
  Services subject to an annual out-of-pocket expense on coinsurance of $1,500 individual and $3,000 family aggregate
- **Skidmore College PPO Plan: Prescription coverage for Medicare eligible retirees, and their dependents who are Medicare eligible, is through SilverScript www.skidmorecollege.silverscript.com.
- Skidmore College PPO Plan: NMHCRx prescription provider has changed their name to informedRx.
- Health Maintenance Organizations (HMO) require a designated primary care physician.
- * If prescription filled with brand name drug and there is a generic equivalent drug available, you must pay appropriate co-pay plus cost difference between the generic and brand name drug.
- Federal Mental Health Parity Mandate: The visit and inpatient day limitations of mental health and substance abuse are no more restrictive than the visit and inpatient day limitations of the medical and surgical benefits covered under all plans outlined above.
- The above comparison is intended to provide plan highlights only; Complete plan summaries can be obtained in Human Resources.
- All plans outlined above cover same and opposite sex Domestic Partners – see Domestic Partnership Policy for full details.

Making Decisions About Health Care Plans

To decide which plan is right for you, there are several things you should consider. This section lists some of the key questions you should ask before electing any of the plans.

Can You Get Health Care Coverage Under Another Plan?

If you have a spouse who works, you may be eligible for coverage under his/her plan. You should review the cost and coverage of your spouse's plan before you make your election.

Must You Enroll in a Health Care Plan?

If you don't have health care coverage elsewhere, you must elect one of the College's health care plans. Health care coverage helps to keep medical problems from becoming financial problems, especially in cases of serious illness or injury.

How Do You Decide If an HMO Is Best for You?

HMOs (MVP Health Plan and Capital District Physicians' Health Plan) are different from a Preferred Provider Organization (Skidmore College PPO Plan). You should be sure that the Plan you elect offers the services that are specific to your needs.

Your Decision

When you decide which health care plan is right for you, enter your selection on the Benefits Election Form (or the online benefits enrollment system during open enrollment). Be sure to complete the dependent information on the form and complete all additional applications that must be forwarded to the insurance carriers by Human Resources.

DENTAL PLAN COVERAGE

The College offers two comprehensive dental plans.

What is covered under the dental plan?

Dental Plan A		
Services	**In-Network Dentists**	**Out-of-Network Dentists***
Preventive Services	100% covered by Plan	100% covered by Plan
Basic Services	90% covered after deductible	80% covered after deductible
Major Services	60% covered after deductible	50% covered after deductible
Orthodontics (up to age 19)	50% covered after deductible	50% covered after deductible
Maximum Benefit Per Family Member Per Year	$1,250	$1,250
Orthodontics Maximum Lifetime Benefit Per Child up to age 19	$1,250	$1,250
Discounted Services	Up to 30%	n/a

Dental Plan B		
Services	**In-Network Dentists**	**Out-of-Network Dentists***
Preventive Services	100% covered by Plan	100% covered by Plan
Basic Services	80% covered after deductible	80% covered after deductible
Major Services	50% covered after deductible	No Coverage
Orthodontics (up to age 19)	No Coverage	No Coverage
Maximum Benefit Per Family Member Per Year	$1,000	$1,000
Discounted Services	n/a	n/a

Dental Services are outlined below. However, please review the Dental Plan brochure for a detailed description of coverage.

Preventive Services
Teeth Cleaning
Oral Examinations
Emergency Treatment
X-Rays

Basic Services
Laboratory Tests
Extractions and other Oral Surgery
Fillings: Amalgam, Silicate & Acrylic
Periodontal Services
Root Canal
Repair & Maintenance of Bridgework & Dentures
Anesthesia

Major Services
Gold & Porcelain Fillings & Crowns
Installation of Bridgework & Dentures

- In-Network = Participating Dentists in the Delta Dental Plans;
- *Out-of-Network dental charges will be paid for only up to reasonable and customary charges.
- Basic, Major and Orthodontic coverage are subject to a $50 per person/$150 family calendar year deductible;
- Children are eligible for coverage up to age 20, or through age 26 if they are full-time students;
- Discounted Services refers to the set maximum fees that have been negotiated with participating dentists. They average 30% less than the fees usually charged.

What is the cost of the dental plan to employees?

The cost of the dental plan is the responsibility of the participating employee and is purchased with tax-free dollars through the Flexible Benefits Program. The College does not contribute to

the cost of this Plan. The cost of the plan may be found at:
http://cms.skidmore.edu/hr/benefits/benefitsprograminfo.cfm.

Is there an annual deductible?

An annual deductible of $50 per person or $150 per family is applied to all services excluding preventive services. A separate deductible is applied to child orthodontics.

Who may participate in the dental plan?

You are eligible to participate in the dental plan if you are a regular full-time employee or a part-time employee hired to work in a 12-month position for at least 1,365 hours per year; Faculty appointed in temporary positions for the full academic year; or Administrative/ Professional and Support Staff hired in full-time temporary positions for at least 9 consecutive months; Faculty, Administrative/ Professional and Support Staff appointed to an approved shared position. Your participation will begin on the date your Flexible Benefits Program is effective. Children are covered up to age 20, or until age 26 if they are full-time students, in both Plan A and Plan B.

You may choose dental coverage even if you have not enrolled in a health care plan through Skidmore College. If you elected an individual health care plan through the College, you may enroll yourself and family members in the dental plan or vice versa.

GROUP TERM LIFE INSURANCE

Skidmore College provides you with $50,000 group term life insurance which ceases at separation of employment. You may also elect additional group term life insurance at the following levels during your benefits orientation: $50,000; $100,000; $150,000; $200,000; or $250,000.

You may choose any level of additional coverage at the time of hire without filling out a medical questionnaire. You may also request to increase the amount of coverage you have during any open enrollment period; however, be aware that you may have to complete a medical questionnaire at that time, and the insurance company does have right of refusal to increase your coverage based on your answers to the health questions.

Who may participate in the group term life insurance plan?

You are eligible to participate in the group term life insurance plan if you are a regular or temporary full-time U.S. employee hired in a 9 to 12 month appointment, or a part-time employee hired to work in a 12-month position for at least 1,365 hours per year; full-time Faculty appointed in temporary positions for at least two consecutive semesters; and Faculty, Administrative/Professional and Support Staff appointed to an approved shared position.

What is the cost of the group term life insurance plan?

There is no cost to you for the base $50,000 plan the College provides. The cost for additional coverage you elect will be based on the amount elected and your age at the time of benefit eligibility. Thereafter, the cost will be based on your age each January 1. Your cost can be found at http://cms.skidmore.edu/hr/benefits/benefitsprograminfo.cfm. Continuing employees will receive their cost during each open enrollment period for the following January 1. When you decide what level of additional life insurance you want to elect, indicate it in the appropriate section on your Benefits Election Form.

Are there other costs to employees when buying group term life insurance?

Under federal guidelines, the value of group term life insurance in excess of $50,000, referred to as imputed income, is taxable income and, as such, is reported annually on your W2. The taxable value of group term life insurance is determined by age and the rate outlined in Table 1 of Treasury Regulation Section 1.79-3 (see next page). While the value is subject to federal, state and FICA taxes (Social Security/Medicare taxes), the College is only required to withhold FICA taxes.

Imputed Income Table I Rates

Your Age on December 31	Monthly Rate Per $1,000 of Benefit
<25	0.05
25 – 29	0.06
30 – 34	0.08
35 – 39	0.09
40 – 44	0.10
45 – 49	0.15
50 – 54	0.23
55 – 59	0.43
60 – 64	0.66
65 – 69	1.27
70+	2.06

EXAMPLE:

Employee age 45

$150,000 group term life insurance coverage elected in addition to the basic $50,000 the College provides. Table I rate for age 45 is 15 cents per $1,000 per month.

<u>$150,000</u> group term life insurance coverage in excess of $50,000

Imputed Income per month:	$22.50 ($0.15 x 150)
Imputed Income annually:	$270.00.00 ($22.50 x 12)
Imputed Income per paycheck:	$10.38 ($135.00 / 26 pay periods)
FICA tax withheld per paycheck:	$ 0.79 ($10.38 x .0765*)
Amount of Imputed Income reported on W2:	$270.00

Federal and state income tax liability will depend on your personal circumstances. *Full FICA rate applied to first $87,900 of earnings as of January 1, 2004. Thereafter, only the Medicare

portion of the FICA rate is applied. Current FICA rate is 7.65% (6.20% Social Security and 1.45% Medicare) and it will be adjusted accordingly as the rate is increased.

Beneficiary Designation

It is important to name at least one primary beneficiary for your group term life insurance coverage. You may also choose to name at least one secondary beneficiary. Make sure that the total percentage you designate for your primary (and secondary) beneficiaries equals 100%.

If you die while covered, your beneficiaries will be notified of the following death benefit payment guidelines:

- □ Payment will be made to the primary beneficiary(ies) in the manner indicated on the enrollment form.
- □ If no primary beneficiary is living, benefits are paid to the contingent beneficiaries.
- □ If the beneficiary is a minor, application for benefits must be made by the court-appointed guardian of the minor's property. The insurance company will require a notarized copy of the guardianship appointment prior to payment of the benefit.
- □ If no beneficiary designation was made, the indemnity for loss of life will be payable in equal shares to the surviving relatives of the highest rank as listed below:
    - Legal spouse;
    - Surviving children (including legally adopted children), in equal shares;
    - Surviving parents, in equal shares;
    - Surviving siblings, in equal shares; or if none of the above,
    - Estate

Accelerated Death Benefit

Benefits may also be paid to you prior to your death, if you are terminally ill. If you have a terminal illness in which life expectancy is less than six months, you may receive a onetime, lump-sum payment of up to 75 percent of your combined Basic and Optional (if applicable) Life Insurance benefit, subject to a maximum benefit of $500,000.

The type of disbursement will be agreed upon by the insured and the insurance carrier. This benefit may be paid as a single lump sum or, if agreed to, in four quarterly installment payments. The amount of life insurance coverage that remains in effect will be reduced by the amount paid out under the accelerated death benefit.

Filing a Claim
Life insurance coverage

In the event of your death or need for an accelerated death benefit, your family / survivors should contact the benefits administrator in Human Resources, who will provide assistance in the claims process. The insurance carrier will review and approve claims. The insurance carrier's appeals process is available from the carrier.

Policy Conversion at Employment Termination

You may convert your Basic and Optional Life Insurance coverage to an individual policy when your employment terminates or you are no longer eligible. You may *not* exceed the amount for which you were insured under the College's group policy. This individual policy will be issued at the insurance company's regular rates and will not require proof of good health. You must submit an application and pay the first premium within 30 days after your coverage ends. Call Human Resources to request an application.

FLEXIBLE SPENDING ACCOUNTS

The Flexible Spending Accounts are composed of two funds: a Health Care Spending Account and Dependent Care Spending Account. These accounts are also known has Health Care Reimbursement Account (HCRA) and Dependent Care Reimbursement Account (DCRA). As a newly hired benefit eligible employee, you can establish these accounts to help pay for certain uninsured health care expenses and dependent day care expenses with tax-free dollars incurred as of your benefit eligibility date and prior to the 1st of the following year. As a continuing employee, you can change the amount of your annual election during any open enrollment period to be effective the following January 1.

Employees who change to a non-participating status (see page 8), or who leave college employment, can not submit bills for services to their health care spending account beyond the date they participate in the Flexible Benefits Program unless they elect COBRA. That election allows the opportunity to continue funding the health care spending account on an after-tax basis and to continue submitting expenses through the remainder of the calendar year. Otherwise, affected employees will have 90 days from their non-participation status date to submit expenses incurred while participating in the plan for reimbursement. Participants in the dependent care spending account can continue to submit claims after their last day worked (non-participating status date) at the College as long as they are looking for employment, working, are a full-time student attending an educational institution, or incapacitated.

Salary Reduction Contributions

Employees can elect to contribute tax-free up to $2,500 per calendar year to a Health Care Spending Account to pay for eligible expenses. The Dependent Care Spending Account allows you to contribute tax-free up to $5,000 (or $2,500 if married and filing separately) per calendar year. As a newly hired employee, you should indicate the total amount you want deducted from your paychecks for the remainder of the benefit year (calendar year). You will have the opportunity to adjust this amount during open enrollment each year for the following benefit year (calendar year beginning January 1). Please note that married couples who are both employed at the College, and who are both eligible to participate in the Dependent Care Spending Account, can not exceed the limit on a combined basis.

Health Care Spending Account

You can use your Health Care Spending Account to pay for out-of-pocket expenses for yourself, spouse, and eligible children associated with health and dental care services. See page 23 for a partial list of eligible expenses. Contributions to the Health Care Spending Account will be credited to your account on a prorated basis over the Plan year. The College's third party administrator will reimburse expenses up to your annual election on a daily basis. Health Care Reimbursement forms may be obtained from Human Resources or downloaded from http://cms.skidmore.edu/hr/benefits/index.cfm. Please choose "Forms." You will also be able to utilize a debit card available to all plan participants.

Dependent Care Spending Account

The Dependent Care Spending Account reimburses dependent care expenses for children under the age of thirteen (13) or for other dependents including, but not limited to, your legally dependent parents if you are single and require dependent care so you can work, or you are married and require dependent care so both you and your spouse can work, or if your spouse is a student. You can not use this account if you are married and your spouse does not work or is not a student.

Subject to the above conditions, and as long as receipts are submitted with your provider's tax identification number or Social Security number, your Dependent Care Spending Account reimburses the following expenses:

- Licensed nursery or day care center;
- Individuals (not including your dependents) who provide care for your eligible dependents in or outside your home; or
- Housekeepers in your home (including their food and lodging) hired to care for an eligible dependent.

Contributions into the Dependent Care Spending Account will be credited to your account on a prorated basis over the Plan year. The College's third party administrator will reimburse expenses submitted up to your account balance on a daily basis. Any amount submitted by you in excess of your account balance will be automatically processed once additional contributions are credited to your account. Reimbursement forms are available from Human Resources or can be downloaded from http://cms.skidmore.edu/hr/benefits/index.cfm. Choose "Forms." You will also be able to utilize a debit card available to all plan participants. If your dependent care provider accepts debit cards, you will be able to "debit" your account balance each month as long as you have sufficient funds in your account.

Tax Effective Reimbursement

Currently, you must pay for miscellaneous non-reimbursable health and dependent care expenses after you cash your paycheck and after taxes have already been deducted. The annual limits for these accounts are published by the Internal Revenue Service in IRS Publication 15-B (www.irs.gov).

With a Spending Account you can pay for many of these expenses on a tax-free basis. By directing a portion of your pay to a Spending Account, you actually reduce the amount of salary on which you will pay taxes. For instance, if you earn $25,000 and decide to contribute $2,500 to your Health Care or Dependent Care Spending Account, your gross income as reported on your W-2 form will be $22,500. Instead of paying federal, state and Social Security taxes on $25,000, you pay taxes on $22,500. You will pay less tax on your salary, and you will have money set aside to pay for eligible health and/or dependent care expenses. Please note that retirement benefits are calculated on your unreduced base salary ($25,000 in the above example).

Example of Tax Savings Provided by Spending Accounts

Ann decides to contribute $665 per year for health and dental care expenses and $2,335 per year for dependent care expenses. She is in the 28% Federal income tax bracket and the 6.85% New York State income tax bracket. Accordingly, her tax savings will be as follows:

Health Care spending account	$	665
Dependent Care spending account		2,335
Total before tax contribution	$	3,000
FICA tax savings (FICA rate is 7.65%)	$	230
Federal income tax savings (28% bracket)		840
New York State income tax savings (6.85% bracket)		206
Total tax savings	$	1,275

Debit Card

All participants in the Flexible Spending Accounts will receive a Visa debit card from our third party administrator. Wherever possible, you will be able to “swipe” your debit card at your physician’s office or pharmacy and pay your copay without writing your own check. If your day care provider accepts Debit Cards or Visa Cards, the same will hold true for this benefit. You will also be able to go online with our third party administrator and look up your available balance. If you elect a spending account in future years, your current debit card will be adjusted each year. More detailed information can be reviewed at: http://cms.skidmore.edu/hr/benefits/benefitsprogram info.cfm

What Else Should You Consider?

- □ If there is a balance in your spending account at the end of the plan year (calendar year), you may submit expenses incurred within 60 days following the end of the Plan Year toward your balance. Since there is some risk involved, you should designate funds into a Spending Account if you know you will incur expenses. The College will apply any forfeited benefit dollars to the College benefit budget for the following year.

- The maximum annual amount you can contribute tax-free to a Health Care Spending Account per plan year is $2,500 per employee. Amounts will be deposited into your Spending Account prorated over the plan year and paid to you as services are incurred up to the amount of your annual election.

- The Dependent Care Spending Account allows you to contribute tax-free up to $5,000 (or $2,500 if married and filing separately) per calendar year. Amounts will be deposited into your Spending Account prorated over the plan year and paid to you as services are incurred up to the amount deposited into your account. (This is different than the Health Care Spending Account). Please note if you and your spouse are benefit eligible employees, you can not contribute more than $5,000 between you.

- Important - please note: Depending on your income level and amount of annual dependent care expenses, it may not be in your best interest to establish a Dependent Care Spending Account. Current IRS regulations may allow you to take a credit against your income taxes for qualifying child and dependent care expenses. Both the Federal and the New York State credits vary based on income level. You may not take advantage of the Federal and New York State child and dependent care credits on your tax return for dependent care expenses paid from a Dependent Care spending account. Due to changes in tax code and individual circumstances, it is best to check with your tax advisor for current credits and advice. You may also refer to IRS Publication 503 and/or IRS Publication 15-B for additional information concerning child and dependent care expenses as well as any updated limits and/or Federal credits.

- Once you designate an amount into a Spending Account, the dollars cannot be increased or reduced unless you incur a change in status as outlined on page 8, incur a significant cost change in your dependent care expenses, or until the following plan year.

- By Federal law, you can not transfer funds from one Spending Account to the other.

- You need to submit proper documentation in order to be reimbursed, so you should obtain bills or itemized receipts for all expenses for which you want to be reimbursed. When you are requesting reimbursement from your Health Care Spending Account, and the services are covered under an insurance plan, it is necessary to submit a copy of the explanation-of-benefits statement to be reimbursed for any balance.

- It is not necessary to include individual bills when you are submitting an explanation-of-benefits statement from your insurance provider.

- You will receive periodic statements that will tell you the status of your Spending Accounts (i.e. "deposits," reimbursements, and your balance) and you can review your balance online. The link and instructions to do so are on the Human Resources web page at the following web site: http://cms.skidmore.edu/hr/benefits/benefitsprograminfo.cfm.

- Expenses can be submitted through March 31 of the following year for services incurred for the previous plan year.

- You can not submit eligible expenses incurred after your termination date or the date your eligibility status changes to non-participation in the Flexible Benefits Program (see page 8). You have 90 days after this date to submit expenses for reimbursement.

Making Decisions About Spending Accounts

First, estimate your out-of-pocket expenses incurred for health and dental care during the plan year for yourself and family members. If you have dependents and pay for their care while you are working (and your spouse, if any, also works or is a student), estimate how much you spend on dependent care each year. If you have predictable expenses, you may want to consider taking advantage of one or both of these accounts.

Your Decision

When you have decided how much you want to put into each Spending Account, enter the amounts on your Election Form (or electronic enrollment during open enrollment) and submit it to Human Resources.

Eligible Health Care Spending Account Expenses

The following list of approved Spending Account expenses has been taken from IRS documents. It is not complete. Consult your tax advisor for more information.

- Acupuncture
- Air purifier, humidifier, and house and home air conditioners, prescribed by doctor for allergy treatment
- Alcoholism treatment
- Ambulances
- Anesthesiologist's fees
- Artificial limbs
- Car hand controls and other equipment for handicapped person, and wheelchair lift to car
- Car, specially designed for transporting handicapped persons confined to wheelchairs
- Childbirth preparation classes, except for portion for mother's coach, feeding, and new born care
- Chiropractor's fees
- Cosmetic surgery needed to address congenital abnormality, personal injury, or disfiguring disease
- Crutches
- Dental services
- Dermatologist's fees
- Diagnostic services
- Elastic stockings
- Eye examination fees
- Gynecologist's fees
- Hearing aids
- Home modifications to accommodate handicapped person
- Laboratory services

- Neurologist's fees
- Nursing services
- Optometrist's fees
- Osteopath's fees
- Over the counter drugs (requires prescription)
- Ophthalmologist's fees
- Pediatrician's fees
- Podiatrist's fees
- Psychiatrist's fees
- Smoking cessation program fee
- Weight loss program prescribed by doctors for treatment of hypertension, obesity, and hearing problems directly related to excessive weight
- Wheelchair

Examples of Non-eligible Reimbursements (partial list)

- Cosmetic surgery other than that needed to address congenital abnormality, personal injury, or disfiguring disease
- Drinking water, distilled, merely to avoid distasteful or fluorinated city water
- Dust elimination system
- Exercise equipment, not specifically prescribed by doctor
- Health club dues, not related to a particular medical condition
- Premiums paid for health or dental plans
- Weight loss program recommended by doctor to improve general health but not for curing any specific ailment
- Over-the-counter medications that are not considered necessary for medical treatment, toiletries, cosmetics, and vitamins for general health and well-being.
- More detail on over the counter drugs can be located at: http://cms.skidmore.edu/hr/benefits/benefitsprograminfo.cfm.

COORDINATION OF BENEFITS

Duplicate health care coverage often occurs when you and your spouse both work. To ensure that duplicate benefit payments do not occur, many plans, including the health and dental care plans available under this Program, use a Coordination of Benefits provision to eliminate duplicate payments.

If you have duplicate coverage, the insurers involved determine which insurance plan is “primary” and “secondary” using the order of benefits described in each health care plan booklet.

The primary plan always pays the full benefits available under the plan. The secondary plan pays for any remaining balance, but not more than the difference between the primary plan payment and the allowable expenses for the service under that plan. You should refer to your health care plan booklet for information regarding coordination of benefits.

SUBROGATION

Subrogation is another method used to restrict duplicate benefit payments. Whenever your coverage pays for care you received, and you have the right to recover those expenses from another source, we have the right to recover the amount paid. Examples include amounts you receive as a result of a lawsuit or settlement with any third party or liability insurance company.

CONTINUATION OF COVERAGE REQUIRED BY FEDERAL LAW

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) establishes your right to continue your health care coverage beyond your scheduled benefit termination date by paying the monthly premiums directly to the Plan Administrator. So, in certain circumstances, known as qualifying events, if you or your dependents are no longer eligible for health care or dental care coverage, you (or they) will be able to continue these benefits. If you elect to extend your coverage and/or that of your spouse or dependents (each of you is called a "qualified beneficiary" under COBRA), health care coverage may continue for up to 18 months, but may end sooner if one of the following events occurs:

- □ A qualified beneficiary becomes covered under any group health plan that does not exclude coverage of any pre-existing medical conditions that affect the coverage available to the qualified beneficiary;
- □ A qualified beneficiary becomes entitled to Medicare after COBRA coverage is elected;
- □ Failure to pay the monthly premium equivalent for this coverage within 30 days of the due date;
- □ The College no longer sponsors any employee health plans.
- □ You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

Any qualified beneficiary may extend COBRA coverage from 18 months to 29 months if the Social Security Administration has determined (or determines) that one of the qualified

beneficiaries in your household is totally disabled at anytime during the first 60 days of COBRA coverage. To qualify for the extension, you must submit a copy of the Social Security disability determination notice within 60 days of the date of the determination to Skidmore College (but in no event later than the end of the initial 18 month COBRA period). If the qualified beneficiary is no longer disabled, COBRA coverage for all qualified beneficiaries who have extended coverage as a result of that disability determination will be terminated. Your covered spouse or dependents may opt for additional coverage up to a combined total of 36 months, if any of the following occurs:

- □ Employee's Death
- □ Divorce
- □ Legal Separation
- □ Employee's Entitlement to Medicare
- □ Dependent Child's Termination of Eligibility

If any of these events occurs you must notify the Plan Administrator within 60 days of the event, or the end of the coverage period, whichever is earlier.

Under the law, you will have at least 60 days from the date you would lose coverage because of one of the events described above, or the date notice of your election rights is sent to you, whichever is later, to inform the Plan Administrator that you want continuation coverage. You will have an additional 45 days to remit retroactive monthly premiums to bring your participation current. Premiums for elected coverage are due on the first of each month. It is your responsibility to remit payments in a timely manner.

In addition to your COBRA election, if you have a Health Care Spending Account ("health FSA") through the Flexible Benefits Program for the current year, you may be able to continue this coverage by remitting monthly contributions to this account directly to the College on an after-tax basis. If, as of the date your coverage would terminate, you could receive a higher benefit from the health FSA than the amount the Plan may charge for COBRA premiums for the rest of the year, you may elect to continue coverage under the health FSA for the remainder of the year (but not for any subsequent year). If, as of the date your coverage would terminate, the maximum amount the plan may charge for COBRA premiums under the health FSA for the rest of the year equals or exceeds the maximum benefit that you could receive for the remainder of the year, then continuation coverage under COBRA is not available. Whether or not you are eligible to continue coverage under the health FSA is indicated on your Election Form.

COBRA AND ARRA RIGHTS

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. These rights may apply to employees who experience a loss of coverage at some time on or after September 1, 2008 and December 31, 2009 and chose to elect COBRA continuation coverage. If an employee's loss of health coverage was due to an involuntary termination of employment the employee may be eligible for the temporary premium reduction for up to nine months. Upon termination, eligible employees will receive the "Summary of the COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual."

FLEXIBLE BENEFIT PROGRAM CLAIMS PROCEDURE

Claims for benefits under the Flexible Benefits Program may be filed with the Claims Administrator on forms supplied by the Claims Administrator. Written notice of the disposition of a claim will be furnished to the claimant within 60 days after the application is filed. If the claim is denied, the reasons or the provisions of the Program or related plan will be cited and, where appropriate, an explanation as to how you can appeal the claim will be provided.

Any employee, former employee, or dependents who have been denied a benefit, in whole or in part, may appeal the denial of that claim to the Claims Administrator. If you wish further consideration of your position, you may obtain a form from the Claims Administrator on which to request a hearing. This form, together with a written statement of your position, must be filed with the Claims Administrator no later than 60 days after receipt of the written notification. The Claims Administrator will schedule an opportunity for a full and fair hearing of the issue and decide on the appeal within 60 days after the receipt of the written notification. The appropriate Claims Administrator's decision will be communicated in writing to you and will advise you if you have any right to appeal the decision.

A FINAL MESSAGE

You will find that your benefit needs change as your circumstances do. It would be wise to use the Flexible Benefits Program's annual open enrollment period to re-examine your benefit needs and to change your elections accordingly. Each year you will have an opportunity to review your current benefits, along with your cost, if any, for the coming year.

If you do not update your Benefits Election Form on the Benefits Self-Service System by the designated due date, your benefits, with the exception of your Flexible Spending Accounts, will remain the same throughout the following plan year. Under IRS regulations, Flexible Spending Accounts must be elected annually by employees or they will revert to zero. Also under IRS regulations, changes may not be made after the initial election unless there is a life event change or it is during open enrollment.

Every attempt has been made to ensure that all information in this brochure is clear and accurate. However, this Summary is not a legal document. Each benefit plan available through Skidmore's Flexible Benefits Program is governed by the individual Summary Plan Description. Benefits may be changed, revised, or terminated at the sole discretion of the College.

ADMINISTRATION OF PLAN

Plan Name:	Skidmore College Flexible Benefits Program
Plan Number:	The Plan number assigned by the Sponsor is 510
Employer Identification Number:	Skidmore College's Employer Identification Number (EIN) is 14-1338562
Plan Year:	The plan year is the 12-month period ending on the last day of December. Plan records are maintained on this basis.
Employer Information:	Skidmore College 815 North Broadway Saratoga Springs, NY 12866
Program Administrator:	Skidmore College 815 North Broadway Saratoga Springs, NY 12866 (518) 580-5000
Service of Process:	Skidmore College 815 North Broadway Saratoga Springs, NY 12866
Claims Administrator for the Self –Insured Preferred Provider Organization (PPO):	Blue Shield of Northeastern New York. 30 Century Hill Drive Latham, NY 12110 (518) 220-4600 (800) 888-1238 informedRx® an SXC Health Solutions Company (formerly NMHCRx) 23 British American Blvd. Latham NY 12110
Claims Administrator for the Flexible Spending Accounts:	The Preferred Group PO Box 15136 Albany, NY 12212 (518) 641-0321 or (800)573-7474
Privacy Officer:	Barbara Beck, Vice President, Human Resources Skidmore College 815 North Broadway, Saratoga Springs, NY 12866 (518) 580-5809

MENTAL HEALTH PARITY

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was enacted as part of the Emergency Economic Stabilization Act of 2008. Although the new law does not require group health plans to provide benefits for mental health and substance abuse, it requires those plans that offer both medical/surgical and mental health/substance abuse benefits to do so on an equal basis.

- The financial requirements of the plan, such as deductibles and copayments, can be no more restrictive for mental health or substance use disorder benefits than those that apply to substantially all medical and surgical benefits covered by the plan;
- Mental health and substance abuse benefits cannot be subject to separate cost sharing requirements;
- Any treatment limitations applicable to such mental health or substance use disorder benefits can be no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan; and
- There can be no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.
- A plan must provide out-of network coverage for mental health or substance use disorder benefits if the plan provides coverage for medical or surgical benefits provided by out-of network providers.

The financial parity requirements of the law do not apply if, after complying with the Act for a minimum of six months, an actuary determines and certifies that compliance with the new law results in an increase in the total costs of coverage (medical and surgical benefits and mental health and substance use disorder benefits) of more than 2% for the first plan year and 1% for each subsequent plan year. If the exemption is claimed, a notification must be sent to plan participants and beneficiaries, the Secretary of Health and Human Services, and appropriate state agencies.

In addition to financial parity provisions, the new law requires the plan administrator to disclose the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for services made under the plan with respect to mental health or substance use disorder benefits.

The new law is effective for plan years beginning on or after October 3, 2009 (January 1, 2010 for calendar year plans). For collectively bargained plans, the law applies to plan years beginning on or after the later of January 1, 2009 or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after October 3, 2008).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Federal law requires group health plans that provide medical and surgical benefits for mastectomies to provide coverage in connection with the mastectomy (in the manner determined by the attending physician and the patient) for:

- reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and physical complications at all stages of the mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. In addition, the law prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care, or providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with this law.

The above described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similar benefits. If you have any questions about this coverage, please contact the applicable benefits/claims administrator.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under this Federal law, sometimes referred to as the "NMHPA," certain requirements are imposed on group health plans that provide maternity or newborn infant coverage. This includes the fact that the group health plans and health insurance issuers (such as insurance companies and HMOs) may not restrict benefits for any hospital 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 caesarean section.

However, the NMHPA does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

You may obtain a copy of the procedures governing qualified medical child support orders, without charge, by contacting Human Resources at Skidmore College.

MEDICARE ELIGIBILITY AS AN ACTIVE EMPLOYEE

If you are an active employee who becomes eligible for Medicare Part B while covered by Skidmore health insurance, you should not enroll for Part B until three months before you retire. Since you'll have continuous coverage with your Skidmore Plan as an active employee, you won't be penalized by Medicare for joining the program late.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA), H.R. 2

On February 4, 2009, President Obama signed into law H.R. 2, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA reauthorizes the State Children's Health Insurance Program (SCHIP) for four and a half years through Fiscal Year 2013, and expands coverage to approximately 4 million children beyond the 7 million children currently covered under the program. The $32.8 billion cost ($40 billion over 5 years) is completely offset, primarily through increasing tobacco taxes, including a $.62 rise in the cigarette tax to $1.01 per pack. Restrictions on physician-owned hospitals, which were included in the House-passed version of the reauthorization legislation, are not included in the final enacted bill. Key provisions of interest to the AMA are as follows:

Allotments. States will receive increased SCHIP allotments, through an updated formula that reflects actual projected spending and state demographic and national spending trends. Under the formula, state allotments will be rebased every few years to ensure that funding is targeted to states that are using them for coverage of children. States that face a funding shortfall and meet enrollment goals will receive adjustment payments. The formula also sets in place new overall caps on federal funding to ensure the program's expenditures do not exceed the authorized amounts.

Initiatives to Enroll the Lowest-Income Uninsured Children. New tools are included to simplify and streamline enrollment, such as Express Lane eligibility, to encourage the enrollment of already-eligible uninsured children in coverage, as well as increased funding for outreach activities to states, local governments, schools, community-based organizations, safety-net providers, and others. Bonus payments are available to states when they significantly increase their enrollment of the lowest-income uninsured children in Medicaid and adopt specified measures to streamline enrollment and retention in both Medicaid and SCHIP.

Changes in Eligibility Rules. Several changes in eligibility are made:

Although state flexibility is preserved to determine the income eligibility level for children and the methodologies used to determine income or assets under the program, new limits are imposed on expansions to children in families with income above 300% of the federal poverty level (FPL). States may continue to use specific disregards, such as work expenses, when setting their income rules. However, states are specifically barred from using "block of income" disregards (e.g., disregarding all income between 300% and 400% of FPL) to effectively expand coverage to children above 300% FPL. States providing coverage to children above 300% FPL will receive the Medicaid matching rate rather than the enhanced SCHIP matching rate; states (e.g., New York and New Jersey) that have an approved state plan amendment or waiver, or state law to provide coverage above 300% FPL are grandfathered.

States are provided with a new option to cover pregnant women under their state plan, but can continue to cover pregnant women under existing options (waiver or regulation).

No new waivers will be allowed to cover parents under SCHIP. States that have received waivers to cover low-income parents will be allowed to extend such waivers through fiscal year 2011; in subsequent years, states will be allowed to transition parents into a separate block grant.

The current law prohibiting new waivers for coverage of childless adults is retained. Childless adults currently covered through a waiver will be transitioned out; for states that have received waivers, those waivers will be terminated after one year. These states will be allowed to apply for a Medicaid waiver for any further coverage for such adults.

States have a new option to cover children and pregnant women lawfully residing in the U.S. who otherwise meet Medicaid or SCHIP eligibility requirements, without a five-year waiting period. Federal payments for individuals who are not legal residents are specifically prohibited.

Citizenship/Nationality Verification. States are allowed to use an alternative to a controversial proof-of-citizenship requirement that has been found to have denied Medicaid coverage for many eligible children. Instead of requiring documentation proving identity and citizenship, as required under the Deficit Reduction Act of 2005, states would be allowed to submit the name and social security numbers of applicants to the Social Security Administration (SSA) for verification. If the SSA determines that the applicant is not a citizen, states have up to 90 days in which to determine an applicant's legal status. This verification process would also be applied to SCHIP. States would also be required to annually certify the legal status of beneficiaries.

Premium Assistance. The legislation expands current premium assistance options for states and streamlines coordination between public and private coverage by allowing states to offer a premium assistance subsidy for qualified cost-effective employer-sponsored coverage to children and parents eligible for SCHIP. A demonstration program would be created under which states could allow employers with less than 250 employees and at least one employee with a SCHIP-eligible child or SCHIP-eligible pregnant woman to buy into a purchasing pool that offers SCHIP benchmark benefits. Federal ERISA law is amended to promote coordination between public and private coverage by establishing that both the loss of or gaining of Medicaid/SCHIP coverage counts as a “qualifying event” for the purposes of being eligible for employer-sponsored coverage. There are several provisions to encourage outreach on premium assistance, and a GAO study on state programs is mandated.

Improving Quality. A new quality child health initiative is created to develop and implement evidence-based quality measures for children enrolled in SCHIP and Medicaid and improve state reporting of quality data. The Secretary of HHS would develop an initial core set of measures, based on consultations with states, pediatricians and other primary and specialized pediatric health care professionals,, national organizations and individuals with expertise in pediatric health quality measurement, and voluntary consensus standards setting organizations, and would award grants and contracts to develop, test and update such measures. The Secretary is also required to establish a program to encourage the creation and dissemination of model electronic health record format for children, and to create a demonstration program to reduce childhood obesity.

Improving Benefits. Dental benefits will be provided to all children enrolled in SCHIP. States will also be allowed to use SCHIP funds to provide dental benefits for children who are otherwise insured but lack dental coverage. Mental health benefits are to be provided on par with medical and surgical benefits. In addition, a commission will be created to study and report on SCHIP and Medicaid access to care and provider payments.

American Medical Association’s Summary of Key Provisions

STATEMENT OF ERISA RIGHTS

As a participant in the Flexible Benefits Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1997. ERISA provides that all participants will be entitled to:

- ☐ Examine, without charge, at the Program Administrator's office and at other specified locations such as worksites, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Program with the U.S. Department of Labor, such as detailed annual reports and summary plan descriptions.

- ☐ Obtain copies of all Program documents and other Program information upon written request to the Program Administrator; the Program Administrator may make a reasonable charge for the copies.

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

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Program. The individuals who administer your Program, called "fiduciaries," have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Program benefit or exercising your rights under ERISA. If your claim for a plan benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the applicable Claims Administrator review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Program 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 Program Administrator to provide materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Program Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Program fiduciaries misuse the Program's assets, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if it finds your claim is frivolous. If you have any questions about your Program, you should contact Human Resources. If you have any questions about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

YOUR PRIVACY RIGHTS UNDER HIPAA

Skidmore College is the sponsor of group health plans that are subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA privacy rules, although Skidmore is not itself generally a "covered entity," the group health plans sponsored by Skidmore College are covered entities. Skidmore College and its group health plans are committed to maintaining the privacy of health information pertaining to individuals enrolled in the Plan.

"Protected health information" (PHI) is all individually identifiable information that relates to the past, present, or future physical or mental health or condition of an individual, or the past, present, or future payment for health care for an individual, regardless of the form (oral, written or electronic) in which the information is held.

Each of the plans may disclose PHI to Skidmore to carry out the following administration functions for the plan:

- to determine if an individual is participating in the plan;
- to modify, amend or terminate the plan;
- to obtain premium bids to provide insurance coverage for the plan, including reinsurance;
- to carry out other administrative functions of the plan such as:
    - Claims Assistance: Designated personnel may assist Covered Persons (i.e., employees of Skidmore who are plan participants and their covered dependents) in attaining a resolution of any issues related to obtaining payment for claims, including coverage and eligibility issues.
    - Appeal of Benefit Denials: Designated personnel may assist Covered Persons in appealing benefit denials of the insurer or third party claims administrator.
    - Individual Rights Requests: Refer to FLEXIBLE BENEFIT PROGRAM CLAIMS PROCEDURE for more information.
    - Audit Functions: Designated Personnel may review PHI such as Check Registers to confirm payment and perform other audit functions.

Designated Personnel are Skidmore College employees who administer the group health plans.

Designated Personnel will provide the services on behalf of the Plan as part of the payment and/or health care operations of the plan. As a result, it is intended and understood that any and all disclosures of PHI of plan participants by an insurer or third party administrator to the Designated Personnel shall be permitted by 45 CFR 164.506(c) (1) and shall be exempt from the authorization requirement of 45 CFR 164.508.

These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information may not be disclosed or used by Skidmore College for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the College.

With respect to the health plans identified as being self- insured in the Summary of Plans contained herein, Skidmore College may receive PHI in connection with its role as the final arbiter of claims that have been appealed as provided under the administrative services agreements.

With respect to PHI that Skidmore receives from the Plan, Skidmore shall:

- □ Not further use or disclose the PHI other than as permitted or required by the Plan Documents or as required by law;
- □ Ensure that any agents, including an insurance broker or a subcontractor, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Skidmore College with respect to such information;
- □ Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Skidmore College;
- □ Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for herein, of which it becomes aware;
- □ Make available PHI as required by 45 C.F.R.§164.524;
- □ Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;
- □ Make available the PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- □ Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance by the Plan;
- □ If feasible, return or destroy all PHI received from the Plan that Skidmore College still maintains in any form, and not retain copies when the PHI is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;
- □ Ensure that adequate separation between the Plan and Skidmore College is established.
- □ The plans will disclose PHI to Skidmore College only upon receipt of a written certification by Skidmore College that the plan documents have been amended to incorporate the foregoing provisions of this paragraph.

The Plan will disclose, as permitted or required by the Plan, PHI to only the following classes of employees or other persons under the control of Skidmore College Employees who administer the group health plans.

These employees and the Designated Personnel shall use and disclose only the minimum amount of PHI necessary to perform the administration functions identified in this Section.

Participants can report complaints concerning Skidmore's use or disclosure of PHI to: Privacy Officer, Vice President for Human Resources, Skidmore College, Barrett Center, 815 N. Broadway, Saratoga Springs NY 12866 .

Please refer to the Notice of Privacy Practices issued by each of the plans for more information. Those Notices are incorporated into and considered a part of your summary plan description (member handbook) for each of the health plans.

Your rights regarding your PHI:

- **Right to inspect and copy.** You have the right to inspect and receive a copy of your protected health information, except under a few unusual circumstances. If you request a copy of your protected health information, the Plan may charge a fee for the costs of copying.

- **Right to amend.** If you feel that protected health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. To request an amendment, your request must be made in writing and should include the reasons(s) why you believe the Plan should amend your information. The Plan will respond to your request for amendment no later than 60 days after the receipt of your request. If the Plan denies your request for an amendment, the Plan will provide you with a written notice that explains its reasons. You will have the right to submit a written statement disagreeing with the denial. You will also be informed of how to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.

- **Right to an accounting of disclosures.** You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures the Plan has made of your protected health information. Disclosures that were made to carry out payment and health care operations, disclosures to persons involved in your care or payment for your care, disclosures that were made to you or made in accordance with your written authorization, and certain other disclosures need not be included in an accounting of disclosures.

  To request an accounting of disclosures, you must submit your request in writing and must state the time period for which you are requesting an accounting of disclosures, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request will be free. If you request additional lists within 12 months, the Plan will charge you for the costs of providing the list. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before costs are incurred. The Plan will respond to your request for an accounting of disclosures within 60 days.

- **Right to request restrictions.** You have the right to request a restriction or limitation on the protected health information the Plan uses or discloses about you for treatment, payment or health care operations. The Plan is not required to agree to your request. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care, like a family member or friend. If the Plan agrees to your request for restriction, the Plan will limit the disclosure of your protected health information, unless the information is needed to provide you with emergency treatment or to comply with law. To request restrictions on disclosures, you must make your request in writing, and you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- **Right to request confidential communications.** You have the right to request that the Plan communicate with you in a certain way or at a certain location. For example, you have the right to request that messages not be left on an answering machine. To request confidential communications, you must make your request in writing. The Plan will not ask you the reason for your request, and the Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and how payment for your health care will be handled if the Plan communicates with you through this alternative method or location.

- **Right to receive a notice of privacy practices.** You have the right to receive a Notice of Privacy Practices from a plan. To obtain a copy of this Notice, please contact the Privacy Official at the Benefits/Claims Administrator identified on page 30.