

**BRIDGEWATER COLLEGE HEALTH REIMBURSEMENT
ARRANGEMENT**

Health Reimbursement Arrangement (HRA) Plan

Effective: January 1, 2018

Bridgewater College Health Reimbursement Arrangement

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Bridgewater College Health Reimbursement Arrangement
Health Reimbursement Arrangement (HRA) Plan

ARTICLE I

Introduction

1.1 Amendment and Restatement of Plan Bridgewater College, ("the Employer") hereby amends and restates the provisions of the Bridgewater College Health Reimbursement Arrangement ("the Plan"), as amended, effective as of January 1, 2018. The Plan was originally effective July 1, 2007. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II, Definitions.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from the Health Reimbursement Arrangement (HRA) account.

1.2 Legal Status This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b).

ARTICLE II

Definitions

"**Account**" means the Health Reimbursement Arrangement (HRA) account.

"**Appeals Committee**" means the Committee appointed by the Employer that acts on behalf of the Plan Administrator with respect to appeals.

"**Benefits**" means the reimbursement benefits for Medical Care Expenses described under Article VI.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Compensation**" means all the earned income, salary, wages and other earnings paid by the Employer to a Participant during a Plan Year, including any amounts contributed by the Employer pursuant to a salary reduction agreement which are not includable in gross income under sections 125, 132(f)(4), 401(k), 403(b), 408(k) or 457(b) of the Code.

"**Covered Individual**" means, for purposes of Article VII, a Participant, Spouse or Dependent.

"**Dependent**" means: for purposes of accident or health coverage and for purposes of the Health Reimbursement Arrangement a dependent as defined as in Code section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, (2) any child (as defined in Code section 152(f)(1)) of the Participant who as of the end of the taxable year has not attained age 27, and (3) any child of the Participant to whom IRS Rev. Proc. 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year);

For purposes of the new income exclusions under Code sections 105(b) and 106, the term "child" includes adult children under the age of 27 that is the employee's son, daughter, stepson, stepdaughter, legally adopted individual (or an individual placed with the employee for adoption), and eligible foster child. Under Notice 2010-38, such a child does not have to satisfy the age limits, residency, support and other tests described in Section 152 of the Code in order to be considered an employee's child for purposes of these new income exclusions.

"**Effective Date**" of this Plan has the meaning described in Section 1.1.

"**Electronic Payment Card**" means a debit card, stored value card, or credit card that allows a Participant to access funds in a health reimbursement arrangement to pay the service provider at the point-of-sale (i.e., the time a service or item is provided).

"**Electronic Protected Health Information**" has the meaning described in 45 C.F.R. Section 160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"**Eligible Employee**" means any Employee who is employed by a participating Employer other than:

- (a) An Employee covered by a collective bargaining agreement as to which retirement benefits were the subject of good faith bargaining, unless such agreement expressly provides for participation in the Plan;
- (b) A non-resident alien with no US source of income;
- (c) A "leased employee" within the meaning of Section 414(n);

- (d) Employees who are self-employed individuals as defined in section 401(c) of the Internal Revenue Code (including sole proprietors and partners in a partnership);
- (e) Employees who own (or are considered to own within the meaning of section 318 of the Internal Revenue Code) more than two percent (2%) of the outstanding stock of an S corporation or stock possessing more than two percent (2%) of the total combined voting power of all stock of such corporation.

In the event an individual who is not characterized or treated by the Participating Employer as a common law employee of a Participating Employer is reclassified as a common law employee of a Participating Employer who meets the definition of an Eligible Employee, the individual shall continue to be excluded from the Plan until the Plan is amended to classify such individual as an Eligible Employee (to the extent such individual otherwise qualifies as an Eligible Employee hereunder). In no event shall such individual be eligible to participate in the Plan prior to the effective date of such Amendment.

The Plan Administrator shall have full and complete discretion to determine eligibility for participation and benefits under this Plan, including, without limitation, the determination of those individuals who are deemed Employees of the Employer (or any controlled group member.) The Plan Administrator's decision shall be final, binding, and conclusive on all parties having or claiming a benefit under this Plan. This Plan is to be construed to exclude, and the Plan Administrator is authorized to exclude, all individuals who are not considered Employees for purposes of the Employer's payroll system.

"Employee" means a person who is currently or hereafter employed by the Employer and any Affiliate Employers that have adopted the Plan. Former Employees are also considered "Employees" of the Employer strictly for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Bridgewater College.

"Employment Commencement Date" means the first regularly-scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"Enrollment Form" means the form provided by the Plan Administrator for the purpose of allowing an Eligible Employee to participate in this Plan.

"Entry Date" means the date that an Eligible Employee actually becomes a Participant in the Plan. Eligibility requirements are defined in Section 3.1 and the specific Entry Dates for the Plan are listed in Section 3.1.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"GINA" means the Genetic Information Nondiscrimination Act of 2008.

"High Deductible Health Coverage (HDHC)" means a general term for coverage under a health plan with a higher than normal deductible.

"Highly Compensated Individual" means an individual defined under Code Section 105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HITECH" means the Health Information Technology for Economic and Clinical Health Act.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"Limited (Vision/Dental/Preventive Care) HRA Option" has the meaning described in Section 6.2.

"Medical Care Expenses" has the meaning defined in Section 6.2.

"Medical Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies, dental care, vision care, etc.

The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"MHPA" means the Mental Health Parity Act.

"MHPAEA" means the Mental Health Parity Addiction Equity Act.

"Michelle's Law" means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Open Enrollment Period" means with respect to a Plan Year the month preceding the Plan Year, or such other period as may be prescribed by the Plan Administrator. If the initial Plan Year is a short plan year, then the Plan Administrator may specify an Open Enrollment Period in a nondiscriminatory manner.

"Participant" means a person who is an Eligible Employee and who enters the Plan after meeting the eligibility requirements of Section 3.1 including those covered through COBRA and their respective beneficiaries.

"Participating Employer" means Bridgewater College and any Related Employer that adopts the Plan.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"Plan" means the Bridgewater College Health Reimbursement Arrangement as set forth herein and as amended from time to time.

"Plan Administrator" means Bridgewater College or such other person or committee as may be appointed by the Employer to administer the Plan.

"Plan Year" means the 12-month period commencing January 1st and ending on December 31st, except for a short Plan Year beginning July 1, 2009 and ending December 31, 2009.

"Protected Health Information" (PHI) shall have the meaning described in 45 C.F.R. Section 160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

"QMCSO" means a qualified medical child support order, as defined in ERISA Section 609(a).

"Related Employer" means any employer affiliated with Bridgewater College that, under Code sections 414(b), (c), or (m), is treated as a single employer with Bridgewater College for purposes of Code section 105.

"Run-Out Period" means a period after the close of a Plan Year or other period during which Participants may request reimbursement for expenses incurred during the Period of Coverage.

"Spouse" means an individual who is legally married to a Participant as determined under the laws of the state or sovereign Country where the place of celebration occurred and who is treated as a spouse for federal income tax purposes pursuant to Revenue Ruling 2013-17.

"Suspension Election Form" means the form provided by the Plan Administrator for the purpose of allowing a Participant to suspend his or her HRA account for a Plan Year.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

Eligibility and Participation

3.1 Eligibility to Participate An individual is eligible to participate in this Plan if the individual satisfies all of the following:

- (a) is an Eligible Employee;
- (b) is eligible to participate in the Employer's group medical insurance; and
- (c) has enrolled in the Employer's group medical insurance plan or the group health plan or another employer (e.g., the spouse's employer).

Once an Employee has met the Plan's eligibility requirements, the Eligible Employee may commence participation on the same day as the Employer's group medical plan or for any subsequent Plan Year, in accordance with the procedures described in Article IV, Method and Timing of Enrollment.

3.2 Termination of Participation A Participant will cease to be a Participant in this Plan upon the earlier of:

- * the termination of this Plan; or
- * the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Plan Administrator on a uniform and consistent basis under Section 6.7.

Reimbursements from the HRA account after termination of participation will be made pursuant to Section 6.7 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA).

3.3 Participation Following Termination of Employment or Loss of Eligibility If a Participant terminates his or her employment, or ceases to be an Eligible Employee, for any reason, including, but not limited to, disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of termination of employment and is otherwise eligible to participate in the Plan, then the Employee may immediately rejoin the Plan and be reinstated with the same HRA account balance that such individual had before termination.

If an Employee (whether or not a Participant) terminates employment and is not rehired within 30 days for any other reason, including, but not limited to, a reduction in hours, and then becomes an Eligible Employee again, the Employee will be treated as a new hire and must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan as described in Section 3.1 before becoming eligible to participate in the Plan. Any unused reimbursement benefits account balance prior to the initial separation of service date will be forfeited.

If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including, but not limited to, a reduction of hours, and then becomes an Eligible Employee again, the Employee may rejoin the Plan without having to re-satisfy (complete the waiting period) Plan eligibility requirements as described in Section 3.1.

3.4 FMLA and USERRA Leaves of Absence Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

3.5 Non-FMLA and Non-USERRA Leaves of Absence If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 3.2.

ARTICLE IV

Method and Timing of Enrollment

4.1 Enrollment When First Eligible For the first year of the Plan, once an Employee has met the Plan's eligibility requirements, the Employee may commence participation on the same day as the Employer's group medical plan and no Enrollment Form is required, unless the employee opts out.

An Eligible Employee may opt out and waive future reimbursements from the HRA, at least annually.

Once the Eligible Employee is enrolled as a Participant, his or her participation will continue month-to-month and year-to-year until his or her participation ceases pursuant to Section 3.2.

4.2 Election to Suspend HRA Account A Participant may elect to suspend his or her HRA account for any future Plan Year by submitting a Suspension Election Form to the Administrator before the beginning of that Plan Year. The Participant's suspension election will remain in effect for the entire Plan Year to which it applies, and the Participant may not modify or revoke the election during that Plan Year. The Participant will not receive reimbursements for any Medical Care Expenses incurred during the Plan Year to which the suspension election applies except for dental or vision expenses.

If a Participant suspends his or her HRA account for a Plan Year, the Employer will cease to make contributions to the HRA account.

Medical Care Expenses incurred before the beginning of the suspended Plan Year will be reimbursed during the suspended Plan Year, subject to the reimbursement procedures contained in Section 6.6, so long as no suspension election was in effect for the Plan Year in which such expenses were incurred.

4.3 Permanent Opt-Out In lieu of a temporary suspension of a Participant's HRA Account as provided in Section 4.2, a Participant may elect to permanently opt-out of and waive future reimbursements from his or her HRA Account. A Participant who makes that election will not receive reimbursements for any Medical Care Expenses incurred after the opt-out election takes effect, except for limited-scope dental or vision expenses that qualify as excepted benefits for HIPAA purposes. Medical Care Expenses incurred before the opt-out election takes effect, however, may be reimbursed during the first Plan Year to which the opt-out election applies, subject to the reimbursement procedures contained in Section 6.6, so long as no suspension election was in effect for the Plan Year in which such expenses were incurred.

If a Participant permanently opts out of this Plan, the Employer will also discontinue contributions to the Participant's HRA Account.

The opportunity to make a permanent opt-out election shall be offered to each Participant at least annually. No similar offer shall be required at termination of employment because in that case Section 6.7 limits reimbursements automatically.

ARTICLE V

Benefits Offered and Method of Funding

5.1 Benefits Offered When an Eligible Employee becomes a Participant in accordance with Articles III and IV, an HRA account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Article VI. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses.

5.2 Employer and Participant Contributions

- (a) *Employer Contributions.* The Employer funds the full amount of the HRA accounts.
- (b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan.
- (c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions be treated as Employer contributions to the Plan.

5.3 Funding This Plan All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

ARTICLE VI

Health Reimbursement Benefits

6.1 Benefits The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's HRA account, as set forth and adjusted under Section 6.3.

6.2 Eligible Medical Care Expenses Under the HRA account, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

- (a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible.
- (b) *Medical Care Expenses.* "Medical Care Expenses" will vary depending on what type of group health plan coverage the employee has elected.
- (c) *Limited-Purpose HRA Option.* For purposes of this Option, "Medical Care Expenses" means expenses incurred by a Participant for medical care, as defined in Code section 213(d), provided, however, that such expense is for medical expenses that apply towards the deductible, co-insurance, co-pays and the out-of-pocket maximums of the Group Health Plan.

If only a portion of a Medical Care Expense has been reimbursed elsewhere (e.g., because the Medical Insurance Plan imposes co-payment or deductible limitations), then the HRA can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this Article.

HSA Benefits cannot be elected with HRA Benefits unless the Limited (Vision/Dental/ Preventive Care) HRA Option is selected.

6.3 Maximum Benefits

- (a) *Maximum Benefits.* The maximum dollar amount that may be credited to an HRA account for an Employee is \$750 for employee-only coverage, \$1,500 for employee plus one dependent coverage, and \$1,500 for family coverage.
- (b) *Changes.* For subsequent Plan Years, the maximum dollar limit may be changed by the Plan Administrator and shall be communicated to Employees through the Enrollment Form, the SPD or another document.
- (c) *Nondiscrimination.* Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code section 105(h), as may be determined by the Plan Administrator in its sole discretion.

6.4 Establishment of Account The Plan Administrator will establish and maintain an HRA account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

- (a) *Crediting of Accounts.* A Participant's HRA account will be credited at the beginning of the Plan Year. If the initial Plan year is a short plan year, the Participants' HRA accounts will be credited with a full plan year's contributions.
- (b) *Debiting of Accounts.* A Participant's HRA account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.
- (c) *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount

credited to the Participant's HRA account under subsection (a) reduced by prior reimbursements debited under subsection (b).

6.5 Carryover of Accounts If any balance remains in the Participant's HRA account after all reimbursements have been made for the Period of Coverage, such balance will be carried over to the next Plan Year, up to a maximum balance of \$1,500 for Employee Only or \$3,000 for Employee Plus Dependent.

However, upon termination of employment or other loss of eligibility, the Participant's coverage ceases, and expenses incurred after such time will not be reimbursed unless COBRA is elected as provided in Section 6.7. In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited.

6.6 Reimbursement Procedure

- (a) *Timing.* Within 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his or her claim has been denied. This time period may be extended by an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete the previously incomplete reimbursement claim.

If the HRA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43 or other IRS.

- (b) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting a request in writing to the Plan Administrator in such form as the Plan Administrator may prescribe, no later than the 120 days following the close of the Plan Year in which the Medical Care Expense was incurred setting forth:

- * the individual(s) on whose behalf Medical Care Expenses have been incurred;
- * the nature and date of the Medical Care Expenses so incurred;
- * the amount of the requested reimbursement;
- * a statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source, and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted; and
- * other such details about the expenses that may be requested by the Plan Administrator in the reimbursement request form or otherwise (e.g., a statement from a medical practitioner that the expense is to treat a specific medical condition, or a more detailed certification from the Participant).

The request shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Plan Administrator may request.

- (c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article VIII.

6.7 Reimbursements After Termination; COBRA When a Participant ceases to be a Participant under Section 3.2, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim by 120 days following the close of the Plan Year in which the Medical Care Expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Account because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA Account on the day before the qualifying event for the periods

prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly-situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants. At the beginning of each month in the Period of Coverage, Qualified Beneficiaries may be credited with the monthly reimbursement accrual (i.e., the maximum annual reimbursement amount, divided by the number of months in that Period of Coverage) that is made available to similarly situated non-COBRA beneficiaries, and any unused reimbursement amounts from the previous Period of Coverage may be carried over to the next Period of Coverage (provided that the applicable premium is paid) subject to other provisions of the Plan. A premium for COBRA continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Administrator and permitted by COBRA.

6.8 Named Fiduciary; Compliance with ERISA, COBRA, HIPAA, etc.

- (a) *Named Fiduciary.* Bridgewater College is the named fiduciary for the Plan for purposes of ERISA Section 402(a).
- (b) *Laws Applicable to Group Health Plans.* Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

6.9 Coordination of Benefits; Health FSA to Reimburse First Benefits under this Plan are solely intended to reimburse Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Medical Care Expenses are covered by both this Plan and by a Health FSA, then this Plan shall not be available for reimbursement of such Medical Care Expenses until after amounts available for reimbursement under the Health FSA have been exhausted.

ARTICLE VII

HIPAA Privacy and Security

7.1 Employer's Certification of Compliance The Plan shall not disclose Protected Health Information to the Employer unless the Employer certifies that the Plan document incorporates the provisions of 45 CFR § 164.504(f)(2)(ii) and the Employer agrees to conditions of disclosure set forth in this Article.

7.2 Permitted Disclosure of Enrollment/Disenrollment Information The Plan may disclose to the Employer information on whether an individual is a Participant in the Plan.

7.3 Permitted Uses and Disclosures of Summary Health Information The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means information (a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

7.4 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer, provided that the Employer will use or disclose such Protected Health Information only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing (including appeals), auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article (including, but not limited to, the restrictions on the Employer's use and disclosure described in Section 7.5) and the specifications and requirements of the administrative simplification provisions of HIPAA and its implementing regulations at 45 CFR Parts 160-64.

7.5 Restrictions on Employer's Use and Disclosure of Protected Health Information

- (a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by the Plan document, or as required by law.
- (b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan, agrees to the restrictions, conditions, and security measures of the Plan document that apply to Employer with respect to the Protected Health Information or Electronic Protected Health Information, respectively.
- (c) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.
- (d) Employer will report to the Plan any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under the Plan document of which the Employer becomes aware.
- (e) Employer will make Protected Health Information available to the Plan or to the Covered Individual who is the subject of the information in accordance with 45 CFR § 164.524.
- (f) Employer will make a Covered Individual's Protected Health Information available for amendment, and

will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 CFR § 164.526.

- (g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 CFR § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528.
- (h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the plan available to the Plan and to the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 CFR Part 164, Subpart E.
- (i) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, received from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.
- (j) Employer will ensure that the adequate separation between Plan and Employer (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied.

7.6 Adequate Separation Between Employer and the Plan

- (a) Only the following employees or classes of employees or other workforce members under the control of Employer may be given access to a Covered Individual's Protected Health Information or Electronic Protected Health Information received from the Plan or a business associate servicing the Plan:
 - * Human Resource and payroll staff performing HRA functions; and
 - * Any other class of employees designated in writing by the Privacy Official.
- (b) The employees, classes of employees, or other workforce members identified in Section 7.6(a) will have access to a Covered Individual's Protected Health Information or Electronic Protected Health Information only to perform the plan administration functions that Employer provides for the Plan, as specified in Section 7.4.
- (c) The employees, classes of employees, or other workforce members identified in Section 7.6(a) will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information or Electronic Protected Health Information in breach or violation of or noncompliance with the provisions of this Article.

7.7 Security Measures for Electronic Protected Health Information The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of a Covered Individual's Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on the Plan's behalf.

7.8 Notification of Security Incident The Employer will report to the Plan any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

ARTICLE VIII

Appeals Procedure

8.1 Procedure If Benefits Are Denied Under This Plan If a claim for reimbursement under this Plan is wholly or partially denied, they shall be administered in accordance with the procedure set forth below and in the summary plan description of this Plan. The Appeals Committee, separate and distinct from the individual(s) that adjudicate the claims, shall act on behalf of the Plan Administrator with respect to appeals.

If (a) a claim for reimbursement is wholly or partially denied, or (b) Participant is denied a benefit under the Plan due to an issue germane to said coverage under the Plan, then the procedure described below will apply.

Claims Under the HRA.

If a claim is denied in whole or in part, Participant will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received the claim. (This time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow the Participant 45 days from receipt of the notice in which to provide the specified information and will have the effect of suspending the time for a decision on the claim until the specified information is provided.)

Notification of a denied claim will include:

- * a statement of the specific reason(s) for the denial;
- * reference(s) to the specific Plan provision(s) on which the denial is based;
- * a description of any additional material or information necessary for Participant to validate the claim and an explanation of why such material or information is necessary;
- * appropriate information on the steps to be taken if Participant wishes to appeal the Plan Administrator's decision, including their right to submit written comments and have them considered, their right to review (upon request and at no charge) relevant documents and other information, and their right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of their claim.

Appeals.

If a claim is denied in whole or part, then Participant (or authorized representative) may request review upon written application to the Appeals Committee. The appeal must be made in writing within 180 days after Participant's receipt of the notice that the claim was denied. If Participant does not appeal on time, Participant will lose the right to appeal the denial and the right to file suit in court. Participant's written appeal should state the reasons that they feel their claim should not have been denied. It should include any additional facts and/or documents that they feel support their claim. Participant will have the opportunity to ask additional questions and make written comments, and Participant may review (upon request and at no charge) documents and other information relevant to their appeal.

Participant will not be allowed to take legal action against the Plan, the Employer, the Administrator, or any other entity to whom administrative or claims processing functions have been delegated unless they exhaust the internal appeal rights. A Participant does not have to pursue external review in order to preserve the right to file a lawsuit; however, a Participant may be unable to take further legal action if they pursue an external appeal because the external appeal process results in a binding determination.

Decision on Review of Internal Appeal.

Participant's internal appeal will be reviewed and decided by the Appeals Committee within a reasonable time not later than 60 days after the Appeals Committee receives Participant's request for review. The Appeals Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with their internal appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with the internal appeal will be provided. If the decision on review affirms the initial denial of the claim, Participant will be furnished with a notice of adverse benefit determination on review setting forth:

- * a statement of the specific reason(s) for the decision on review;
- * reference(s) to the specific Plan provision(s) on which the decision is based;
- * a statement of Participant's right to review (upon request and at no charge) relevant documents and other information;
- * if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to Participant upon request; and
- * a statement of Participant's right to bring an external appeal or a civil action under ERISA Section 502(a) (where applicable).

Participant may have the right to an external review of the Administrator's denial of the internal appeal unless the Benefit denial was based on the Participant's (or their Spouse's or Dependent's) failure to meet the Plan's eligibility requirements.

Requirements for an External Appeal.

Participant may request an external appeal by completing the form provided by the Administrator which must include the following information:

- * Participant's name, address, daytime telephone number and email address; and
- * A brief description of why the Participant disagrees with the decision, along with any additional information, such as a physician's letter, bills, medical records, or other documents to support their claim.

Deadline for filing an External Appeal.

Participant's external appeal must be filed with the external reviewer within four (4) months of the date the Participant was served with the Administrator's response to their internal appeal request. If Participant does not file an external appeal within this 4-month period, the Participant shall lose the right to appeal. For example, if Participant received the internal appeal decision on January 3, 2012, they must appeal the decision by May 3, 2012 (or, if that is not a business day, the next business day thereafter).

The plan must complete a preliminary review within five (5) business days upon receipt of the external review request to determine if the claimant was covered under the plan, the claimant provided all of the necessary information to process the external review and that the claimant has exhausted the internal appeals process. The plan must provide the claimant written notice of its preliminary review determination within one (1) business day after completing its review. If the request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide EBSA contact information. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The plan must permit the claimant to "perfect" (i.e., complete) the external review request within the four-month filing period or, if later, 48 hours after receipt of the notice.

Decision on Review of External Appeal.

The plan must assign an accredited Independent Review Organization (IRO) to perform the external review. The external reviewer must notify you and the Administrator of its decision on your external appeal within 45 days after its receipt of your request for external review. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Duty of Beneficiary/Third Party Recoveries.

Any Beneficiary under the Plan that receives a payment, whether by lawsuit, settlement, or otherwise, from third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party must reimburse the Plan to the extent the Beneficiary has received payments from the Plan for such sickness or injury. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

The Plan further requires covered Beneficiaries promptly advise the Plan Administrator of third-party claims and to execute any assignments, liens, or other documents the Plan Administrator requests. The Plan may withhold Benefits until such documents are received.

Subrogation/Acts of Third Parties.

The Plan Administrator, on behalf of the Plan, has the right to recover any payments made to Beneficiaries, whether by lawsuit, settlement, or otherwise, by third parties for costs associated with sickness or injury resulting from the acts or omissions of another person or party. The Plan has a first lien upon any such recovery. Any recovery by the Plan Administrator from such payments is subject to a deduction for reasonable attorney fees and court costs incurred by the Beneficiaries in securing the third-party payments, and shall be prorated, to reflect that portion of the total recovery reimbursed to the Plan Administrator for the benefits it had paid from the Plan. However, the Plan's share of the recovery will not be reduced because the Beneficiary has not received the full damages claimed, unless the Plan Administrator agrees in writing to such a reduction.

ARTICLE IX

Recordkeeping and Administration

9.1 Plan Administrator The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

9.2 Powers of the Plan Administrator The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section the Appeals Committee shall exercise such exclusive power with respect to an appeal of a claim as outlined in the Appeals Procedure Section);
- (b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- (d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;
- (e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate;
- (f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;
- (g) to employ any agents, attorneys, accountants or other parties (who may also be employed by the Employer) and to allocate or delegate to them such powers or duties as is necessary to assist in the proper and efficient administration of the Plan, provided that such allocation or delegation and the acceptance thereof is in writing;
- (h) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;
- (i) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;
- (j) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal;
- (k) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements; and
- (l) to report to the Employer, or any party designated by the Employer, after the end of each Plan Year regarding the administration of the Plan, and to report any significant problems as to the administration of the Plan and to make recommendations for modifications as to procedures and benefits, or any other change which might ensure the efficient administration of the Plan.

However, nothing in this Section is meant to confer upon the Plan Administrator any powers to amend the Plan or

change any administrative procedure or adopt any other procedure involving the Plan without the express written approval of the Employer regarding any amendment or change in administrative procedure, or Benefit Provider.

9.3 Reliance on Participant, Tables, etc. The Plan Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

9.4 Provision for Third-Party Plan Service Providers The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

9.5 Fiduciary Liability To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for the Plan Administrator's own willful misconduct or willful breach of this Plan.

9.6 Compensation of Plan Administrator Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer.

9.7 Bonding Fiduciaries shall be bonded to the extent required by ERISA.

9.8 Insurance Contracts The Employer shall have the right to: (a) enter into a contract with one or more insurance companies for the purpose of providing any benefits under the Plan; and (b) replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

9.9 Inability to Locate Payee If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

9.10 Effect of Mistake In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the HRA account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code section 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE X

General Provisions

10.1 Expenses All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

10.2 No Contract of Employment Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

10.3 Amendment and Termination This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

10.4 Governing Law This Plan shall be construed, administered and enforced according to the laws of the Commonwealth of Virginia to the extent not superseded by the Code, ERISA or any other federal law.

10.5 Code and ERISA Compliance It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA, and PPACA.

10.6 No Guarantee of Tax Consequences Neither the Plan Administrator nor the Employer makes any commitment nor will guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.7 Indemnification of Employer If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

10.8 Non-Assignability of Rights The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.9 Headings The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

10.10 Plan Provisions Controlling In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.11 Severability Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

* * *

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Bridgewater College HRA Plan, Bridgewater College has caused this Plan to be executed in its name and on its behalf, on this _____ day of _____, _____.

Employer:
Bridgewater College

Anne Keeler
Vice President of Finance & Treasurer

Appendix A

Exclusions – Medical Expenses That Are Not Reimbursable

The Bridgewater College Plan document contains the general rules governing what Medical Care Expenses are reimbursable. This Appendix A, as referenced in the Plan document, specifies certain expenses that are not reimbursable, under IRS guidance pertaining to HRAs.

Exclusions:

- * Long-term care services.
- * Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- * The salary expense of a nurse to care for a healthy newborn at home.
- * Funeral and burial expenses.
- * Household and domestic help (even though recommended by a qualified physician due to an Employee's, Spouse's, or Dependent's inability to perform physical housework).
- * Custodial care.
- * Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- * Social activities, such as dance lessons (even though recommended by a physician for general health improvement).
- * Bottled water.
- * Cosmetics, toiletries, toothpaste, etc.
- * Uniforms or special clothing, such as maternity clothing.
- * Automobile insurance premiums.
- * Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- * Any item that does not constitute "medical care" as defined under Code § 213(d).