

**FERRUM COLLEGE
HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN**

SUMMARY PLAN DESCRIPTION

Effective: January 1, 2018

Ferrum College Health Reimbursement Arrangement

Summary Plan Description

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Summary Plan Description

Article I

INTRODUCTION

Ferrum College, (the "Employer") sponsors the Ferrum College Health Reimbursement Arrangement for Eligible Employees. Under the federal tax law, the HRA Plan is known as a "Health Reimbursement Arrangement" or "HRA" plan.

The purpose of the HRA Plan is to reimburse Eligible Employees, up to certain limits, for their own Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the HRA Plan generally are excludable from taxable income.

This Summary Plan Description (SPD) describes the basic features of the HRA Plan, how it operates, and how to get the maximum advantage from it. This Summary does not describe every detail of the HRA Plan and is not meant to interpret or change the provisions of your Plan. A copy of the Plan is on file at your Employer's office and may be read by you, your Beneficiaries, or your legal representatives at any reasonable time. In the event of any inconsistencies or conflict between the actual provisions of the HRA Plan Document and this Summary, the HRA Plan Document shall govern.

Article II

PARTICIPATION IN YOUR PLAN

How can I participate in the HRA Plan?

Once an Employee has met the Plan's eligibility requirements, and provided that the procedures outlined under **How do I become a Participant and when is my Entry Date?** section are followed, the Eligible Employee may participate in the Plan.

What are the Eligibility Requirements to participate in the Plan?

Employees who are eligible to participate in the Employer's group medical insurance, have enrolled in the Employer's HDHC Plan and are employed by a participating Employer may participate in the Plan provided that the election procedures outlined under **How do I become a Participant and when is my Entry Date?** Section are followed.

Are there any Employees who are not eligible to participate in the Plan?

The following Employees are excluded from participating in the Plan:

- * Employees 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
- * Non-resident aliens with no US source of income
- * "Leased employees" within the meaning of Section 414(n)
- * Part-time employees who regularly work less than 20 hours per week
- * Temporary Employees
- * Self-employed individuals, partners in a partnership, or more-than-2% shareholders in a Subchapter S corporation.

How do I become a Participant and when is my Entry Date?

After you satisfy the eligibility requirements described under **What are the Eligibility Requirements to participate in the Plan?**, you will automatically be enrolled and become a Participant in the HRA Plan on the same day as the Employer's group medical plan.

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

Employees who actually participate in the HRA Plan are called "Participants." An Employee continues to participate in the HRA Plan until: (a) termination of the HRA Plan; or (b) the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason).

However, for purposes of pre-taxing COBRA coverage for the HRA benefits, certain Employees may be able to continue eligibility in the HRA Plan for certain periods. See **What is Continuation Coverage and how does it work?**, and **What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?** for information about how termination of participation affects your Benefits.

What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If you cease to be an Eligible Employee (for example, if you die, retire, or terminate employment), your participation in the HRA Plan will terminate unless you elect COBRA continuation coverage as described below. You will be reimbursed for any Medical Care Expenses incurred prior to your termination date, up to your account balance in the HRA account, provided that you comply with the reimbursement request procedures required under the HRA Plan (see **How will the HRA Plan work?** for more information on the reimbursement request process). Any unused portions will be unavailable after termination of employment.

If a Participant terminates his or her employment 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, the Employee will be treated as a new hire and must re-satisfy (complete the waiting period) Plan eligibility requirements to rejoin the Plan.

If you are rehired more than 30 days after you terminated employment, you will be treated as a new hire and must re-satisfy the eligibility requirements to rejoin the Plan.

If you cease to be an Eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described under **How do I participate in the HRA Plan?** before again becoming eligible to participate in the Plan.

What is COBRA continuation coverage and how does it work? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the HRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA (except in the case of certain small employers) to elect to continue his or her coverage under the HRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- * Your termination from employment or reduction of hours;
- * Your divorce or legal separation from your Spouse;
- * Your becoming eligible to receive Medicare benefits;
- * Your Dependent child's ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Plan Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual, disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

FMLA and USERRA Leaves of Absence

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain HRA Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

Non-FMLA and Non-USERRA Leaves of Absence

If you go on a leave of absence that is not subject to the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), you will be treated as having terminated participation.

Article III

WHAT BENEFITS ARE PROVIDED UNDER THE PLAN

What Benefits are offered under the HRA Plan?

Once you become a Participant, the HRA Plan will maintain an "HRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from any health insurance plan before any Benefits are payable from this Plan.

In the event that an expense is eligible for reimbursement under both the HRA and a Health FSA, you must seek reimbursement from the HRA first until that account balance has been exhausted before you can seek reimbursement from the Health FSA.

Before the start of each Plan Year, the Employer will determine a maximum annual amount that may be credited during that Plan Year to the HRA Account of each Participant in the HRA Plan. At the beginning of each Plan Year that you are a Participant, your HRA Account will be credited with:

	Plan 5	Plan 7
Employee only	800.00	1200.00
Employee plus spouse	1600.00	2400.00
Employee plus children	1600.00	2400.00
Employee plus family	1600.00	2400.00
Employee plus child	1600.00	2400.00

For example, if the maximum annual amount is determined by the Employer to be \$1,200 for the Plan Year and credited on an annual basis, your account will be credited with \$1,200 at the beginning of the plan year in which you are a Participant. Your HRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses. The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your HRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of the Plan Year, the unused amount, if any, in your HRA Account will be forfeited.

How will the HRA Plan work?

The HRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your HRA Account. The following procedure should be followed:

- * You must submit a claim to the Plan Administrator and provide any additional information requested by the Plan Administrator;
- * A request for payment must relate to Medical Care Expenses incurred by you during the time you were a Participant under this Plan;
- * A request for payment must be submitted within 90 days following the close of the Plan Year in which the Medical Care Expense was incurred;

Claims must be submitted in writing. The Plan Administrator may require that Participants submit claims on a form provided by the Plan Administrator. The claim must set forth:

- * The individual(s) on whose behalf the Medical Care Expenses were incurred;
- * The nature and date of the Medical Care Expenses so incurred;
- * The amount of the requested reimbursement; and
- * A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and showing the

amounts of such Medical Care Expenses, along with any additional documentation that the Plan Administrator may request.

If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the HRA, some expenses may be validated at the time the expense is incurred (like co-pays for medical care). For other expenses, the card payment is only conditional and you will still have to submit supporting documents.

Are there any limitations on Benefits available under the HRA Plan?

The benefit coverage option, and its respective exclusions, available under the HRA Plan:

Deductible HRA.

Reimburses all medical expenses that are applicable to the health plan's deductible. Qualified expenses are those incurred by you or your family, if applicable.

Plan 5 HRA will reimburse:

- For Employee only coverage – up to \$800 of the \$2,000 deductible expense for the Plan 5 PPO Group Health Plan.
- For Employee plus dependent coverage – up to \$1600 of the \$4,000 deductible expense for the Plan 5 PPO Group Health Plan.

Plan 7 HRA will reimburse:

- For Employee only coverage – up to \$1200 of the \$3,000 deductible expense for the Plan 7 PPO Group Health Plan.
- For Employee plus dependent coverage – up to \$2400 of the \$6,000 deductible expense for the Plan 7 PPO Group Health Plan.

For purposes of the HRA and Coverage Options, "Spouse" means the person who is legally married to you and is treated as a spouse under the Code. 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.

When must the Medical Care Expenses be incurred for the HRA?

For Medical Care Expenses to be reimbursed to you from your HRA Account for the Plan Year, they must have been incurred during that Plan Year. The Plan Year for the HRA is a 12-month period beginning on January 1st and ending on December 31st.

A Medical Care Expense is incurred when the service that causes the expense is provided, not when the expense was paid. If you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred. For example, if you prepay on the first day of the month for medical care that will be given during the rest of the month, the expense is not incurred until the end of that month (and cannot be reimbursed until after the end of that month). You may not be reimbursed for any expenses arising before the HRA Plan became effective, before your Enrollment Form became effective, for any expense incurred after the close of the Plan or after a separation from service (except for Continuation Coverage, as described under **What is "Continuation Coverage" and how does it work?**).

Will I pay any administrative costs under the HRA Plan?

No. The cost of the plan includes administrative expenses and is paid entirely by the Employer.

Are my Benefits taxable?

The HRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the HRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax adviser.

How long will the HRA Plan remain in effect?

Although the Employer expects to maintain the HRA Plan indefinitely, it has the right to amend or terminate all or any part of the HRA Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the HRA Plan be amended accordingly.

Article IV

CLAIMS PROCEDURE

What happens if my claim for benefits is denied?

If (a) a claim for reimbursement under the HRA Plan is wholly or partially denied, or (b) you are denied a benefit under the HRA due to an issue germane to your coverage under the HRA Plan (for example, a determination of a Change in Status; or eligibility and participation matters under the HRA Plan document), then the claims procedure described below will apply. If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days after the date the Plan Administrator received your 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 you 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 your claim until the specified information is provided.)

Notification of a denied claim will set out:

- * Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- * The specific reason for the denial;
- * A reference to the specific HRA Plan provision(s) on which the denial is based;
- * Any denial code (and its corresponding meaning) that was used in denying the claim;
- * A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary;
- * A description of the HRA Plan's internal and external review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA §502(a) following a denial on review; and
- * If the Administrator relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request.

Appeals

If your claim is denied in whole or part, then you (or your authorized representative) have the right to an internal appeal and, if applicable, an external review to an independent review organization. You may request review upon written application to the "Appeals Committee" for an internal review.

You 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 you exhaust your internal appeal rights. But you do not have to pursue external review in order to preserve your right to file a lawsuit. In fact, as explained later in this summary, you may be unable to take further legal action if you pursue an external appeal because the external appeal process results in a binding determination.

Requirements for an Internal Appeal

Your internal appeal must be in writing, must be provided to the Administrator, and must include the following information:

- * Your name and address;
- * The fact that you are disputing a denial of a claim or the Administrator's act or omission;
- * The date of the notice that the Administrator informed you of the denied claim; and
- * The reason(s), in clear and concise terms, for disputing the denial of the claim or the Administrator's act or omission.

You should also include any documentation that you have not already provided to the Administrator.

Deadline for Filing an Internal Appeal

Your internal appeal must be delivered to the Administrator within 180 days after receiving the denial notice or the Administrator's act or omission. If you do not file your internal appeal within this 180 day period, you lose your right to appeal. Your internal appeal will be heard and decided by the Committee.

Decision on Review of Internal Appeal

Any time before the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to the Committee. The HRA Plan is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, the Administrator will take into account all relevant documents, records, comments, and other information that you have provided with regard to the claim, regardless of whether or not such information was submitted or considered in the initial determination.

If the Administrator receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for the Administrator's notice of final internal adverse benefit determination. Similarly, if the Administrator identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you and you will be given a reasonable opportunity to respond to that new rationale before the due date for the Administrator's notice of final internal adverse benefit determination.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim.

If your internal appeal is denied, the notice that you receive from the Committee will include the following information:

- * Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- * The specific reason for the denial upon review;
- * A reference to the specific Plan provision(s) on which the denial is based;
- * Any denial code (and its corresponding meaning) that was used in denying the claim;
- * A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- * If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- * A statement of your right to bring an external appeal or a civil action under ERISA §502(a), where applicable.

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

Requirements for an External Appeal

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

- * Your name, address, daytime telephone number and email address; and
- * A brief description of why you disagree with the decision, along with any additional information, such as a physician's letter, bills, medical records, or other documents to support your claim.
- * Return the Request for External Review and your denial notice as instructed on the form.

You should also include any documentation that you have not already provided to the Administrator.

Deadline for filing an External Appeal

Your external appeal must be filed with the external reviewer within four (4) months of the date you were served

with the Administrator's response to your internal appeal request. If you do not file your appeal within this 4-month period, you lose your right to appeal. For example, if you received the internal appeal decision on January 3, 2012, you 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 your external review request to determine if you were covered under the plan, you provided all of the necessary information to process the external review and that you have exhausted the internal appeals process. The plan must provide you with a written notice of its preliminary review determination within one (1) business day after completing its review. If your request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide you with the Employee Benefits Security Administration (EBSA) contact information. If your request is incomplete, the notice must describe the information or materials needed to complete the request. The plan must permit you 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 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 V

STATEMENT OF ERISA RIGHTS

What are my ERISA Rights?

The HRA Plan is an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA) and is governed by ERISA.

Your Rights. As a participant in the HRA Plan, you may be entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

- * Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- * Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies); and
- * Receive a summary of the HRA Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Fiduciary Obligations. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plan. The people who operate your HRA Plan, called "fiduciaries" of the HRA Plan, have a duty to do so prudently and in the interest of the HRA Plan Participants and beneficiaries.

No Discrimination. 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 plan benefit or exercising your rights under ERISA.

Right to Review. If your claim for a benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforcing Your Rights. Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court (but only if you have first filed your claim under the plan's claims procedures and, if applicable, filed a timely appeal of any denial of your claim). If it should happen that plan fiduciaries misuse the HRA Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

HIPAA Privacy Rights - Use and Disclosure of Protected Health Information. Except for certain permitted

uses and disclosures, the Privacy Rule issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization. For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official:

Ferrum College
PO Box 1000
215 Ferrum Mountain Road
Ferrum, VA 24088
(540) 365-4287

If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

Permitted Uses and Disclosures. The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- * Health care treatment;
- * Payment for health care;
- * Health care operations; and
- * Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official.

Disclosures to the Employer. After the Employer has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Employer without your authorization to the extent that the PHI is necessary for the Employer to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Employer than is necessary for the Employer to fulfill its administration functions, and the HRA Plan may not disclose PHI to the Employer for purposes of any employment-related actions or in connection with any other employee benefit provided by the Employer.

To the extent that your PHI is disclosed to the Employer, the Employer will:

- * not use or further disclose PHI other than as permitted or required by the official HRA Plan document or as required by law;
- * ensure that any agents to whom the Employer provides PHI (or certain Electronic Protected Health Information (E PHI)) received from the HRA Plan agree to the same restrictions and conditions that apply to the Employer with respect to PHI;
- * not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- * not use or disclose PHI in connection with any other benefit provided by the Employer unless authorized by you;
- * report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
- * make PHI available to you in accordance with the requirements of the Privacy Rule;
- * make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- * make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- * make internal practices, books, and records relating to the Employer's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and
- * if feasible, return or destroy all PHI received from the HRA Plan that the Employer still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Employer may only disclose your PHI (or certain EPHI) to the following employees and may only do so to the extent that the employees perform HRA Plan administration functions:

- * Human Resource and payroll staff performing HRA functions; and
- * Any other class of employees designated in writing by the Privacy Official.

If an employee does not comply with the requirements of the Privacy Rule, then the Employer may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.

Article VI

GENERAL INFORMATION

General Plan Information

- * Name: Ferrum College Health Reimbursement Arrangement
- * Plan Number: 505
- * Effective Date: January 1, 2018
- * Plan Year: January 1st to December 31st. Your Plan's records are maintained on this 12-month period of time
- * Type of Plan: Welfare Plan
- * Your plan shall be governed by the Laws of the State of Virginia.

Employer/Plan Sponsor Information

- * Name and Address: Ferrum College
PO Box 1000
215 Ferrum Mountain Road
Ferrum, VA 24088
(540) 365-4287
- * Federal Employer Tax Identification Number (EIN): 54-0506457

Plan Administrator Information

Name, address, and business telephone number:

Ferrum College
PO Box 1000
215 Ferrum Mountain Road
Ferrum, VA 24088
Attention: Benefits Administrator
(540) 365-4287

The Plan Administrator appoints the Benefits Administrator to keep the records for the Plan and to be responsible for the administration of the Plan. However, the Appeals Committee acts on behalf of the Plan Administrator with respect to appeals. The Benefits Administrator will answer any questions that you may have about our Plan. You may contact the Benefits Administrator at the above address for any further information about the Plan.

Funding and Type of Plan Administration

The HRA is a group health plan and is self-funded by the Employer. This is a contract administration plan. A third-party administrator processes claims for the Plan.

All of the amounts payable under this Plan may 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. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an unrelated third-party paying agent to make Benefit payments on its behalf.

Named Fiduciary

The named fiduciary for the HRA Component is: Ferrum College

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Ferrum College
PO Box 1000
215 Ferrum Mountain Road
Ferrum, VA 24088
(540) 365-4287

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Qualified Medical Child Support Order

The HRA will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

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

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law

"Michelle's Law" requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA (Genetic Information Non-Discrimination Act) prohibits discrimination by health insurers and employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions: prohibits the use of genetic information in making employment decisions; restricts the acquisition of genetic information by employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

Health Information Technology for Economic and Clinical Health Act was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules. HITECH defines an EHR as "electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff."

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

This new law amends the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.