This section contains important information, required by the Employee Retirement Income Security Act of 1974 ("ERISA"), about your medical benefits.

**Plan Name/Identification**
The medical benefits described in this SPD are governed by the official Plan document. This Plan is named the **Bloomfield College Health and Welfare Plan**.

The Plan is an employer-sponsored welfare benefit plan governed by ERISA and subject to the reporting and disclosure requirements of that law.

The plan number assigned by Bloomfield College is 509.

**Plan Employer/Plan Sponsor/Employer Identification Number**
The Plan employer/Plan sponsor for the Plan is:

Bloomfield College  
467 Franklin Street  
Bloomfield, NJ 07003

The employer identification number is 22-1494428.

Employees may obtain a complete list of employers that sponsor the Plan, upon written request to the Plan Administrator, and receive information as to whether a particular employer is a sponsor of the Plan, with that employer’s address.

**Plan Administrator**
The Plan Administrator for the Plan is:

Bloomfield College  
Attn: Vice President for Finance and Administration  
Knox Hall  
467 Franklin Street  
Bloomfield, NJ 07003  
Telephone: 973-748-9000

**Type of Administration**
The medical benefits under the Plan are fully-insured and administered by Oxford Health Plans (NJ), Inc., which is the claims administrator for these benefits.

**Claims Administrator and Authority to Review Claims**
Your eligibility for benefits is determined by the Plan. The Plan Administrator has full discretionary authority to interpret the terms of the Plan summarized in this SPD and determine your eligibility and benefit claims under the Plan’s terms. In some cases, the Plan Administrator has delegated this authority.
The Plan Administrator has delegated its authority to determine benefit claims to the claims administrator, Oxford Health Plans (NJ), Inc. Benefits under the Plan are paid only if the claims administrator decides, in its discretion, that the claimant is entitled to them. The claims administrator has:

- The authority to make final determinations regarding benefit claims under the Plan.
- The discretionary authority to:
  - Interpret the Plan based on provisions and applicable law and make factual determinations about benefit claims arising under the Plan.
  - Decide the amount, form, and timing of benefits.
  - Resolve any other matter under the Plan that is raised by a claimant or that is identified by the claims administrator.

In case of an appeal, the claims administrator’s decision is final and binding on all parties to the full extent permitted under applicable law, unless the claimant later proves that the claims administrator’s decision was an abuse of administrator discretion.

**Agent for Service of Legal Process**

The agent for service of legal process under the Plan is:

Bloomfield College  
Attn: Vice President for Finance and Administration  
467 Franklin Street  
Bloomfield, NJ 07003

**Plan Year**

The Plan Year is a calendar year, which runs from January 1 through December 31.

**Funding and Source of Contributions**

The Plan is funded by participant contributions and Employer contributions. Employer contributions are made from Employer assets. Participant contributions may be made on a pre-tax basis or paid with after-tax dollars.

The medical benefits under the Plan are fully-insured, and the Employer pays the insurance company a premium, from Employer assets and participant contributions, for providing coverage for the insured benefits. Insured benefits are paid by the insurance company, which has entered into a contract with the Employer to provide those benefits.

Continuation of medical benefits after termination is paid for by the qualified beneficiary on an after-tax basis.

The Employer determines the amount of the required participant contributions for coverage under the Plan and reserves the right to change the amount of required participant contributions at any time, with or without advance notice to participants.
Qualified Medical Child Support Orders (“QMCSO”)
A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide medical benefits for a child (often because of legal separation or divorce). A QMCSO cannot require the Plan to cover any type or form of benefit not otherwise offered. However, an order may require the Plan to comply with state laws regarding a child’s coverage.

A QMCSO may require medical coverage under the Plan for your child even if you are divorced, your ex-spouse has legal custody of the child, and the child is not dependent on you for support. The QMCSO also gives you a special enrollment right to add medical coverage outside of any annual open enrollment period restrictions.

If the Employer receives a valid QMCSO, you may enroll a dependent child for medical benefits under the Plan pursuant to the QMCSO’s terms. The change you elect takes effect as of the date the QMCSO is processed.

If the Employer receives a valid QMCSO and you do not enroll the dependent child for medical benefits under the Plan pursuant to the QMCSO’s terms, the Plan will provide medical benefits for your child in accordance with the terms of the QMCSO. The cost of coverage provided pursuant to the QMCSO will be automatically withheld from your pay, subject to any limits set by state or federal law.

Federal law requires that a QMCSO must meet certain form and content requirements to be valid. The Employer follows certain procedures to determine if a medical child support order is “qualified”. You may request, without charge, a copy of the Plan’s QMCSO administrative procedures from the Plan Administrator. If you become subject to an order, you will receive a copy of the QMCSO administrative procedures, free of charge, from the Plan Administrator.

No Employment Rights or Guarantee of Benefits
All terms of the Plan are legally enforceable. However, neither the Plan nor this SPD constitutes a contract of employment or guarantee of any particular benefit.

Misrepresentation or Fraud
If you or your dependent makes a false or misleading statement that is material to your claim for benefits, the Plan Administrator may offset against future payment any amount paid to you to which you were not entitled. The Plan Administrator has the authority to take any additional action as may be deemed necessary to make the Plan whole, in accordance with the law. The Plan Administrator reserves the right to rescind your coverage under the Plan if you or your dependent performs an act, practice, or omission that constitutes fraud or if you or your dependent makes an intentional misrepresentation of material fact.

Amendment/Termination
Although the Employer presently intends to continue the Plan, it reserves the right to, at any time, amend or terminate any and all health and welfare benefits under the Plan, to amend or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other term or condition of the Plan, and to terminate the entire Plan, or any part, subject to applicable law. The procedures by which these actions may be taken are contained in the legal Plan document, which is available for inspection and copying from the Plan Administrator.

No consent of any participant is required to amend or terminate the Plan.
Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any expenses incurred prior to the date that the Plan terminates. Likewise, any extension of benefits under the Plan due to your or your dependent’s total disability which began prior to and has continued beyond the date the Plan terminates will not be affected by the Plan’s termination. No extension of benefits or rights will be available solely because the Plan terminates.

**Employer’s Right to Use Your Social Security Number for Administration of Benefits**

Under the Medicare Secondary Payer requirements, the Centers for Medicare and Medicaid Services (“CMS”) generally require Social Security numbers for employees and dependents to assist with reporting. Accordingly, the Employer will require that you and your dependents provide Social Security numbers at the time of enrollment so that the Employer can assist the claims administrator in complying with these reporting requirements.

The Employer retains the right to use your Social Security number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security numbers for benefit administration purposes, the Employer generally takes the position that ERISA preempts such state laws.

**Outcome of Covered Services and Supplies**

The Employer is not responsible for, and makes no guarantees concerning, the outcome of the covered services or supplies you receive under the Plan.

**Unclaimed Funds**

If you fail file a claim using the Plan’s procedures, or you fail to accept or cash a claim reimbursement check within 120 days after the reimbursement check has been issued, and the Plan Administrator has made a reasonable attempt to reimburse you, the funds will be considered unclaimed and will be treated as Plan forfeitures. However, if you should later renew your written claim for reimbursement of the forfeited amount, the Employer will reimburse that amount to you within 90 days of the renewed claim.

**Collective Bargaining Agreements**

You may contact the Plan Administrator about the relevant collective bargaining agreements pursuant to which the Plan is maintained. The agreements are available for examination and may be obtained upon written request to the Plan Administrator.

With respect to the faculty, the Plan is maintained pursuant to the Agreement between Bloomfield College and the Bloomfield College Chapter of the AAUP.

**Reimbursement**

This section applies when you recover damages (by settlement, verdict, or otherwise) for an injury, illness, or other condition, including death. If you have received, or in the future may receive, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat the injury or illness or the treatment of the injury or illness. These benefits are specifically excluded.

If the Plan does advance moneys or provide care for the injury, illness, or other condition, you must promptly send to the Plan the moneys or other property that you receive from any settlement, arbitration award, verdict, insurance proceeds, or monetary recovery from any party for the reasonable value of the health benefits advanced or provided to you by the Plan, regardless of whether or not:
- You have been fully compensated or made whole for your loss.
- You or any other party admits to liability.
- The recovery is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan has first priority to receive reimbursement for any payments made on your behalf, before payment is made to you or any other party. This reimbursement is required from any recovery you make, including uninsured and underinsured motorist coverage; any no-fault insurance; medical payment coverage (auto, homeowners, or otherwise); Workers’ Compensation settlements, compromises, or awards; other group insurance (including student plans); and direct recoveries from liable parties.

In order to secure the Plan’s rights when it pays benefits in these situations, you must acknowledge and agree to the following when you accept benefits from the Plan:

- Acknowledge that the Plan has first priority against the proceeds of any such settlement, arbitration award, verdict, or other amounts you receive.
- Acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by you or any other person, are being held for the benefit of the Plan.
- Assign to the Plan any benefits you may have under any automobile policy or other coverage, to the extent of the Plan’s claim for reimbursement.
- Cooperate with the Plan and its agents, provide relevant information, and take actions that the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of benefits paid.
- Consent to the Plan’s right to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan’s rights under this section.
- Consent to the Plan’s right to deduct from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.
- Agree to not take any action that prejudices the Plan’s rights of reimbursement.

The Plan is responsible only for those legal fees and expenses to which it agrees in writing. You cannot incur any expenses on behalf of the Plan in pursuit of the Plan’s rights under this section. Specifically, no court costs or attorney’s fees can be deducted from the Plan’s recovery without the express written consent of the Plan. Any so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall not defeat this right.

In cases of occupational illness or injury, the Plan’s recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any Workers’ Compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan’s interest, and the Plan shall be reimbursed in first priority from any such award or settlement.
The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary or covered person, whether under comparative negligence or otherwise.

**Subrogation**

This section applies when another party (including insurance carriers who are financially liable) is, or may be considered, liable for your injury, illness, or other condition, including death, and the Plan has advanced benefits. Subrogation is similar to reimbursement, but allows the Plan to “step into your shoes” and obtain a benefit from a third party who was negligent or responsible for your injury or illness. This occurs when the Plan has to pay a benefit due to your injury, illness, or other condition, but would not have owed the payment if the third party had not caused the problem.

In consideration for the advancement of benefits, the Plan is subrogated to all of your rights against any party liable for your injury, illness, or other condition, including death, or which is or may be liable for the payment for the medical treatment of the injury or occupational illness (including any insurance carrier), to the extent of the value of the health benefits advanced to you under the Plan. The Plan may assert this right independently of you. This right includes, but is not limited to, the covered person’s rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), Workers’ Compensation coverage, or other insurance, as well as your rights under the Plan to bring an action to clarify your rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on your behalf, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

You are obligated to cooperate with the Plan and its agents in order to protect the Plan’s subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan’s subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that you fail to cooperate with this provision, including executing any documents required herein, the Plan will, in addition to remedies provided elsewhere in the Plan and/or under the law, offset from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan’s subrogation right is a first priority right and must be satisfied in full prior to any of your or your representative’s other claims, regardless of whether you are fully compensated for your damages. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of your legal representation are borne solely by you.

**Right of Recovery**

If, for some reason, a benefit is paid that is larger than the amount allowed by the Plan, the Plan has a right to recover the excess amount from the person or agency that received or holds this benefit. This excess amount is subject to a constructive trust in favor of the Plan. The person receiving or holding Plan benefits must produce any instruments or papers necessary to ensure this right of recovery.
Your Rights Under ERISA
As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Plan participants shall be entitled to:

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

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

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:
If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court.

If you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, 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 Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.