UTICA COLLEGE

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT PLAN
(With Health Savings Account Contributions)

SUMMARY PLAN DESCRIPTION

DISCLAIMER

EBS-RMSCO, Inc. is providing this form summary plan description to assist the sponsoring employer with its obligations under the Employee Retirement Income Security Act of 1974 (“ERISA”), including its disclosure obligations to plan participants. This form summary plan description was completed using information provided by the sponsoring employer. EBS-RMSCO, Inc. is not a law firm, has not reviewed that information for legal sufficiency, and does not give legal or tax advice. The sponsoring employer should have this form summary plan description reviewed by its own legal counsel for compliance with ERISA, tax requirements, and other applicable laws and regulations.

The sponsoring employer, as the plan sponsor and plan administrator, is also responsible for the accuracy of the summary plan description, its distribution to participants, and the overall operation of the plan. The sponsoring employer should review this form summary plan description carefully to ensure that it accurately reflects all of the terms and provisions of the employer’s plan. Please note that EBS-RMSCO, Inc. will make substantive changes to this form summary plan description, but will not make format, stylistic and other non-substantive changes.

Generally, ERISA requires that employee contributions to an employee health plan be held in a trust. The U.S. Department of Labor (DOL) has issued ERISA Technical Release 92-01, which explains the ERISA trust requirement, and states that the DOL will not enforce the requirement with respect to certain types of plans. The sponsoring employer should consult with its own legal counsel about whether a trust must be established to hold employee contributions to this plan. The sponsoring employer is solely responsible for determining whether the ERISA trust requirement applies and, if it does, complying with it.
UTICA COLLEGE

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT PLAN
(With Health Savings Account Contributions)

SUMMARY PLAN DESCRIPTION

Of the Provisions of the Plan
in Effect on January 1, 2010
INTRODUCTION

This Summary Plan Description ("SPD") presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection at the Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502, during regular business hours.

The information in this SPD may be modified by a “Summary of Material Modification” ("SMM"). Check to see if there are any SMM’s attached when you refer to this SPD.
IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name: Utica College
Limited Purpose Flexible Spending Account

Plan Number: 511

Plan Type: Cafeteria (Section 125) Plan

Plan Year: The Plan Year begins on January 1 and ends on December 31

Employer and Plan Sponsor: Utica College
1600 Burrstone Road
Utica, New York  13502
(315) -792-3276

Employer Identification Number: 16-1476258

Plan Administrator: Utica College
1600 Burrstone Road
Utica, New York  13502
(315) -792-3276

Type of Plan Administration: The Plan is administered by the Employer through a Committee appointed by the Employer. All benefits are paid from the general assets of the Employer. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the amount of Employer and participant contributions. The Benefits Coordinator is the primary source for information about these aspects of the Plan.

Plan Agent for Service of Legal Process: Utica College
1600 Burrstone Road
Utica, New York  13502

Legal process may also be served upon the Plan Administrator.
1. **What is the advantage to me of the Limited Purpose Flexible Spending Account Plan?**

You can use the Plan to pay your premium on a pre-tax basis for the type(s) of group coverage sponsored by your Employer and listed in Question and Answer 4. (Your cost for the group coverage listed is referred to in this SPD as your “premium” whether the coverage is provided through an insured plan or is self-insured by your Employer.)

Other pre-tax contributions can be made and used to pay or reimburse you for dependent care expenses.

Your contributions under the Plan are deducted from your pay and are not reported as taxable income on your W-2 Form, so you do not pay income tax or Social Security taxes on them, provided certain tax requirements are satisfied.

Alternatively, under the Plan you will receive an additional amount in your paycheck at the end of the Plan Year if you are eligible for, but decline and do not receive, the following group coverage sponsored by your Employer:

- accidental death and dismemberment coverage
- dental coverage
- high deductible medical coverage

The additional amounts you receive in your paycheck are subject to income tax and Social Security taxes, and are reported as taxable income on your W-2 form.

Finally, if you are enrolled in high deductible medical coverage sponsored by the Employer, you may be able to make pre-tax contributions through the Plan to your “health savings account” or “HSA” and the Employer may make additional contributions to your HSA. However, it is important that you keep in mind that to be eligible for HSA contributions you must also satisfy certain requirements under tax law. For example, you must not have any other health coverage, except for certain “permitted” coverage, and must not be claimed as a dependent on someone else’s federal tax return or be entitled to Medicare. There can be negative tax consequences if contributions are made to your HSA when you do not satisfy the HSA eligibility requirements, and the HSA eligibility rules and the limits on HSA contributions can be complicated. **The Employer is not responsible for determining whether you are eligible for HSA contributions or the maximum contribution that can be made to your HSA. You should contact your own tax advisor to make certain you understand all HSA rules and requirements.**
2. **Who is eligible to participate in the Plan?**

You are eligible to participate in the Plan if you are:

- a benefit eligible employee of the Employer.

Notwithstanding the above, the following persons are not eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation (“LLC”), any member of the LLC; and (iv) if the Employer is a Subchapter S corporation, and any person who owns directly or indirectly more than 2% of the Employer.

Generally, you cease to be a participant in the Plan when you no longer satisfy the eligibility requirements above.

Also, see Questions and Answers 13 - 15 for additional requirements to make HSA contributions through the Plan.

3. **When can I begin participating in the Plan?**

If you meet the eligibility requirements listed above, you may begin participating in the Plan:

- **pre-tax insurance premiums** - the first day of employment;

- **medical, dental, vision, and dependent care expenses reimbursement** - the first of the month following 6 months of employment.

Your premiums for group coverage sponsored by your Employer are deducted from your pay throughout the Plan Year, unless you elect otherwise in a writing signed by you and filed with the Committee. If you file such an election you will not be able to pay your premiums through the Plan until the next Plan Year, unless a change in status occurs that allows you to change your election (see Question and Answer 11).

Before you can make contributions for other expenses, you must complete and file an election form. Failure to complete and return the form by the date specified by the Committee will be considered an election not to make contributions for other...
expenses. In that case, you will not be able to make contributions for other expenses until the next Plan Year, unless a change in status occurs that allows you to change your election (again see Question and Answer 11). Your Plan contributions are deducted from your pay throughout the Plan Year.

For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.

Also, see Question and Answer 15 for different election rules for HSA contributions made through the Plan.

4. **What premiums can I pay through the Plan?**

You can pay your premiums for the following types of group health coverage sponsored by your Employer:

- dental coverage
- high deductible medical coverage

and these other types of group coverage sponsored by your Employer:

- accidental death and dismemberment coverage

5. **What other expenses can be paid under the Plan?**

You can also make contributions to the Plan that can be used to pay or reimburse you for the following types of expenses:

- dependent care expenses that would otherwise qualify for a dependent care credit on your federal income tax return if they were not paid or reimbursed under the Plan; provided they have not been paid or reimbursed, and are not payable or reimbursable, from any other source.

- dental care and vision care expenses that would otherwise be deductible on your federal income tax return if they were not paid or reimbursed under the Plan (but without regard to any minimum amount of expenses required to take a deduction), such as cleanings, filings, crowns, orthodontics, eyeglasses, contact lenses, refractions and vision correction procedures; provided they have not been paid or reimbursed, and are not payable or reimbursable, under insurance or any other health plan coverage. (Note, however, that if such a dental or vision expense is eligible for reimbursement under both this Plan and
your HSA, you can seek payment or reimbursement either from this Plan or the HSA, but not both.)

6. **How much can I contribute for these other expenses?**

   Before you can first participate in the Plan, and at the beginning of each Plan Year, you will be notified of the minimum and maximum amount you can contribute for that Plan Year for expenses other than premiums.

   HOWEVER, SEE QUESTIONS AND ANSWERS 15 - 17 FOR SPECIAL RULES REGARDING THE TIMING AND MAXIMUM AMOUNT OF HSA CONTRIBUTIONS.

7. **How do I receive my benefits from the Plan?**

   Amounts are deducted directly from your pay and used to pay your premiums. Your Employer may make arrangements for automatic payment or reimbursement of other expenses covered under the Plan. Otherwise, these other expenses will be paid/reimbursed at least monthly, provided you file a written claim for payment or reimbursement at least five business days before a scheduled payment/reimbursement date.

   The Committee will inform participants of the scheduled payment/reimbursement dates. Claims for payment or reimbursement must be made on forms provided by the Committee. You may request forms from Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502.

   Note:

   - The amount of dependent care expenses paid or reimbursed cannot exceed the contributions you have made to the Plan for dependent care expenses, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.

   - The total amount of dental and vision care expenses paid or reimbursed cannot exceed the amount of your contribution election for the Plan Year for dental and vision care expenses, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.

   - Only expenses incurred on or after the date you begin participating in the Plan and before the date you stop participating in the Plan are covered under the
Plan. Generally, you stop participating in the Plan when you no longer satisfy the eligibility requirements in the Answer to Question 2.

- If you are employed through the end of the Plan Year, you have until the April 30th after the end of each Plan Year to submit a claim for payment or reimbursement for expenses that you incurred during the Plan Year. (Question and Answer 9 explains rules that apply when you terminate employment before the end of a Plan Year.)

By January 31st, you will receive a W-2 Wage and Tax Statement showing the amount of your contributions made the previous calendar year for dependent care expenses.

8. **What happens if I am employed by the Employer through the end of a Plan Year but my contributions for expenses (other than premiums) are greater than my actual expenses during the Plan Year?**

If the amount you contribute for expenses exceeds the amount of those expenses which you actually incur during the Plan Year, you will forfeit the excess contributions. Therefore, you should be careful to contribute only the amount you think will be needed to cover your anticipated expenses for the Plan Year.

9. **What happens if my employment terminates before the end of a Plan Year?**

You may claim payment or reimbursement for expenses incurred before your termination, provided you submit your claim for payment or reimbursement no later than 90 days after your termination. You may also have a right to COBRA continuation coverage. (See “COBRA Continuation Coverage” in Question and Answer 22).

10. **What happens if I take a leave of absence during the Plan Year?**

A paid leave of absence is not itself a change in family status, so your elections will stay in place unless you have another reason to change them. However, an unpaid leave, and a leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act is a change in status, so you may change your elections as explained in Question and Answer 7. Also, see Question and Answer 22 for special rules applicable to a leave under the Family and Medical Leave Act.
11. When can I change the amount I contribute to the Plan?

There are special rules for changes to an election for HSA contributions. Those rules are discussed in the Answer to Question 15. You can change your other elections before the beginning of each new Plan Year and, once the Plan Year has started, federal tax laws permit you to change your other elections only when one of the following “changes in status” occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (This applies only to elections for group health coverage premiums.)

- You, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law under a group health plan of your Employer. (This applies only to elections for group health coverage premiums.)

- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage. (This applies only to elections for group or individual health coverage premiums and contributions for dental and vision expenses.)

- You, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines). (This applies only to elections for group high deductible medical coverage premiums and contributions for dental and vision expenses.)

- Your premium for group coverage increases significantly or the insurer unilaterally increases your premium for your individual insurance coverage (not due to any action on your part). (However, if there is an ordinary increase or decrease in premiums, your contributions will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- There is a significant curtailment in, or cessation of, your group coverage. (In the case of group health coverage, there must be reduced coverage for employees generally.) Note that a significant curtailment in, or cessation of, your group coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the
amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- A new group coverage option is added or a group coverage option you have selected is eliminated. Note that the addition or elimination of a coverage option allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- Your legal marital status changes (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).

- The number of your dependents changes (including a change resulting from a birth, death, adoption or placement for adoption of a child).

- There is a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or dependent to become or cease to be eligible for group coverage under the Plan or other employer plan providing the same type of benefits. However, if your employment terminates and resumes in the same Plan Year within a period of 30 days or less, your elections in effect before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in your elections.

- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for group coverage at the new place of residence. Note that a change in residence allows you to change the amount of the premiums you pay through the Plan for the group coverage for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- Your dependent’s eligibility for group health coverage changes due to the dependent’s age, student status or marital status or similar circumstance.

- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children’s health insurance program under Title XXI of the Social Security Act, a medical care
program of an Indian Tribal government (as defined in Section 7701(a)(40)),
the Indian Health Service, a tribal organization, a State health benefits risk
pool, or a foreign government group health plan. Note loss of such coverage
allows you to change the amount of premiums you pay through the Plan for
high deductible medical coverage, but does not allow you to change the
amount of any other premiums you pay through the Plan or any other
contributions to the Plan. (This applies only to elections for group health
coverage premiums.)

- There is a change in your dependent care provider or a change in the cost of
  services provided by a dependent care provider who is not a relative.

- A person’s status as a dependent for purposes of your dependent care election
  changes.

- Your spouse, former spouse or dependent makes a change under another plan
  which is either (i) consistent with one of the events described above, or (ii) for
  the normal election period under the other plan and that election period is
different from the Plan Year of this Plan. (This does not apply to elections for
individual policy premiums or contributions for dental and vision expenses.)

**Note that an election change must be made within 30 days of an event described
above, and must conform to and be consistent with that event.**

Also, even if you are allowed to change your election for dental and vision care
expenses, you may not reduce the annual contribution for those expenses to less than
the amount of those expenses already paid for or reimbursed to you for the Plan
Year.

12. **What is an HSA?**

An HSA is an individual trust or custodial account that you establish with a trustee
or custodian (which you choose) and is used primarily to reimburse you for
reimbursement “eligible medical expenses.” It is not an employer-sponsored
employee benefit plan, and the Employer has no authority or control over the funds
deposited in your HSA. An HSA is administered by the HSA trustee or custodian,
and the Employer’s role, if any, is limited to forwarding contributions to your HSA
through this Plan if you satisfy the eligibility requirements described in the Answers
to Questions 13 - 15. All terms and conditions of HSA coverage and benefits (e.g.,
eligible medical expenses, claims, procedures, etc.) should be set forth in documents
provided by the HSA trustee or custodian. Those documents are not part of this
Plan.
13. **Can I make HSA contributions?**

To make HSA contributions, you must be an “HSA eligible individual.” This means you must satisfy specific requirements under tax law. For example, you must be covered under a qualifying high deductible health plan, like the high deductible health plan sponsored by the Employer. Also, you must not have any other health coverage, except for certain other “permitted” coverage, and must not be claimed as a dependent on someone else’s federal tax return or be entitled to Medicare.

14. **Who can make HSA contributions through the Plan?**

An employee who satisfies the eligibility requirements described in Question and Answer 2 and has high deductible medical coverage sponsored by the Employer may elect to have a portion of his compensation forwarded by the Employer as contributions to his HSA, provided he certifies to the Employer, and the Committee reasonably believes, the employee satisfies all of the tax requirements to make HSA contributions.

15. **How does an employee elect to make HSA contributions?**

The Committee will provide an election form to each employee who provides this certification and who the Committee reasonably believes satisfies all of the requirements to make HSA contributions. The form must be completed and filed with the Committee on or before the date specified by the Committee, must indicate the contributions to be forwarded to the employee’s HSA, and must contain sufficient identifying information about the employee’s HSA to facilitate the forwarding of his contributions to the HSA trustee or custodian. An employee’s failure to submit election form(s) by the date specified by the Committee will be deemed an election to not make any contributions to his HSA.

HSA contribution elections and changes to HSA contributions elections (i.e., increases, decreases or revocations) will be effective (and apply to compensation that would otherwise be paid) no earlier than the first day of the calendar month following the date the election form (or changed election form) is filed. An employee’s contributions to his HSA will stop when he no longer satisfies the eligibility requirements described in the Answer to Question 2 or the Answer to Question 14. In addition, the following rules also apply to HSA contribution elections:

- An employee may elect to have his compensation for a calendar month reduced for HSA contributions only if he has high deductible medical coverage sponsored by the Employer as of the first day of that month.
• An employee may elect to have his compensation for a calendar month reduced for HSA contributions only if he is not covered as of the first day of that month under another cafeteria plan (as defined in tax laws and regulations) maintained by the Employer.

• An employee may not elect to have his compensation reduced for HSA contributions for any calendar month (or portion thereof) which is part of a “grace period” under a cafeteria plan maintained by the Employer if the employee had a health flexible spending account (“health FSA”) under that plan during the plan year preceding the grace period, unless: (i) the health FSA provided only “permitted” dental, vision or preventive care coverage (as described in HSA tax law and regulations); or (ii) he had no balance remaining in the health FSA as of the last day of the plan year preceding the grace period (disregarding any claims incurred as of that day but not yet submitted, or not yet paid or reimbursed).

Employee HSA contributions are made through equal payroll reductions. The amount of reduction for each pay period is equal to the employee’s total HSA contribution election for the Plan Year (or remainder of the Plan Year) divided by the number of pay periods in the Plan Year (or remainder of the Plan Year).

The Employer will forward each employee’s HSA contributions to his HSA trustee or custodian within a reasonable time after the pay period from which the contributions are made, and will maintain records of his HSA contributions. However, neither the Employer nor the Plan Administrator will create a separate fund or otherwise segregate assets for this purpose.

16. Does the Employer make any HSA contributions for me?

Yes. If you are eligible to make HSA contributions to your HSA for the month of January, April, July or October, the Employer will make contributions to your HSA on or as soon as practical after the first day of that month, provided you furnish the Employer with information sufficient to facilitate the forwarding of these contributions to your HSA trustee or custodian. The amount of the contribution for each January 1st, April 1st, July 1st and August 1st will equal an amount based on the level of your high deductible health plan coverage in effect as of that month and in accordance with the following table:
<table>
<thead>
<tr>
<th>High Deductible Health Plan Coverage</th>
<th>Amount of Employer Quarterly Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual (employee only)</td>
<td>$360.00</td>
</tr>
<tr>
<td>Employee Plus One (employee plus one dependent)</td>
<td>$720.00</td>
</tr>
<tr>
<td>Family (employee plus two or more dependents)</td>
<td>$720.00</td>
</tr>
</tbody>
</table>

If you first become eligible to make HSA contributions for any other month, the Employer will make a contribution to your HSA on or as soon as practical after the first day of that month, provided you furnish the Employer with information sufficient to facilitate the forwarding of these contributions to your HSA trustee or custodian. The amount of this contribution will equal to: (i) the number of months until the next January 1st, April 1st, July 1st and August 1st, multiplied by an amount based on the level of your high deductible health plan coverage if effect as of the first day of that month and in accordance with the table below.

<table>
<thead>
<tr>
<th>High Deductible Health Plan Coverage</th>
<th>Amount of Employee Monthly Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>One Person (employee only)</td>
<td>$120.00</td>
</tr>
<tr>
<td>Two Person (employee plus one dependent)</td>
<td>$240.00</td>
</tr>
<tr>
<td>Family (employee plus two or more dependents)</td>
<td>$240.00</td>
</tr>
</tbody>
</table>

Thereafter, any Employer contributions to your HSA will be determined and made quarterly, as described in the first paragraph in the Answer to this Question.

Prior to the beginning of each Plan Year, the Employer will provide written notice to participants of any changes to the amount of Employer HSA contributions.
17. **Are there circumstances where the Employer can stop HSA contributions?**

Yes. The Employer will stop contributions to your HSA, and take any other corrective action required under HSA tax laws, if the Employer becomes aware that the total contribution to your HSA for the calendar year exceeds (or otherwise will exceed) the maximum amount applicable under HSA tax law and regulations (which is based on the level of your high deductible health plan coverage (i.e., single or family)), reduced on a proportional basis for the number of months less than twelve (12) that you are not eligible to make HSA contributions during the year. However, if you are age 55 or older and eligible to make HSA contributions, you may make additional “catch-up” contributions as permitted under HSA tax laws and regulations, provided you certify to the Employer that you have attained age 55.

Note that, under a special rule, an employee who is an HSA eligible individual on December 1st of a calendar year, but was not an HSA eligible individual for that entire calendar year, may be able to contribute up to the maximum HSA contribution applicable if he had been an HSA eligible individual for the entire year. To qualify for this special rule, the employee must remain an HSA eligible individual through the end of the next calendar year. The excess of the contribution permitted under this special rule over the maximum contribution described above must be made on an after-tax basis outside the Plan.

18. **What tax rules apply to HSAs?**

The tax rules that apply to HSA contributions and distributions are very different than the rules that apply to other contributions made to the Plan and to benefits paid from the Plan. If certain requirements are satisfied, HSA contributions made through the Plan are not subject to federal income tax, contributions you make to your HSA outside the Plan are deductible, HSA earnings accumulate tax free, and distributions from HSAs to pay qualified medical expenses are tax-free. To familiarize yourself with these rules, you should review the information provided by your HSA trustee or custodian and see IRS Publication 969 (“Health Savings Accounts and Other Tax-Favored Health Plans”).

**The Employer does not provide tax or legal advice, and does not guarantee that your HSA contributions or HSA distributions will be eligible for any favorable tax treatment. If you need an answer upon which you can rely, you should contact your own tax advisor to make certain you understand all HSA rules and requirements.**
19. **Can the Employer amend or terminate the Plan?**

The Employer can amend or terminate the Plan at any time, but will notify you in advance. Amendment or termination of the Plan will not affect your right to payment or reimbursement for expenses incurred before the date of the change. The Employer may also take action to assure compliance with nondiscrimination requirements and limitations that apply to the Plan under federal tax law, including reducing contributions made by certain highly compensated employees and/or key employees in order to satisfy those requirements and limitations.

20. **Who controls the operation of the Plan?**

A Committee appointed by the Employer controls and manages the operation of the Plan. The Committee decides all questions arising in the interpretation and application of the Plan, and may establish rules for the operation of the Plan.

21. **What if I have questions about coverage or benefits, or want to make a claim for benefits?**

You should contact Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502 if you have questions about any group coverage sponsored by the Employer. Claims for group coverage benefits should be filed in accordance with the procedures applicable to that coverage. See Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502 if you need information on how to file a claim for a group coverage benefit.

You should contact Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502 if you have questions about the operation of this Plan.

If you disagree with a decision concerning your right to participate in the Plan or wish to make a claim for a benefit, you may file a claim in writing with the Committee. If you wish, you may appoint someone to file the claim and act on your behalf, provided you give the Committee signed written notification of the appointment. The claim procedure is different depending on whether the claim is related to a dental or vision care expense or is any other type of claim. If any part of the claim is denied, the Committee will provide you with a written notice, within 30 days after the receipt of a dental or vision expense claim or 90 days after the receipt of any other type of claim. However, if an extension is necessary due to reasons beyond the Committee’s control, the time to make the determination may be extended for up to another 15 days for a dental or vision expense claim or 90 days for any other type of claim. (If an extension for a dental or vision expense claim is necessary because additional information is needed from you, then you will be
given 45 days from the date you receive the notice to provide the information.) In any case, you will receive written notice of the reasons for the extension, any additional information required for the Committee to make the determination, and the date the determination is expected.

If a claim is denied in whole or in part, you will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan’s review procedures and time limits; and (v) a statement that you have a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review. In the case of a dental or vision expense claim, the notice will also state the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a dental or vision expense claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a dental or vision expense claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If a claim is denied and you want a review, you must notify the Committee in writing within 180 days after you receive the written notice of denial of dental or vision expense claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) a statement that you have a right to sue under the Employee Retirement Income Security Act; and (iv) the following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.” If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a dental or vision expense claim,
the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a dental or vision expense claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

22. What additional rights do I have as a participant?

Federal law gives you rights with regard to coverage and certain specific benefits. The following is a summary of those rights.

COBRA Continuation Coverage

You may have a right under “COBRA” to continue to participate in the dental and vision expense portion of the Plan only after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose group health coverage. It can also become available to other members of your family when they would otherwise lose group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:
(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason other than your gross misconduct.

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

(1) Your spouse dies;
(2) Your spouse’s hours of employment are reduced;
(3) Your spouse’s employment ends for any reason other than his or her gross misconduct;
(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
(5) You become divorced or legally separated from your spouse.

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

(1) The parent-employee dies;
(2) The parent-employee’s hours of employment are reduced;
(3) The parent-employee’s employment ends for any reason other than his or her gross misconduct;
(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
(5) The parents become divorced or legally separated; or
(6) The child stops being eligible for coverage under the plan as a “dependent child.”

**When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

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

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502. The notice must be in writing, and must
contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage, which lasts no longer than the last day of the Plan Year in which the qualifying event occurs. Furthermore, COBRA continuation coverage is not available to a qualified beneficiary even for that Plan Year unless the qualified beneficiary could become entitled to payment or reimbursement for dental or vision care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Plan for the remainder of that Plan Year.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502.

Health Insurance Portability and Accountability Act of 1996 and Uniformed Services Employment and Reemployment Rights Act

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). Information concerning your HIPAA and USERRA rights is available from the R. Barry White, Utica College, 1600 Burrstone Road, Utica, New York, 13502, phone (315) 792-3024, fax (315) 792-3386.

Family and Medical Leave Act

If you are eligible for and take a leave of absence under the Family and Medical Leave Act (“FMLA Leave”), you may continue your contributions during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave. Coverage will continue as if you were actively employed by the Employer until the earlier of the date (1) the FMLA Leave ends, or (2) you notify the Employer that you will not return to work. If you choose not to continue coverage during an FMLA Leave, you may resume Plan contributions when the FMLA Leave expires, provided you are still an employee eligible to participate in the Plan (see Question and Answer 2).

Information concerning your right to and obligations during a leave is available from the Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502.

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act (“HIPAA”) regarding the use and disclosure of your protected health information (“PHI”). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.
The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan’s privacy notice or more information about the Plan’s privacy practices, or you want to file a privacy violation complaint, please contact R. Barry White, Utica College, 1600 Burrstone Road, Utica, New York, 13502, phone (315) 792-3024, fax (315) 792-3386.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for a parent to provide a child or children with health coverage. If the Plan receives a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan’s QMCSO procedures are available, without charge, from the Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York 13502.

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

This includes the ability to:

- 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), if applicable, 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), if applicable, 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, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

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 that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, 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 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.