SUMMARY PLAN DESCRIPTION
OF THE VISION BENEFITS
UNDER THE
UTICA COLLEGE HEALTH BENEFITS PLAN
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INTRODUCTION

Utica College (the "Employer") established the Utica College Health Benefits Plan (the "Plan") effective July 1, 1995 to provide health benefits for its eligible employees. This Summary Plan Description ("SPD") presents a brief description of the vision benefits under the Plan. It is not meant to interpret, extend, or change the official Plan documents, including the health insurance policies issued by an insurer. 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 in the Plan Office at the office of the Compensation & Benefits Manager, 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 SMMs attached when you refer to this SPD.
IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name: Utica College Health Benefits Plan
Plan Number: 501
Plan Type: Welfare Plan providing vision benefits
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
315-792-3024

Employer Identification Number: 16-1476258

Plan Administrator:
Utica College
1600 Burrstone Road
Utica, New York 13502
315-792-3024

Type of Plan Administration: The Plan is insured through one or more insurers. The insurer(s) also processes claims and pays benefits. The Employer is responsible for other aspects of the Plan, such as choosing the type(s) of vision insurance coverage available under the Plan, deciding requirements for eligibility to participate in the Plan, and determining the portion of insurance premiums that participants must pay. The Compensation & Benefits Manager is the primary source for information about these aspects of the Plan.
Insurer(s): Davis Vision  
175 Express Street  
PO Box 9122  
Plainview, NY 11803

Plan Agent for Service of Legal Process: Utica College  
1600 Burrstone Road  
Utica, New York 13502
1. Who is eligible to become a participant in the Plan?

An employee of the Employer is eligible to become a participant if he is a benefit eligible employee of the Employer who works at least 17 1/2 hours per week, excluding Adjunct Faculty.

Note that, throughout this SPD, this term “Employer” generally includes any affiliated employer that has adopted the Plan. If any affiliated employer has adopted this Plan, its name will be shown on an attachment to this SPD.

Notwithstanding the above, a person providing services to the Employer through a temporary agency or employee leasing organization, or as an independent contractor, is not eligible to participate even if that person is later classified as an employee of the Employer for employment tax, unemployment insurance, or other purpose, by a government agency or a court.

2. What insurance coverage is available to a participant?

One or more types of vision insurance coverage are available from Davis Vision. The insurer guarantees benefits under the insurance it provides, and is responsible for processing claims and paying benefits. Descriptions of the benefits available under each type of insurance coverage are contained in benefit booklets and summaries which should accompany, and are part of, this SPD. If you do not have the booklets and summaries, you should request them from the Compensation & Benefits Manager. Also see the benefit summary attached to this SPD.

The Employer does not guarantee that every employee, spouse, domestic partner and child will be eligible for vision insurance. To obtain and continue insurance coverage, you must meet any requirements imposed by the insurer. You should refer to the benefit booklets and summaries for such requirements.

3. How do I apply for vision insurance?

You must complete an enrollment form and return it to the Compensation & Benefits Manager no later than:

• within 30 days after you satisfy the requirements for eligibility
or before the end of any open enrollment period announced by the Employer (assuming you still satisfy the eligibility requirements)

You must indicate your choice for the type and level of insurance coverage (single, employee + 1, or family coverage) on the enrollment form. By returning a completed enrollment form, you agree to pay your portion of the cost for insurance coverage through payroll deductions.

If you do not enroll during the periods described above, special enrollment rules may allow you to enroll at other times. (See Question & Answer 5).

4. When does vision insurance coverage begin?

If you satisfy all of the requirements for coverage, vision insurance coverage for an employee will begin on:

- the first day of employment provided you satisfy the requirements for eligibility and you complete and file your enrollment form within 30 days of satisfying the requirements

- the first day of the Plan Year after the end of an open enrollment period if you complete and file your enrollment form during the open enrollment period

- if a special enrollment rule applies (see Question & Answer 5), the date you complete and file your enrollment form

Except when a special enrollment rule applies (see Question & Answer 5), if your spouse, domestic partner or child satisfies all of the requirements for coverage, his or her vision insurance coverage will begin on:

- the date your insurance coverage begins if you enrolled the spouse, domestic partner or child for coverage

- the date you acquire the spouse, domestic partner or child (through marriage, or birth or adoption of a child), provided you enroll the spouse, domestic partner or child and change to the appropriate coverage level within thirty (30) days thereafter.
For purposes of the Plan, your "spouse" is the person to whom you are legally married for purposes of State law. However, if your spouse is covered under the Plan but is not considered your spouse for federal income tax purposes and is not your tax dependent, you will have imputed taxable income equal to the fair market value of your spouse's coverage (less any amount paid for that coverage on an after-tax basis).

For a person to be considered an employee's domestic partner for purposes of Plan coverage, the employee and domestic partner must satisfy the following requirements:

- You must share a close committed personal relationship, and have shared the same regular permanent residence for at least six (6) months.
- You must be financially interdependent.
- You can not have a blood relationship that would bar you from marrying in the State where you reside.
- Each of you must be at least eighteen (18) years old.
- Each of you must be the other's sole domestic partner and intend to remain so indefinitely.
- Neither of you may be legally married to, or have had another domestic partner relationship with, anyone else within the last six (6) months.
- You must both sign and file an affidavit with the employer stating: (i) the date your domestic relationship began; (ii) that you satisfy all of the requirements above; and (iii) that you will give the employer written notice no later than thirty (30) days after the date you fail to satisfy any of the requirements above. The affidavit must also state whether your domestic partner qualifies as your dependent for federal income tax purposes.

You and your domestic partner must also provide any other information and documentation that the employer, or insurer providing Plan coverage, may require to verify your domestic partner relationship.

The value of Plan coverage for an employee's domestic partner is treated as taxable income to the employee if the domestic partner does not qualify as a dependent under tax law. The employer will comply with all federal and state tax withholding and reporting requirements for domestic partner coverage.
Your child is eligible for Plan coverage:

- until the first or fifteenth day of the month following the date on which the child reaches age 26
- the child is unmarried and: (i) is incapable of self-sustaining employment because of a mental or physical condition; (ii) became incapable of self-sustaining employment while he was covered under the Plan; and (iii) is dependent on you for health care, financial support and maintenance

Your child is:

- a newborn, natural child, or a child placed with you for adoption;
- a stepchild who receives more than one-half of his or her support from you; or
- any other child for whom you have legal guardianship or court-ordered custody, provided that the child receives more than one-half of his or her support from you.

Note that a domestic partner’s child is not eligible for Plan coverage unless the child qualifies as the employee’s child.

If you and your spouse are both employees and participating in the Plan, your children will be considered children of one, but not both, of you.

5. **When do the special enrollment rules apply?**

Generally, these special rules apply in the following situations:

- If you initially decline Plan coverage because you had other vision care coverage, but you later lose that other coverage through no fault of your own (including a situation in which you, your spouse, domestic partner or child, incur a claim under that other vision care coverage that meets or exceeds a lifetime limit on all benefits under that coverage), you can enroll yourself, your spouse or domestic partner and your children within thirty (30) days after losing the other vision care coverage. Note, in order for this
special enrollment rule to apply, at the time you initially declined Plan coverage you must have provided in writing your reason for declining it.

- If you initially decline Plan coverage because you had other vision care coverage from another employer, but that employer stops contributing toward the cost of that other coverage, you can enroll yourself, your spouse or domestic partner and any child within thirty (30) days after that employer stops contributing toward the cost of the other coverage. Note, in order for this special enrollment rule to apply, at the time you initially declined Plan coverage you must have provided in writing your reason for declining it.

- If you decline Plan coverage and you later acquire a new spouse, domestic partner or child (through birth or adoption of a child), and you wish to cover that person, you can enroll yourself, your spouse or domestic partner and your children within the thirty (30) day period after the marriage, birth, adoption or placement for adoption.

- If you, your spouse, domestic partner or child loses eligibility for Medicaid coverage or coverage under a State Children’s Health Insurance Program, you can enroll yourself, your spouse or domestic partner or your child within the sixty (60) day period following the loss of that coverage.

- If you, your spouse, domestic partner or child becomes eligible to participate in a premium assistance program under Medicaid or a State Children’s Health Insurance Program, you can enroll yourself, your spouse or domestic partner or your child within the sixty (60) day period following that eligibility determination.

6. How much must I pay for vision insurance?

You are required to pay for the vision insurance coverage you select. The following chart shows your cost for coverage.

If there are ordinary increases or decreases in the premium, your payroll deductions will automatically be adjusted to reflect any change in your cost. The Employer will provide participants with advance written notice of any changes to their cost.
<table>
<thead>
<tr>
<th>Vision Option</th>
<th>Monthly Rate</th>
<th>Employee Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>5.91</td>
<td>5.91</td>
</tr>
<tr>
<td>Employee+1</td>
<td>10.63</td>
<td>10.63</td>
</tr>
<tr>
<td>Family</td>
<td>16.54</td>
<td>16.54</td>
</tr>
</tbody>
</table>

7. **When can I change my vision insurance coverage?**

In general, once you have enrolled (or decided not to enroll) in the Plan and selected vision insurance, you cannot change your decision until an open enrollment period, which is usually just before the next Plan Year. However, you may be able to change your enrollment decision, and/or your type or level of coverage, if any event occurs that entitles you to special enrollment rights (see Question & Answer 5).

You may also be able to make a change if any of the following occurs during a Plan Year:

- a change in vision coverage available through your spouse's or domestic partner’s employment

- your domestic partner relationship terminates (i.e., the date you and your domestic partner no longer satisfy the requirements listed in the Answer to Question 4).

- a change in legal marital status (e.g., through marriage, divorce, legal separation, annulment, or death of spouse)

- a change in your employment status, or the employment status of your spouse, domestic partner or child

- a change in the number of your children eligible for coverage

- your residence changes to a place outside the area for the type of coverage you chose
• a change in your work schedule or the work schedule of your spouse, domestic partner or child (e.g., an unpaid leave of absence, switch between full-time and part-time, or a strike or lockout)

• the coverage you chose is eliminated or is significantly curtailed

• the cost of the coverage you chose significantly increases.

Contact the Compensation & Benefits Manager immediately if any of these events occurs and you want to change your enrollment decision and/or your type or level of coverage. Even if you can make the change you desire, you will have a limited period of time after the event (e.g., 30 days) to make it.

8. When does my vision insurance coverage end?

Unless you are eligible for and elect COBRA coverage (see Question & Answer 17 for explanation of this coverage), your insurance coverage under the Plan will end on:

• the first or the fifteenth day after the date your employment terminates or you no longer satisfy the eligibility requirements to participate in the Plan

• the last day of the month for which you paid your cost for insurance coverage

9. When does vision insurance coverage for my spouse, domestic partner or child end?

Unless your spouse or child is eligible for and elects COBRA coverage (see Question & Answer 17 for an explanation of this coverage), his or her coverage under the Plan will end on:

• the date your coverage ends

• the date as of which you remove the spouse or child from coverage

• in the case of your spouse, upon divorce

• in the case of a child, the first or the fifteenth day after the date when he or she no longer qualifies as a child for purposes of the Plan (See Question & Answer 4.)
If your domestic partner is covered under the Plan, his or her coverage will end on the earlier of the date:

- the date your coverage under the Plan ends;
- the date as of which you remove your domestic partner from Plan coverage
- the date your domestic partner relationship terminates (i.e., the date you and your domestic partner no longer satisfy the requirements listed in the Answer to Question 4).

Note that employees’ domestic partners are not eligible for COBRA coverage.

10. What happens when I retire?

Retirement is treated as the termination of your employment and your vision insurance coverage under the Plan will end as described above. (See Question 8 “When does my vision insurance coverage end?”)

11. What happens if the Plan pays or provides a benefit that it should not have paid or provided?

If payments are made, or benefits are provided, by an insurer which exceed the applicable insurance policy’s benefit limits, or are inconsistent with some other policy provision, the insurer may be able to recover the excess amount paid, or value of the benefit provided, from the person who received the payment or benefit, the person for whom the payment was made or the benefit was provided, or from any other insurer or other party that should pay the expense or provide the benefit. The insurer may also have other rights under the policy.

12. What happens if the Plan pays a benefit for a participant, his spouse, domestic partner or child relating to an injury, sickness or condition caused by another person?

In that case, the Plan is subrogated to any right the participant, spouse, domestic partner or child (or his or her legal representative, heirs or beneficiaries) may have against the person(s) who caused the injury, sickness or condition. The participant, spouse, domestic partner or child (and his or her legal representative, heirs and beneficiaries) may not act to prejudice this right of subrogation, and must execute and deliver documents and do
whatever else is necessary to secure the Plan’s right of subrogation (including the right to sue). The Plan Administrator may require the participant, spouse, domestic partner or child (and his or her legal representative, heirs or beneficiaries) to sign an agreement acknowledging these subrogation rights as a condition to receiving payment from the Plan. However, the Plan’s subrogation rights will not be affected if the Plan Administrator does not require such an agreement. These subrogation rights are not diminished or otherwise affected if the total recovery obtained by the participant, spouse, domestic partner or child is less than the amount necessary to make him whole for all of the expenses and other damages related to the injury, sickness or condition.

13. **Who decides what coverage is available under the Plan and which employees are eligible to participate?**

The Plan Administrator has the power and discretion to: change the terms of the Plan (including rules for eligibility to participate); change the type of insurance coverage available under the Plan; decide issues of fact relevant to the eligibility of a person to participate in the Plan; administer the Plan; interpret any ambiguous or uncertain provision of the Plan; and reconcile any inconsistency that may appear in the Plan. However, neither the Employer nor the Plan Administrator has the power to change or interpret the insurance policy through which vision coverage is provided. Only the insurer can change the policy and make determinations on when and what benefits are payable under the policy.

14. **Can the Employer ever amend or terminate the Plan?**

Yes. The Employer maintains the Plan on a voluntary basis and has the right to amend or terminate the Plan, and terminate any vision insurance coverage provided under the Plan, at any time with respect to any individual, group, or class of employees or former employees. No person ever has a vested right to vision insurance coverage.

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

If you have questions about eligibility under the Plan or the cost of insurance coverage, you should contact the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502, 315-792-3024. If you have questions about specific benefits under your vision insurance, you should contact:
The insurer is responsible for processing claims and paying benefits. If you believe you are entitled to specific benefits you should submit a benefit claim directly to the insurer at the address above.

The claim procedures are different for “concurrent claims,” “pre-service claims,” “post-service claims,” and “urgent claims.” A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. A post-service claim is any claim that is not a pre-service claim. An urgent claim is any claim for medical care or treatment that, if non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient’s medical condition would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment. In the case of an urgent claim, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

Post-service claims must be filed within 90 days after the service or expense claimed was incurred. All claims must be filed on forms provided by the insurer and submitted by mail, except urgent claims may be made orally and information may be transmitted to Davis Vision, by telephone 1-888-790-9910, provided that any necessary written forms are later completed and filed.

If you make a request for benefits that does not comply with the Plan’s procedure for pre-service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five days if it involves a non-urgent pre-service claim. (This notification may be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information
within 48 hours, and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the request is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any other urgent claim (or earlier if possible); 15 days in the case of a non-urgent pre-service claim; or 30 days in the case of a post-service claim. However, if an extension to make a determination on a non-urgent claim is necessary due to reasons beyond the Plan’s control, the time to make the determination may be extended for up to another 15 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given 45 days from the date he receives the notice to provide the information.

If an adverse determination is made, the claimant 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) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan’s review procedures and time limits; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review; (vii) if the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (viii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant’s medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will then be sent to the claimant in writing within three days after oral notification.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal to Davis Vision for a full and fair review of the claim and determination. He 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. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted to Davis Vision by telephone 1-888-790-9910, provided that any necessary written forms are later completed and filed.

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the participant or beneficiary will be notified sufficiently in advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgment (e.g., whether a treatment or drug is experimental, investigational, or medically necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within 72 hours after the Plan receives the request for review of an urgent claim (or earlier if possible), 30 days after the Plan receives a request for review of a non-urgent pre-service claim, or 60 days after the Plan receives a request for review of a post-service claim.

The 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, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either 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; (v) if the determination is based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act; and (vii) 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.”

17. What additional rights does a participant have?

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

**Health Insurance Portability and Accountability Act of 1996**

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”). Information concerning your HIPAA rights is available from the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, NY, 13502, 315-792-3024.

**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 Plan coverage during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave and you pay the participant cost for Plan coverage during the FMLA Leave. Plan 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 Plan coverage during an FMLA Leave, you may resume Plan coverage when you return to work, provided you return when the FMLA Leave expires and you are still eligible to participate in the Plan (see Question and Answer 1), and any pre-existing condition exclusion rules under the Plan will be waived.

You are also eligible to elect COBRA coverage after the FMLA Leave if you:

- were covered under the Plan on the day before the FMLA Leave,
- do not return to work at the end of the FMLA Leave, and
- would otherwise lose coverage under the Plan.

You also may be able to elect COBRA coverage even if you choose not to continue regular Plan coverage during the FMLA Leave, or you stop paying your cost for Plan coverage during the FMLA Leave.
Information concerning your right to and obligations during a leave is available from the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, NY, 13502, 315-792-3024.

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 Walter DeSocio, Utica College, 1600 Burrstone Road, Utica, New York, 13502, phone (315) 792-3276 or fax (315) 792-3386.

COBRA Continuation Coverage

You may have a right under “COBRA” to continue to participate in the Plan after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on an 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 your group health coverage. It can also become available to other members of your family when they would otherwise lose your 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 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.

Note that employees’ domestic partners are not eligible for COBRA coverage.

Your 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 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 child's losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Compensation & Benefits Manager, 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 persons, 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. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or loss of a child's eligibility, COBRA continuation coverage lasts for up to total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement,
which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you provide proper and timely notice of the SSA determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice to Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502 within 60 days of the date of the SSA determination and before the end of the 18-month period of COBRA continuation coverage. The notice must be in writing, and must contain your name and address, the name and address of the disabled qualified beneficiary, and the date the disability was determined to have begun. You must also attach a copy of the SSA determination. You may be asked to provide additional documentation or information after you have submitted the notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage and you provide proper and timely notice of the second qualifying event, the spouse and children in your family may be entitled to up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the child stops being eligible under the Plan, but only if the event would have caused the spouse or child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice to the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502 within 60 days after the second qualifying event. The notice must be in writing, and must contain your name and address, the name and address of any affected persons, a description of the second qualifying event, and the date of the
second qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

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:

Utica College Health Benefits Plan
Compensation & Benefits Manager
Utica College
1600 Burrstone Road
Utica, NY 13502
315-792-3024

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act ("USERRA") also gives an employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continuation coverage under the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. For example, the period of military service generally cannot exceed five years, and the employee (or an appropriate officer) must give advance oral or
written notice of the absence to the Employer as early as is reasonable under the circumstances, unless notice is prevented by military necessity or is otherwise impossible or unreasonable under the circumstances.

An employee entitled to USERRA continuation coverage may elect continuation coverage (for him/herself and his/her covered spouse and covered children) for a period of up to 24 months. However, USERRA continuation coverage will terminate if the employee’s military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

All election and premium payment procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage election and premium payment procedures, rules and deadlines, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

An employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he/she timely returns to work after a military leave, assuming he/she is otherwise eligible for Plan coverage. If the employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the employee is not reinstated in the Plan because he/she is not eligible for coverage at that time (for reasons unrelated to the military leave), then the employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he/she is reinstated).

**Qualified Medical Child Support Order**

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one 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 Plan Administrator.
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.
Participating Provider Information

To access current Participating Provider Information free of charge, go to the following website:

**Davis Vision – [www.davisvision.com](http://www.davisvision.com)**

Or you may contact the Human Resources Department to request a copy of the Participating Provider List, free of charge.
Summary Plan Description
of the Vision Benefits under the
Utica College Health Benefits Plan

BENEFIT SUMMARY
**Designer 3 Vision Plan**

Healthy eyes and clear vision are an important part of your overall health and quality of life. With the rising cost of eyewear you can’t afford not to be covered through a managed vision care plan. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

**Frame Collection**: Your plan includes a selection of designer, name brand frames that are completely covered in full.1

**Contact Lens Collection**: Select from the most popular contact lenses on the market today with Davis Vision’s Contact Lens Collection.2

**One-year eyeglass breakage warranty included on plan eyewear at no additional cost!**

How to locate a network provider...

Just log on to the Open Enrollment/Discount Plan section of our Member site at davisvision.com and click “Find a Provider” to locate a provider near you including:

![Provider Logos](image)

**Contact your Human Resources department today to enroll.**

For more details about the plan, just log on to the Open Enrollment/Discount Plan section of our Member site at davisvision.com and enter Client Code 4939 or call 1.888.790.9910

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### In-Network Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Without Davis Vision</th>
<th>With Davis Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
<td>$100</td>
<td>$10</td>
</tr>
<tr>
<td>Lenses</td>
<td>$80</td>
<td>$10</td>
</tr>
<tr>
<td>Bifocals</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>Scratch-Resistant Coating</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>Frame</td>
<td>$130</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$330</strong></td>
<td><strong>$20</strong></td>
</tr>
</tbody>
</table>

1The Davis Vision Collection is available at most participating independent provider locations.
2For dependent children, monocular patients and patients with prescriptions of 8.00 diopters or greater.
3Additional discounts not applicable at Walmart or Sam’s Club locations.
4Transitions® is a registered trademark of Transitions Optical Inc.

Davis Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization’s contract with Davis Vision, the terms of the contract or insurance policy will prevail.
Davis Vision plans offer....

Value for our Members: A comprehensive benefit ensuring low out-of-pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations: A national network of credentialed preferred providers throughout the 50 states.

Value-Added features:

- Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
- Laser Vision Correction discounts of up to 25% off the provider’s Usual & Customary fees, or 5% off advertised specials, whichever is lower.
- Additional savings at most participating network locations up to 20% off additional eyeglasses, sunglasses and items not covered by the benefit and 10% off disposable contact lenses.  

Frequently Asked Questions:

How can I contact Member Services?
Call 1-888-790-9910 for automated help 24/7. Live help is also available seven days a week, Monday-Friday, 8 a.m.-11 p.m., Saturday, 9 a.m.-4 p.m., Sunday, 12 p.m.-6 p.m. (Eastern Time) (TTY services: 1-800-523-2847.)

What frames are in Davis Vision’s Collection?
Our Collection offers a great selection of fashionable and designer frames, most of which are covered in full after your copay. No wonder 8 out of 10 members select a Collection frame. Log on to our member Web site at davision.com and take a look!

When will I receive my eyewear?
Your eyewear will be delivered to your network provider generally within five business days of order receipt. Special prescriptions, lens coatings, provider frames or out-of-stock frames may delay the standard turnaround time.

Do I need a claim form?
Claim forms are only required if you visit an out-of-network provider. Claim forms are available on our member Web site.

Can I split my benefits?
You may split your benefits by receiving your eye examination, spectacle lenses and a frame or contact lenses on different dates or through different provider locations. To maximize your benefit value we recommend that all services be obtained from a network provider.

Are there any exclusions to the vision benefits?
Your vision plan does not cover medical treatment of eye disease or injury; vision therapy; special lens designs or coating; other than those described herein; replacement of lost eye wear; non-prescription (plano) lenses; contact lenses and eyeglasses in the same benefit cycle; services not performed by licensed personnel; two pair of eyeglasses in lieu of bifocals.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Value Range</th>
<th>Cost Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear Plastic Lenses, All Ranges Of Prescriptions And Sizes</td>
<td>$60-$120</td>
<td>$0</td>
</tr>
<tr>
<td>Oversize Lenses</td>
<td>$25</td>
<td>$0</td>
</tr>
<tr>
<td>Tinting Of Plastic Lenses</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>Scratch-Resistant Coating</td>
<td>$20</td>
<td>$0</td>
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<tr>
<td>Polycarbonate Lenses</td>
<td>$64</td>
<td>$0</td>
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<tr>
<td>Ultraviolet Coating</td>
<td>$26</td>
<td>$0</td>
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<tr>
<td>Standard Anti-Reflective (AR) Coating</td>
<td>$62</td>
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<tr>
<td>Premium AR Coating</td>
<td>$76</td>
<td>$48</td>
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<tr>
<td>Ultra AR Coating</td>
<td>$114</td>
<td>$60</td>
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<tr>
<td>Standard Progressive Lenses</td>
<td>$154</td>
<td>$50</td>
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<tr>
<td>Premium Progressives (Varilux®*, etc.)</td>
<td>$225</td>
<td>$90</td>
</tr>
<tr>
<td>Intermediate Lenses</td>
<td>$160</td>
<td>$30</td>
</tr>
<tr>
<td>High-Index Lenses</td>
<td>$121</td>
<td>$55</td>
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<tr>
<td>Polarized Lenses</td>
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<td>$75</td>
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<tr>
<td>Plastic Photosensitive Lenses</td>
<td>$126</td>
<td>$65</td>
</tr>
<tr>
<td>Scratch Protection Plan (Single Vision Multifocal Lenses)</td>
<td>$20</td>
<td>$40</td>
</tr>
</tbody>
</table>

*Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.

**Varilux® is a registered trademark of Société Essilor International.

Additional discounts not applicable at Walmart or Sam’s Club locations.

Out-of-Network Benefits:
You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525 Latham, NY 12110

<table>
<thead>
<tr>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Examination</td>
</tr>
<tr>
<td>Frame</td>
</tr>
<tr>
<td>Spectacle Lenses (per pair)</td>
</tr>
<tr>
<td>Single Vision</td>
</tr>
<tr>
<td>Bifocal/Progressive</td>
</tr>
<tr>
<td>Trifocal</td>
</tr>
<tr>
<td>Lenticular</td>
</tr>
<tr>
<td>Elective Contacts</td>
</tr>
<tr>
<td>Medically Necessary Contacts</td>
</tr>
</tbody>
</table>