SUMMARY PLAN DESCRIPTION
OF THE MEDICAL BENEFITS
UNDER THE
UTICA COLLEGE HEALTH BENEFITS PLAN

Copyright © 2010
EBS-RMSCO, Inc.

March 1, 2010

TABLE OF CONTENTS

Copyright © 2010
EBS-RMSCO, Inc.

Copyright © 2010
EBS-RMSCO, Inc.

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 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 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 SMMs attached when you refer to this SPD.

Copyright © 2010
EBS-RMSCO, Inc.

IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name:	Utica College Health Benefits Plan
Plan Number:	501
Plan Type:	Health Insurance 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 315-792-3024
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 health 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 Benefits Coordinator is the primary source for information about these aspects of the Plan.

Copyright © 2010
EBS-RMSCO, Inc.

Insurer(s):	Excellus BlueCross BlueShield Utica Business Park 12 Rhoads Drive Utica, NY 13502
Plan Agent for Service of Legal Process:	Utica College 1600 Burrstone Road Utica, New York 13502

Copyright © 2010
EBS-RMSCO, Inc.

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 full-time employee of the Employer who works at least 17 1/2 hours per week, excluding Adjunct Faculty.

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 health insurance coverage are available from Excellus BlueCross BlueShield. The insurer guarantees benefits under the insurance it provides, and is responsible for processing claims and for paying benefits. Descriptions of the benefits available under each type of insurance coverage available under the Plan 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 Benefits Coordinator.

The Employer does not guarantee that every employee, spouse, domestic partner and dependent will be eligible for insurance under an insurer's policy. 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 health insurance?

You must complete an enrollment form and return it to the Benefits Coordinator 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

Copyright © 2010
EBS-RMSCO, Inc.

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.

4. When do the special enrollment rules apply?

Generally, these special rules apply in the following situations:

- You initially declined Plan coverage because you had other health care coverage, but you later lose that other coverage through no fault of your own. You can enroll yourself, your spouse (or eligible domestic partner) and your eligible dependents within thirty (30) days after losing the other health care coverage. Note, for this special enrollment rule to apply, you may be required to provide in writing the reason you declined Plan coverage at the time you decline it.

- You initially declined Plan coverage because you had other health care coverage from another employer, but that employer stops contributing toward the cost of that other coverage. You can enroll yourself, your spouse (or eligible domestic partner) and any eligible dependent within thirty (30) days after that employer stops contributing toward the cost of the other coverage. Note, for this special enrollment rule to apply, you may be required to provide in writing the reason you declined Plan coverage at the time you decline it.

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

- If you, your spouse (or eligible domestic partner) or eligible dependent lose eligibility for Medicaid coverage or coverage under a State Children's Health Insurance Program on or after April 1, 2009. You can enroll yourself, your spouse (or eligible domestic partner) or your eligible dependent within the sixty (60) day period following the loss of that coverage.

Copyright © 2010
EBS-RMSCO, Inc.

- If you, your spouse (or eligible domestic partner) or eligible dependent become eligible to participate in a premium assistance program under Medicaid or a State Children's Health Insurance Program on or after April 1, 2009. You can enroll yourself, your spouse (or eligible domestic partner) or your eligible dependent within the sixty (60) day period following that eligibility determination.

5. When does my health insurance coverage begin?

If you satisfy all of the requirements for coverage, your health insurance coverage 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 day 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 4), the date coverage begins under the special enrollment rule.

If your spouse, eligible domestic partner, or eligible dependent, satisfies all of the requirements for coverage, his or her health insurance coverage will generally begin on:

- the date your insurance coverage begins if you enrolled him or her for coverage

- if a special enrollment rule applies (see Question & Answer 4), the date coverage begins under the special enrollment rule.

However, in some cases coverage may be delayed under the terms of the applicable health insurance policy if your spouse, eligible domestic partner, or eligible dependent, is confined in a hospital or other health facility on the date coverage would otherwise begin. (Contact the appropriate insurer for more information.)

Copyright © 2010
EBS-RMSCO, Inc.

6. Who qualifies for coverage as my spouse, eligible domestic partner, or eligible dependent?

Your spouse is the person to whom you are legally married under applicable state law.

For a person to be your eligible domestic partner, you and he or she 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.

Copyright © 2010
EBS-RMSCO, Inc.

Your eligible dependents are:

- an unmarried child under age 19 who is not on active military duty in the armed services of any country
- an unmarried child under age 25 who is a full-time college student and is financially dependent on you
- an unmarried child who became physically or mentally disabled (provided such condition occurred before the child reached the age at which his coverage under the Plan would otherwise terminate).

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 the child of an employee's domestic partner is not eligible for Plan coverage.

If both you and your spouse or eligible domestic partner are employees and participating in the Plan, neither of you are treated as the eligible dependent of the other, and your children will be considered eligible dependents of one, but not both, of you.

7. How much must I pay for health insurance?

If there are ordinary increases or decreases in the premium, your payroll deductions will automatically be adjusted to reflect any change in your cost. Following is the current cost for this coverage. The Employer will provide participants with advance written notice of any changes to their cost.

Copyright © 2010
EBS-RMSCO, Inc.

Medical Option	Monthly Rate	Employer Share	Employee Cost
HDHP			
Single	311.80	83%	17%
Employee+1	623.60	83%	17%
Family	860.25	83%	17%
PPO			
Single	540.32	83%	17%
Employee+1	1080.64	83%	17%
Family	1490.74	83%	17%

8. When can I change my health insurance coverage?

In general, once you have enrolled (or decided not to enroll) in the Plan, 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 4).

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

- a change in health coverage available through a spouse's employment
- 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, eligible domestic partner, or eligible dependent
- your residence changes to a place outside the area for the type of insurance coverage you chose

Copyright © 2010
EBS-RMSCO, Inc.

- a change in your work schedule or the work schedule of your spouse, eligible domestic partner, or eligible dependent (e.g., an unpaid leave of absence, switch between full-time and part-time, or a strike or lockout)

- the insurance coverage you chose is eliminated or is significantly curtailed

- the cost of the insurance coverage you chose significantly increases.

Contact the Benefits Coordinator 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.

9. When does my health insurance coverage end?

Unless you are eligible for and elect COBRA coverage (see Question & Answer 17 for explanation of this coverage) or retiree coverage (see Question & Answer 11), your insurance coverage under the Plan will end on:

- 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.

10. When does health insurance coverage for my spouse, domestic partner, or dependent end?

If your spouse is covered under the Plan, unless he or she is eligible for and elects COBRA coverage (see Question & Answer 17 for an explanation of this coverage), his or her coverage will end on the earlier of the date:

- your coverage under the Plan ends;

- you remove your spouse from Plan coverage; or

- you divorce.

If your domestic partner is covered under the Plan, his or her coverage will end on the earlier of the date:

Copyright © 2010
EBS-RMSCO, Inc.

- your coverage under the Plan ends;
- you remove your domestic partner from Plan coverage; or
- 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 6.

Note that employees' domestic partners do not have an independent right to elect COBRA coverage.

If your eligible dependent is covered under the Plan, unless he or she is eligible for and elects COBRA coverage (see Question & Answer 17 for an explanation of this coverage), his or her coverage will end on the earlier of the date:

- your coverage under the Plan ends;
- you remove your eligible dependent from Plan coverage; or
- when he or she no longer qualifies as an eligible dependent.

11. What happens when I retire?

Retirement is treated as the termination of your employment and your health insurance coverage under the Plan will end as described above (See Question 9 "When does my health insurance coverage end?") unless you meet the requirements as described below.

Retirees under the age of 65 may continue their enrollment in the medical plan available to active employees at the prevailing contributory rate.

Retirees aged 65 through 69 will be covered by the College's Medicare Advantage plan under the following conditions and at no cost to the employee:
(1) The employee must have been enrolled in the plan at age 65.
(2) Federal Medicare benefits will be applied as an offset to the plan.
(3) Such coverage is also available to spouse/domestic partners of such retirees who meet the eligibility requirements of the plan.

Retirees 70 or older should contact the Office of Human Resources for details concerning continuing their coverage on a full payment basis.

Copyright © 2010
EBS-RMSCO, Inc.

Retirees residing outside of New York State for more than six months in a calendar year who purchase a Medicare supplement plan that supplements Medicare A, B, and D will receive monthly premium reimbursement up to the current amount of the College's contribution to the premium cost of the College's Medicare Advantage plan for in-state residents.

12. What happens if the insurer 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.

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

Depending on the terms of the applicable policy, the insurer may be subrogated to any right the participant, his spouse, domestic partner, or dependents (or their legal representative, heirs or beneficiaries) have against the third party that caused the injury, sickness or condition. The participant, his spouse or domestic partner, and his dependents (and their legal representative, heirs and beneficiaries) may not act to prejudice this right of subrogation, and may be required to execute and deliver documents and do whatever else is necessary to secure the insurer's rights (including the right to sue the third party). The insurer may also have other rights under the policy.

14. Who decides what health insurance 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

Copyright © 2010
EBS-RMSCO, Inc.

interpret the insurance policy through which health coverage is provided. Only the insurer can change the policy and make determinations on when and what benefits are payable under the policy.

15. 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 health insurance coverage provided under the Plan, at any time with respect to any individual, group, or class of employees, including retirees and employees eligible to retire and elect retiree coverage. Employees and retirees never have a vested right to health insurance coverage.

16. 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 Human Resources Department. If you have questions about specific benefits under your health insurance, you should contact:

Excellus BlueCross BlueShield
Utica Business Park
12 Rhoads Drive
Utica, New York 13502

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 below.

Excellus BCBS
PO Box 22999
Rochester, New York 14692

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

Copyright © 2010
EBS-RMSCO, Inc.

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 by telephone (800) 499-1275 or by facsimile (315) 792-9703, 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.

Copyright © 2010
EBS-RMSCO, Inc.

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 the Customer Advocate Division of Excellus Blue Cross Blue Shield 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 by telephone (800) 499-1275 or by facsimile (315) 792-9703, 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

Copyright © 2010
EBS-RMSCO, Inc.

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; (iv) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act; and (v) 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 Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York, 13502, 315-792-3024.

Copyright © 2010
EBS-RMSCO, Inc.

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 employee's 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 dependents) 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

Copyright © 2010
EBS-RMSCO, Inc.

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).

Family and Medical Leave Act Leave

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 an employee 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 Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, New York, 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.

Copyright © 2010
EBS-RMSCO, Inc.

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 or fax (315) 792-3386.

Women's Health and Cancer Rights Act

The Plan provides coverage in connection with a mastectomy (in the manner determined by the attending physician and the patient) for:

- reconstruction of the breast on which the mastectomy is performed,
- surgery and reconstruction of the other breast to produce symmetrical appearance, and
- prostheses and physical complications at all stages of the mastectomy, including lymphedema.

The Plan may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Deductible and co-payment amounts for covered care will be consistent with those established for other Plan benefits. In addition, the law prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care, or providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

If you have any questions about this coverage, please contact your Plan Administrator.

Copyright © 2010
EBS-RMSCO, Inc.

Newborn Mothers and Minimum Maternity Stay

The Plan generally may not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a caesarian section, or require that a health care provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

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 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 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:

Copyright © 2010
EBS-RMSCO, Inc.

(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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with the respect to Utica College, and that bankruptcy results in the loss of coverage of any retired employee coverage under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

Copyright © 2010
EBS-RMSCO, Inc.

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, NY, 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. 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 as a dependent child, 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

Copyright © 2010
EBS-RMSCO, Inc.

continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice to the Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, NY, 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 dependent 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 dependent 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 dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice to Benefits Coordinator, Utica College, 1600 Burrstone Road, Utica, NY, 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 dependents, 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.)

Copyright © 2010
EBS-RMSCO, Inc.

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
Benefits Coordinator
Utica College
1600 Burrstone Road
Utica, New York 13502
315-792-3024

Michelle's Law

A child is eligible for coverage under the Plan as a dependent until he reaches age 19 unless he qualifies for coverage as a student, in which case his coverage may continue until he reaches age 25 (assuming he satisfies any coverage requirements unrelated to age) or, if earlier, when he no longer qualifies for coverage as a student.

However, under a federal law known as Michelle's Law, a special rule applies if a child takes a leave of absence from (or has any other change in enrollment at) a postsecondary educational institution (e.g., a college or university) due to a serious illness or injury. Under Michelle's Law, the child's coverage may continue until the earlier of: (i) one year from the start of the medical leave (or other change in enrollment), or (ii) the date the child's Plan coverage would otherwise terminate. (For example, the child's coverage stops when he reaches age 25 (at which time the federal COBRA continuation coverage would be available), or if the Plan no longer covers dependent children. The child's coverage during this period will be the same coverage he would have been entitled to receive if he were still a student and had not taken the leave of absence (or had the change in enrollment).

For Michelle's Law to apply, the following conditions must be satisfied:

Copyright © 2010
EBS-RMSCO, Inc.

- The child must be covered under the Plan immediately before the medical leave (or other change in enrollment) and qualify for coverage at that time on the basis of being a student at a postsecondary educational institution.

- The child must suffer a serious illness or injury which requires the medical leave (or other change in enrollment) and which would otherwise cause him to lose student status for purposes of Plan coverage.

- The medical leave (or other change in enrollment) must start on or after January 1, 2010.

- The child's treating physician must provide the Plan with a written certification stating that the child is suffering from a serious illness or injury which necessitates the medical leave (or other change in enrollment).

Contact the Plan Administrator if you want more information about Michelle's Law.

Note: It may be possible for a child to qualify for coverage under Michelle's Law, but not qualify as the tax dependent of the parent-employee covered under the Plan. In that case, the parent-employee has imputed taxable income equal to the fair market value of the child's coverage (less any amount paid for that coverage on an after-tax basis).

New York Extended Dependent Child Coverage and New York Continuation Coverage

Under New York law, if a child has reached the maximum age for dependent child coverage under the Plan he may be entitled to extended health insurance coverage until he reaches age 29 ("New York extended dependent child coverage"). This coverage is provided directly by the insurer providing health coverage under the Plan for the child's parent, and the cost for this coverage is billed by the insurer directly to the child.

To be eligible for New York extended dependent child coverage, the child must be unmarried and satisfy certain other requirements. If you have reached, or are about to reach, the maximum age for dependent child coverage under the Plan and are interested in New York extended dependent child coverage, you should contact the insurer providing your parent's health coverage for more information.

Under New York law, if the maximum period a person is entitled to federal COBRA continuation coverage is less than 36 months and he receives federal COBRA continuation coverage through that period, he may be entitled to continued health

Copyright © 2010
EBS-RMSCO, Inc.

insurance coverage under New York law ("New York continuation coverage"). The maximum period of combined federal COBRA continuation coverage and New York continuation coverage is 36 months. For example, if your maximum federal COBRA continuation coverage period is 18 months, the longest New York continuation coverage would be available is another 18 months. Note that the same circumstances and events that would trigger termination of a person's federal COBRA continuation coverage also trigger termination of New York continuation coverage. The cost for New York continuation coverage is equal to 102% of the full premium for insured health coverage and must be paid by the person receiving the New York continuation coverage.

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.

Certificates of Coverage

If you lose regular Plan Coverage or COBRA coverage, you will receive a "Certificate of Coverage." This Certificate generally shows the level of coverage you had under the Plan and how long it was in effect. The purpose of the Certificate is to allow you to prove the amount of "creditable coverage" that may reduce or eliminate any pre-existing condition requirement under new health coverage you may acquire. The Plan will also make reasonable efforts to provide separate Certificates of Coverage for a spouse or dependent when it has reason to know the spouse or dependent is no longer covered under the Plan.

In addition, the Plan will provide a Certificate of Coverage to you, your spouse or dependent (or their authorized representative) upon request made within 24 months after Plan coverage terminates. The Human Resources Department can give you a form to make such a request.

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:

Copyright © 2010
EBS-RMSCO, Inc.

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

Copyright © 2010
EBS-RMSCO, Inc.

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:

Excellus BlueCross BlueShield – www.excellusbcbs.com

Or you may contact the Benefits Coordinator to request a copy of the Participating Provider List, free of charge**.**

Copyright © 2010
EBS-RMSCO, Inc.