

UTICA COLLEGE

FLEXIBLE SPENDING ACCOUNT

(With Pre-Tax Insurance Premiums)

PLAN DOCUMENT DISCLAIMER

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

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

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

UTICA COLLEGE

FLEXIBLE SPENDING ACCOUNT PLAN DOCUMENT

(With Pre-Tax Insurance Premiums)

SECTION 1
PRELIMINARY MATTERS

- 1.1 **Form.** The Utica College Flexible Spending Account is set out in this document, and any amendments hereto.
- 1.2 **Purpose.** This Plan is maintained for the exclusive benefit of Participants and the sole purpose of this Plan is to provide Qualified Benefits to Participants. It is intended, and shall be interpreted and administered, to comply with Section 125 of the Code.

SECTION 2
DEFINITIONS

- 2.1 “Account” means an account established for a Plan Year to provide a particular Qualified Benefit for a Participant.
- 2.2 “Accidental Death and Dismemberment Coverage” means group accidental death and dismemberment coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which satisfies the requirements of Sections 105 and 106 of the Code.
- 2.3 “Code” means the Internal Revenue Code of 1986, as amended.
- 2.4 “Committee” means the person or persons appointed by the Employer as members of the Committee to administer the Plan in accordance with Section 7 hereof.
- 2.5 “Contribution Election” means an election by a Participant to have Contributions credited to his Account(s) for a Plan Year in accordance with Section 5.
- 2.6 “Contributions” means amounts a Participant contributes to the Plan on a pre-tax basis for a Plan Year or, in the limited circumstances described in Sections 4.11(B) and 5.3(H), on an after-tax basis.
- 2.7 “Coverage” means Accidental Death and Dismemberment, Dental, Medical, Life Insurance, Long-Term Disability, Short-Term Disability, and/or Vision Coverage.
- 2.8 “Dental Coverage” means group dental coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract for “medical care” (as that term is used for purposes of Section 105(b) of the Code), substantially all of which is for treatment of the mouth (as described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(A)) and which satisfies the requirements of Sections 105 and 106 of the Code.

- 2.9 “Dependent,” for purposes of any Coverage that does not constitute medical care, means a person who is a Participant’s dependent and is included in that particular Coverage. For purposes of any Coverage that constitutes medical care, “Dependent” means: (i) a person who is a Participant’s dependent (as determined for purposes of Section 105(b) of the Code) and is included in that particular Coverage; and (ii) a person who is a Participant’s child (as determined for purposes of Section 105(b) of the Code) and is included in that particular Coverage, but only until the end of the calendar year in which the child attains age twenty-six (26). For purposes of payment or reimbursement of Health Care Expenses from a Participant’s Health Care Expense Account, “Dependent” means: (i) a person who is a Participant’s dependent (as determined for purposes of Section 105(b) of the Code) at the time the Health Care Expense is incurred; and (ii) a person who is a Participant’s child (as determined for purposes of Section 105(b) of the Code) at the time the Health Care Expense is incurred, but only through the end of the calendar year in which the child attains age twenty-six (26). For purposes of payment or reimbursement of Dependent Care Expenses from a Participant’s Dependent Care Expense Account, “Dependent” means a person who is a Qualifying Individual at the time the Dependent Care Expense is incurred.
- 2.10 “Dependent Care Expense” means an expense incurred by a Participant which is an employment-related expense as defined for purposes of Section 21(b) of the Code.
- 2.11 “Dependent Care Expense Account” means an Account established for a Participant under the Plan for payment or reimbursement of Dependent Care Expenses.
- 2.12 “Effective Date” means the day the Plan begins as set forth under the name of the first Employer listed in Section 2.14. If this document is an amendment to the Plan, the amendment shall be effective January 1, 2016.
- 2.13 “Employee” means any person who performs services for the Employer as a common law employee and receives compensation for his services other than a pension, retirement allowance, retainer, or fee under contract. Notwithstanding the preceding sentence, the following persons are not considered Employees eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation (“LLC”), any member of the LLC; (iv) if an election is made under the Code for the Employer to be a Subchapter S

corporation, and person who owns directly, or indirectly through attribution rules contained in Section 318 of the Code, more than 2% of the Employer.

- 2.14 “Employer” means the Employer and any Affiliated Employer identified below, and their legal successors; provided, however, that as used in Section 7 (Plan Administration) and Section 8 (Amendment and Termination of the Plan), “Employer” shall mean only the first Employer identified below.

Employer:	<u>Utica College</u>
Address:	<u>1600 Burrstone Road</u>
	<u>Utica, New York 13502</u>
Effective Date:	<u>1/1/2005</u>
Affiliated Employer:	<u>NA</u>
Address:	_____
Effective Date:	_____

An Affiliated Employer may discontinue its participation in the Plan by giving advance written notice of the effective date of discontinuance to the Committee and its Employees.

- 2.15 “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.
- 2.16 “Health Care Expense” means an expense incurred by a Participant for himself, his Spouse or his Dependent for “medical care” (as that term is used for purposes of Section 105(b) of the Code), but excluding expenses for long-term care services; provided, however, that expenses for a medicine or drug shall be included in Health Care Expenses covered by this Plan only if such medicine or drug is insulin or a prescribed medicine or drug (determined without regard to whether such medicine or drug is available without a prescription). Whether a medicine or drug is a prescribed medicine or drug (and, therefore, is included in Health Care Expenses covered by this Plan) shall be determined in accordance with regulations and other guidance issued by the Internal Revenue Service.
- 2.17 “Health Care Expense Account” means an Account established for a Participant under the Plan for reimbursement of Health Care Expenses.
- 2.18 “Highly Compensated Individual” means a highly compensated individual within the meaning of Section 125 of the Code.

- 2.19 “Key Employee” means a person who is a key employee within the meaning of Section 416 of the Code.
- 2.20 “Life Insurance Coverage” means group term life insurance coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which satisfies the requirements of Section 79 of the Code.
- 2.21 “Long-Term Disability Coverage” means group long-term disability coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which satisfies the requirements of Sections 105 and 106 of the Code.
- 2.22 “Medical Coverage” means group medical coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract described in Section 213 of the Code (except long-term care insurance) and which satisfies the requirements of Sections 105 and 106 of the Code.
- 2.23 “Participant” means an Employee who meets the requirements for participation specified in Section 3.
- 2.24 “Plan” means this Flexible Spending Account Plan as set forth in this document and as amended from time to time.
- 2.25 “Plan Administrator” means the Employer or other person(s) appointed by the Employer to serve as Plan Administrator in accordance with Section 7 hereof.
- 2.26 “Plan Year” means:
- each 12-consecutive month period beginning January 1 and ending the following December 31.
- However, if the Employer terminates the Plan pursuant to Section 8, the last Plan Year shall end on the effective date of termination. If an Affiliated Employer discontinues its participation in the Plan, Participants who are Employees of the Affiliated Employer shall be treated as having participated in the Plan for a short Plan Year ending on the effective date of such discontinuation.
- 2.27 “Premium” means the premium, or portion thereof, that a Participant is required to pay for Coverage. (For purposes of the Plan, “Premium” includes a Participant’s cost for Coverage that is self-insured by the Employer.)
- 2.28 “Qualified Benefit” means:
- (a) payment of Premiums for any of the Coverage indicated below:

- Accidental Death and Dismemberment Coverage
- Dental Coverage
- Life Insurance Coverage
- Long-Term Disability Coverage
- Medical Coverage
- Short-Term Disability Coverage
- Vision Coverage

and

(b) payment or reimbursement from the Account(s) indicated below:

- a Participant's Health Care Expense Account for Health Care Expenses incurred during a Plan Year, but only to the extent not payable or reimbursable from any other source.
- a Participant's Dependent Care Expense Account for Dependent Care Expenses incurred during a Plan Year, but only to the extent not payable or reimbursable from any other source.

- 2.29 "Qualifying Individual" means qualifying individual as defined for purposes of Section 21(b) of the Code.
- 2.30 "Short-Term Disability Coverage" means any group short-term disability coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, which satisfies the requirements of Sections 105 and 106 of the Code.
- 2.31 "Spouse" means a person to whom a Participant is legally married and who is treated as the Participant's spouse for federal income tax purposes.
- 2.32 "Statutory Leave" means an unpaid leave of absence under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act.
- 2.33 "Vision Coverage" means group vision coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract for "medical care" (as that term is used for purposes of Section 105(b) of the Code), substantially all of which is for treatment of the eye (as described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(B)) and which satisfies the requirements of Sections 105 and 106 of the Code.

SECTION 3
PARTICIPATION

3.1 Eligibility and Participation Date.

To be eligible to participate in the Plan, an Employee must be among the Employees to whom the Employer makes available group health plan coverage that provides benefits other than excepted benefits described in Internal Revenue Code Section 9832(c), and must meet any other eligibility requirements described below. This paragraph is intended to comply, and shall be interpreted in a manner consistent, with U.S. Department of Labor Technical Release 2013-03 and Internal Revenue Service Notice 2013-54, and any subsequent Department of Labor or Internal Revenue Service regulations or other guidance relating to the requirements for health flexible spending accounts to be exempt from the market reform requirements of the Patient Protection and Affordable Care Act.

Notwithstanding the above, any Employee participating in another cafeteria plan (as defined in Section 125 of the Code) maintained by the Employer and which has health flexible spending accounts compatible with the "eligible individual" requirements under Section 223(a) of the Code (i.e., the requirements for an individual to be eligible to make contributions to a health savings account) cannot also participate in this Plan at the same time.

An Employee shall be eligible to participate in, and make Contributions to, the Plan for the Coverage indicated below -

- Accidental Death and Dismemberment Coverage
- Dental Coverage
- Life Insurance Coverage
- Long-Term Disability Coverage
- Medical Coverage
- Short-Term Disability Coverage
- Vision Coverage
- Health Care Expenses
- Dependent Care Expenses

if he is expected to work at least thirty (30) hours per week for the Employer (the "hours requirement").

Note: If he was hired prior to 1/1/14, if he is expected to work at least seventeen and a half (17 ½) hours per week for the Employer (the “hours requirement”).

Such Employee can participate in the Plan and commence such Contributions on the date he satisfies the requirement(s); provided he has completed and filed all of the forms required for participation by the Committee.

The following rules apply to an Employee whose work schedule is such that it is not certain whether he will be reasonably expected to satisfy the hours requirement but who satisfies the Plan’s other substantive eligibility requirements.

- 1) If he is a newly hired Employee and he works an average of at least thirty (30) hours per week for the Employer during the twelve (12) consecutive month period commencing on the first day of the month coinciding with or immediately following his date of hire (his “initial measurement period”), he can participate in the Plan during the twelve (12) consecutive months beginning with the second month following his initial measurement period (if he continues to satisfy the Plan’s other substantive eligibility requirements).
- 2) Whether or not he is a newly hired Employee, if he works an average of at least thirty (30) hours per week for the Employer during the twelve (12) consecutive months beginning on the first day of any November (the “standard measurement period”), he can participate in the Plan during the twelve (12) consecutive month period beginning on the first day of the Plan Year following that standard measurement period (if he continues to satisfy the Plan’s other substantive eligibility requirements).
- 3) If his employment changes during his initial measurement period or a standard measurement period such that, thereafter, he is reasonably expected to satisfy the hours requirement, he can participate in the Plan on the first day of the month following the change (and until he no longer satisfies the Plan’s substantive eligibility requirements).
- 4) An Employee shall not be considered a newly hired Employee once he has been an Employee for a full standard measurement period, unless he: (i) stops providing services to the Employer for a period of at least 26 consecutive weeks; and (ii) later starts providing

services for the Employer again (in which case he will be considered a newly hired Employee when he starts providing services for the Employer again).

- 5) All hours for which an Employee is paid shall be considered hours worked. If an Employee is on an unpaid leave during a measurement period on account of jury duty or an unpaid leave subject to the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the period of unpaid leave shall be excluded when determining whether he averaged the required number of hours during that measurement period.

- 3.2 No Participation Before Effective Date. Notwithstanding the above provisions of this Section 3, no Employee shall be eligible to participate in the Plan until the Effective Date or, in the case of an Employee of an Affiliated Employer, the effective date that Affiliated Employer adopts the Plan, as indicated in Section 2.14.
- 3.3 Duration of Participation. Except as otherwise provided in this Plan, an Employee shall continue as a Participant so long as he remains an Employee, satisfies the eligibility requirements of this Section 3, makes any required Contributions, and continues to complete and file the forms required for participation by the Committee.
- 3.4 Reinstatement of Former Participant. Subject to Sections 4.11(B) and 5.3(G), and except as provided in Section 3.1(4) a Participant whose employment with the Employer terminates and then resumes shall become a Participant again if and when he again meets the requirements of this Section 3.
- 3.5 Interpretation and Compliance with Federal Law. This Section 3 is intended to comply, and shall be interpreted in a manner consistent, with proposed Treasury Regulations to implement the 90-day maximum waiting period limitation under Section 2708 of the Public Health Service Act (published at 78 Fed. Reg. 17313) and any subsequent Department of Treasury regulations or other guidance relating to the 90-day maximum waiting period limitation.
- 3.6 Notification of Eligibility. The Employer shall notify an Employee before, or as soon as administratively practical after, the Employee satisfies the requirements for eligibility.

SECTION 4
CONTRIBUTIONS AND BENEFITS

- 4.1 Participant Elections. A Participant may elect to receive compensation from the Employer in cash, or have a portion thereof credited to his Account(s). The Employer or Committee shall provide advance written notice to each Participant of the minimum and maximum amount of Contributions he can make and have credited to each Account for a Plan Year.

A Participant who is eligible for, but declines and does not receive any of the Coverage indicated below, shall receive additional cash compensation for:

- Accidental Death and Dismemberment Coverage
- Dental Coverage
- Life Insurance Coverage
- Long-Term Disability Coverage
- Medical Coverage
- Short-Term Disability Coverage
- Vision Coverage

The Employer will provide written notice to eligible employees before the beginning of each Plan Year of any change to the amount of additional cash compensation paid to participants who decline and do not receive Coverage.

- 4.2 Maximum Contributions. The Employer or Committee shall provide advance written notice to each Participant of the minimum and maximum amount of Contributions he can make for a Plan Year (and for each Account), and if the maximum Contribution limit is pro-rated for an Employee who is not a Participant during an entire Plan Year (i.e., multiplied by a fraction, the numerator of which is the number of full months of the Plan Year during which he is a Participant, and the denominator of which is the number of full months during the entire Plan Year.)

Notwithstanding the above or any other provision of this Plan, the maximum amount of pre-tax Contributions a Participant can elect to make for any Plan Year for his Health Care Expense Account shall not exceed \$2,550.00 (indexed for cost-of-living adjustments pursuant to Code Section 125(i)(2) for Plan Years beginning after December 31, 2013).

- 4.3 Credits to Accounts. Contributions shall be credited, through equal payroll deductions, to the Account designated for such Contributions. Subject to the provisions in Section 5 regarding permissible changes to Contribution Elections, the amount credited to an Account for each payroll period shall be the total amount of such Contributions divided by: (i) the number of pay periods in the Plan Year; or (ii) for an Employee who becomes a Participant during the Plan Year, the number of the Participant's pay periods remaining in the Plan Year after he becomes a Participant. Notwithstanding the preceding sentence, except as provided in Section 4.11(B), Contributions shall cease when an Employee ceases to satisfy the eligibility and participation requirements for the Plan.
- 4.4 Health Care and Dependent Care Expenses. No Participant shall be entitled to payment or reimbursement for Health Care Expenses or Dependent Care Expenses incurred in any Plan Year unless the expense is incurred on or after the date he became a Participant and before he ceases to be a Participant. Payment or reimbursement for Health Care Expenses and Dependent Care Expenses shall be made at least monthly, provided the Participant files a written form for payment or reimbursement at least five business days before a scheduled payment/reimbursement date. No Participant shall be entitled to payment or reimbursement for Health Care Expenses incurred in a Plan Year unless he submits a claim for reimbursement within 120 days after the end of the Plan Year or any earlier date specified herein. No Participant shall be entitled to payment or reimbursement for Dependent Care Expenses incurred in a Plan Year unless he submits a claim for reimbursement within 120 days after the end of the Plan Year or any earlier date specified herein.

The Committee shall inform Participants of the scheduled payment/reimbursement dates and also provide them with forms to request payment or reimbursement for Health Care Expenses and Dependent Care Expenses. Such requests shall be accompanied by a copy of the bill supporting the expense and shall contain the Participant's certified statement that the Health Care Expense or Dependent Care Expense has not been reimbursed, and is not reimbursable, from any other source. The amount credited to a Participant's Health Care Expense and Dependent Care Expense Accounts shall be reduced by the amount paid from such Accounts.

Notwithstanding the above, Health Care Expenses and Dependent Care Expenses may be automatically paid and processed using a pre-paid "debit" card designed for such purpose; provided the Employer or Plan Administrator adopts procedures to substantiate such Expenses consistent with substantiation requirements prescribed by regulations under Code Section 125 for cafeteria plan claims paid via pre-paid card. If a claim paid via pre-paid card cannot be substantiated, the Employer or Plan Administrator will take action consistent with such regulations to require the Participant to repay the unsubstantiated amount, including: (i)

denying the Participant access to a pre-paid card (and requiring him to submit written forms for future claims) until the unsubstantiated amount is recovered; (ii) demanding that the Participant repay the unsubstantiated amount; (iii) to the extent permitted under applicable law, deducting the unsubstantiated amount from the Participant's wages; and (iv) offsetting payment of other claims for expenses incurred in the same Plan Year by the unsubstantiated amount. If such efforts are unsuccessful, the Participant shall remain indebted to the Employer for the unsubstantiated amount. In that event, and consistent with its business practices, the Employer may treat the unsubstantiated amount as it would any other business indebtedness. The Employer or Plan Administrator, in its sole discretion, may adopt such other rules that it deems appropriate for the use of such pre-paid cards (e.g., suspending or terminating participation in the Plan for misuse of a pre-paid card, canceling a person's pre-paid card when he ceases participation in the Plan, establishing transaction limits or restrictions on the pre-paid card, and charging fees for the use of such cards.)

If a Participant attempts to have Health Care Expense or Dependent Care Expense paid via a pre-paid card but, for any reason, it is not successfully processed, he may manually submit a claim for the expense in accordance with this Section 4.4. A claim for such expense shall not be considered denied until the Participant manually submits such a claim for the expense and it is denied in accordance with the claims procedures described in Section 7.10.

Payment of other Qualified Benefits shall be made automatically.

- 4.5 Maximum Benefits. The amount available to a Participant for a particular Qualified Benefit shall equal the amount then credited to the Account for that Qualified Benefit Account; provided, however, the amount available for payment or reimbursement for Health Care Expenses incurred during a Plan Year shall equal the amount of his Contribution Election for his Health Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Health Care Expenses incurred during the Plan Year.
- 4.6 Cessation of Contributions. If Contributions to a Participant's Health Care Expense or Dependent Care Expense Account cease during a Plan Year, he may submit claims only for payment or reimbursement of Health Care Expenses or Dependent Care Expenses incurred before his Contributions cease. All such claims must be submitted within 90 days after the date his Contributions cease.
- 4.7 Forfeitability of Benefits. Except as provided in Section 4.8 below, if total Contributions to a Participant's Account exceed the Qualified Benefits paid from that Account for the Plan Year, the Participant shall forfeit the excess Contributions.

4.8 Grace Period. A Qualified Benefit (other than a Dependent Care or Health Care Expense) incurred during the Grace Period for a Plan Year may be treated as incurred during that Plan Year for purposes of this Section 4. To the extent the Contributions made for that Plan Year for such Qualified Benefits have not already been used for, or are not required to pay, Qualified Benefits actually incurred during the Plan Year, the Contributions shall be used to pay such Qualified Benefits incurred during the Grace Period, in accordance with provisions of this Section 4, provided: (i) if the Qualified Benefit is not automatically paid, a claim for the Qualified Benefit is submitted no later than the April 30th following the end of the Grace Period; and (ii) all other requirements and conditions for the Qualified Benefit are satisfied.

A) The Grace Period for a Plan Year shall be the period beginning on the first day of the first calendar month immediately following the end of the Plan Year and ending on the fifteenth day of the third calendar month immediately following the end of that Plan Year.

B) If the total Contributions to a Participant's Account exceed the Qualified Benefits paid from that Account for the Plan Year, including Qualified Benefits (other than Dependent Care and Health Care Expenses) incurred during the Grace Period for the Plan Year, the Participant shall forfeit the excess Contributions. With respect to any such forfeitures, the Committee, in its sole and absolute discretion, may: (i) apply the forfeited amount to any reasonable administrative expenses of the Plan; (ii) refund the forfeited amount to all Participants in the Plan on a uniform basis not related to the amount of their individual forfeitures; or (iii) apply the forfeited amount to provide benefits to all Participants for the following Plan Year on a uniform basis not related to the amount of their individual forfeitures.

C) This Subsection does not change the requirements in this Section 4 relating to when Health Care and Dependent Care Expenses must be incurred and claimed.

D) This Subsection 4.8 shall be interpreted and applied in a manner consistent with IRS Notice 2005-42 and Treasury Regulations issued to reflect IRS Notice 2005-42.

4.9 Health Care Expense Account Carry Over. Any Contributions that remain credited to a Participant's Health Care Expense Account as of the end of any Plan Year (after payment of all timely and valid claims) shall be carried over into his Health Care Expense Account for the following Plan Year (and shall be available for payment or reimbursement of Health Care Expenses incurred in the following Plan Year); provided that: (i) he elects to participate in this Plan the following Plan

Year; and (ii) no more than \$500.00 may be carried over into the following Plan Year. If he is not a Participant in this Plan the following Plan Year, but immediately after the end of the Plan Year in which Contributions remain credited to his Health Care Expense Account he is a participant in another cafeteria plan (as defined in Section 125 of the Code) maintained by the Employer and which has health flexible spending accounts compatible with the “eligible individual” requirements under Section 223(a) of the Code (i.e., the requirements for an individual to be eligible to make contributions to a health savings account), then the amount described in this Section 4.9 shall be carried over and credited to his health flexible spending account under that other cafeteria plan.

The amount carried over into the following Plan Year shall be disregarded for purposes of the limit on the total pre-tax Contributions that may be credited to any Participant’s Account for any Plan Year (as described in Section 4.2).

4.10 Continuation During Leaves of Absence. The Committee or Employer will advise any Employee who is eligible for a Statutory Leave of his right to maintain Coverage during the Statutory Leave, and his specific rights and obligations if he chooses to continue such coverage during the Statutory Leave. The Committee shall advise each Employee who takes any other type of leave of absence of his right, if any, to maintain such Coverage in effect during the period of leave, and the Employer’s right, if any, to recover any Contribution paid by the Employer on behalf of the Employee during the leave period.

4.11 Termination of Employment. If a person ceases to be a Participant during a Plan Year, he shall be eligible to receive Qualified Benefits incurred on or prior to the date he ceases participation; provided, however, claims for Health Care Expenses and Dependent Care Expenses are subject to the following rules.

A) If a Participant’s employment terminates during the Plan Year, he may submit claims only for payment or reimbursement of Dependent Care Expenses incurred prior to his termination. The amount available for reimbursement for Dependent Care Expenses shall be limited to the amount credited to his Dependent Care Expense Account. All such claims must be filed within 90 days after the date of his termination.

B) If a Participant’s employment terminates during the Plan Year and he is entitled to continue Contributions to his Health Care Expense Account through the end of that Plan Year pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), he may make after-tax Contributions to such Account for that period. If the Participant makes such election, he may submit claims for payment or reimbursement of Health Care Expenses incurred: (i) through the end of the Plan Year in which his

employment terminated; or (ii) if earlier, the date his after-tax Contributions cease. The amount available for payment or reimbursement of such Health Care Expenses shall equal the amount of his Contribution Election for his Health Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Health Care Expenses incurred during the Plan Year. If the Participant does not make such election, or makes such election but ceases after-tax Contributions prior to the end of the Plan Year: (i) he may submit claims only for payment or reimbursement of Health Care Expenses incurred prior to his termination or the date his after-tax Contributions ceased; (ii) all such claims must be submitted within 90 days following the date his employment terminated or the date his after-tax Contributions ceased; and (iii) he shall forfeit any amount remaining in his Health Care Expense Account after payment of claims filed before or within such 90-day period.

- 4.12 COBRA Health Continuation Coverage. The Employer shall advise each Participant, his Spouse and Dependents of any rights he may have to continued health insurance coverage, and to continue Contributions to his Health Care Expense Account, pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
- 4.13 Specific Benefits. The specific benefits to which a Participant, his Spouse, Dependent or beneficiary may be entitled under any Coverage shall be as determined under the applicable plan, program, insurance policy or contract providing such Coverage. The Employer does not guarantee payment of any benefits that may be payable under an insurance policy or contract, and eligibility under this Plan does not guarantee that Participants will satisfy any insurer's requirements for such Coverage.
- 4.14 Rescission of Coverage. A person's coverage under the Plan may be rescinded (i.e., retroactively cancelled or discontinued) if the person (or a person who sought coverage for the covered person) performed an act, practice, or omission that constitutes fraud, or made an intentional misrepresentation of fact, to get Plan coverage; provided the person receives at least 30 days advance written notice of rescission before his coverage is rescinded. Rescission of a person's coverage shall be considered an adverse benefit determination for purposes of the Plan's claims procedures described in Section 7.10.
- 4.15 Changes in Premiums. The Employer or Committee shall provide advance written notice to each Participant of the Premiums in effect at the beginning of each Plan Year, and any changes in Premiums during the Plan Year.

- 4.16 Statement of Benefits. By January 31st, each Participant will receive a W-2 Wage and Tax Statement showing the amount of his Contributions to his Dependent Care Expense Account for the previous calendar year.

SECTION 5

ELECTION PROCEDURES

- 5.1 Annual Elections. Before the beginning of each Plan Year, the Committee shall provide one or more election forms (written or in electronic form) to each Employee eligible to participate in the Plan that Plan Year. Employees who become eligible to participate in the Plan during the Plan Year shall be provided with election form(s) during the month in which they meet the eligibility requirements. The completed form(s) shall indicate the Contributions to be credited to the Account for each Qualified Benefit. Election form(s) for a Plan Year must be completed and filed with the Employer on or before the date specified by the Committee. A Participant's failure to submit election form(s) by the specified date shall be deemed an election to not make any Contributions for the Plan Year.

Notwithstanding the above, at the times described above, the Employer may instead notify each Employee who is eligible to participate in the Plan that his Premiums shall automatically be paid through Contributions to the Plan, unless the Employee elects otherwise in writing signed by the Employee and filed with the Committee. An Employee's failure to make such an election shall be deemed an election to participate in and make such Contributions to the Plan.

Notwithstanding the above, an Employee may file his Contribution Election(s) within the 30-day period following the date his employment with the Employer commences and such Contributions Elections will become effective as of the date his employment commences, provided that: (i) all Contributions made pursuant to such Contribution Election(s) must be only from compensation not currently available to the Employee on the date of the Contribution Election(s) are filed; and (ii) this provision shall not apply when an Employee's employment with the Employer terminates and resumes within a period of 30 days or less (or when an Employee returns to employment following an unpaid leave of absence of less than 30 days).

- 5.2 Irrevocability of Elections. Once a Participant makes his Contribution Elections for a Plan Year and the Plan Year commences, the Contribution Elections shall be irrevocable for the entire Plan Year, except as provided in Section 5.3.
- 5.3 Changes in Status. Participants may prospectively revoke their Contribution Elections and make new Contribution Elections for a Plan Year in accordance with

the provisions of this Section. This Section shall be interpreted in a manner consistent with Section 125 of the Code and other guidance issued thereunder.

- A) Health Plan Special Enrollment Rights. Contribution Elections for Dental, Medical and Vision Coverage Premiums may be changed in a manner consistent with the exercise of special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 or the special enrollment or disenrollment rights under a state Children's Health Insurance Program.
- B) COBRA Coverage. If a Participant, his Spouse or Dependent becomes eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (or similar state law) under a group health plan of the Employer, the Participant may increase his Contribution Elections for Dental, Medical or Vision Coverage Premiums to pay for the continuation coverage.
- C) Court Judgment, Decree or Order. A Participant's Contribution Election for Dental, Medical or Vision Coverage may be increased to pay for a Dependent child's or foster child's Dental, Medical or Vision Coverage as required under a court order or state agency notice resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order as defined under Section 609 of ERISA). Similarly, Contribution Elections may be reduced to reflect any decrease in Dental, Medical or Vision Coverage Premiums if such judgment, decree or order requires someone else to provide such Coverage for such child. If and to the extent permitted under Section 125 of the Code, a Participant's Contribution Election for his Health Care Expense Account may also be increased or reduced in a manner consistent with such court judgment, decree or order.
- D) Entitlement to Medicare or Medicaid. A Contribution Election for Dental, Medical or Vision Coverage Premiums may be reduced if the Participant, his Spouse or Dependent becomes entitled to Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines). A Participant's Contribution Election for Dental, Medical or Vision Coverage Premiums may be increased if the Participant, his Spouse or Dependent loses such Medicare or Medicaid eligibility. If and to the extent permitted under Section 125 of the Code, a Participant's Contribution Election for his Health Care Expense Account may also be reduced or increased when the Participant, his Spouse or Dependent becomes entitled to, or loses, such Medicare or Medicaid eligibility.

- E) Loss of Qualifying Individual Status. A Participant's Contribution Election for his Dependent Care Expense Account may be changed in a manner consistent with a change in the status of an individual as a Qualifying Individual.
- F) Other Changes in Status. Contribution Elections may change on account of and in a manner consistent with a change in: (i) the Participant's legal marital status (including: marriage, divorce, death of a Spouse, legal separation, or annulment); (ii) the number of the Participant's Dependents (including a change resulting from a birth, death, adoption or placement for adoption of a child); (iii) the employment status of the Participant, his Spouse or Dependent resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes the Participant, his Spouse or Dependent to become eligible, or cease to be eligible, for Coverage under this Plan or similar coverage under another employer plan; (iv) the place of residence of the Participant, his Spouse or Dependent; (v) a Dependent's eligibility for Dental, Medical or Vision Coverage due to age, student status, marriage or similar circumstance; (vi) any other change considered to be a change in status under Section 125 of the Code and regulations thereunder.
- G) Special Rule for Termination of Employment. Notwithstanding Section 5.3(F), but subject to Section 5.3(H), if a Participant's employment with the Employer terminates and then resumes in the same Plan Year within a period of 30 days or less, his Contribution Elections in effect before termination shall automatically be reinstated upon resumption of employment, unless some other intervening event has occurred that would permit a change to one or more Contribution Elections.
- H) Special Rule for Statutory Leave. If a Participant takes a Statutory Leave, the Participant may (i) revoke his Contribution Elections at the beginning of the Statutory Leave and make new Contribution Elections at the end of the Statutory Leave; or (ii) keep his Contribution Elections in place and prepay Contributions through pre-tax payroll deductions before the beginning of the Statutory Leave or continue to pay Contributions with after-tax payments during the Statutory Leave; provided, however, if the Statutory Leave spans two Plan Years the Participant may not prepay Contributions due after the last day of the Plan Year in which the Statutory Leave begins. A Participant shall not be eligible for reimbursement for Health Care Expenses or Dependent Care Expenses incurred during a period in which Contributions cease as a result of a Statutory Leave. Notwithstanding the above, the Employer may elect to pay Contributions

during a Statutory Leave and recover the cost of these payments through pre-tax payroll deductions after the Statutory Leave if the Employer does so for all Participants on the same type of Statutory Leave.

- I) Change in Premium. If Participants' Premiums change during a Plan Year, there shall be an automatic corresponding change to the Participants' Contributions for such Premiums; provided, however, if there is a significant increase in the Premium for a Coverage option, an affected Participant may revoke the election of that option and may elect another option providing similar Coverage (if available) with a corresponding change to his Contribution Election.
- J) Change in Dependent Care Expense. If there is a change in a Participant's dependent care provider or in the dependent care provider's cost for services, the Participant may make a corresponding change to his Contribution Election for his Dependent Care Expense Account (provided that, in the case of a change in a dependent care provider's cost for services, the dependent care provider is not a qualifying child or qualifying relative of the Participant within the meaning of Sections 152(a) of the Code.
- K) Significant Curtailment or Cessation of Coverage. If there is a significant curtailment in or cessation of Participants' Coverage, an affected Participant may revoke the election of that Coverage and may elect another option providing similar Coverage (if available) with a corresponding change to the Contribution Election for Premiums; provided, however, any curtailment of Coverage must constitute reduced Coverage for Participants generally.
- L) Change in Coverage Options. If a Coverage option is added, the Contribution Election for the Coverage Premium for a Participant who elects the new Coverage option shall be changed to correspond to the Participant's Premium for that Coverage. If a Coverage option is eliminated, the Contribution Election for an affected Participant shall be changed to conform to the change in the Participant's Premium for Coverage.
- M) Change in Coverage under Other Employer's Plan. A Participant may change his Contribution Elections (other than his Contribution for his Health Care Expense Account) under this Plan in a manner consistent with a change by his Spouse, former Spouse or Dependent under another plan providing Qualified Benefits if the change under such other plan (i) is permitted change listed above; or (ii) is made for the normal election period

under such other plan and that period is different from the Plan Year of this Plan.

- N) Loss of Other Group Health Coverage. A Participant may increase his Contribution Election for Dental, Medical or Vision Premiums under this Plan if the Participant, his Spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan.
- O) Reduction of Working Hours. A Participant may prospectively revoke his medical coverage, and his Contribution Election for medical coverage under this Plan, if he: (i) has been reasonably expected to average at least thirty (30) hours of service per week and there is a change in his employment status such that he will no longer reasonably be expected to average at least thirty (30) hours of service per week after the change (even if the change does not result in the Employee ceasing to be eligible for medical coverage); (ii) he represents to the Employer or Committee that he, and related individuals who cease medical coverage due to the revocation, have enrolled (or intend to enroll) in other group health plan coverage which satisfies the requirements for minimum essential coverage, as defined in Code §5000A(f)(1), effective no later than the first day of the second month following the month that includes the date the medical coverage is revoked. This Subsection is intended to comply, and shall be interpreted in a manner consistent, with Internal Revenue Service Notice 2014-55, and any subsequent Internal Revenue Service guidance relating to the conditions under which a Participant may revoke an election to pay for group health plan coverage under a Code Section 125 cafeteria plan for the reasons described herein.
- P) Eligibility for Exchange Coverage. A Participant may prospectively revoke his medical coverage, and his Contribution Election for medical coverage under this Plan, if he: (i) is eligible to enroll in a qualified health plan through an exchange established under §1311 of the Patient Protection and Affordable Care Act (pursuant to guidance issued by the U.S. Department of Health and Human Services and any other applicable guidance) during an exchange's special enrollment period or annual open enrollment period; and (ii) he represents to the Employer or Committee that he, and any related individuals who cease coverage due to such revocation, have enrolled (or intend to enroll) in a qualified health plan through the exchange effective

no later than the day immediately following the last day of his medical coverage. This Subsection is intended to comply, and shall be interpreted in a manner consistent, with Internal Revenue Service Notice 2014-55, and any subsequent Internal Revenue Service guidance relating to the conditions under which a Participant may revoke an election to pay for group health plan coverage under a Code Section 125 cafeteria plan for the reasons described herein.

- 5.4 Limits on Contribution Election Changes. Contribution Election changes must be made within 30 days after, and be consistent with, a change in status event listed in Section 5.3, and shall be effective at the time prescribed by the Committee. A Participant who changes his Contribution Election for his Health Care Expense Account during a Plan Year may not reduce his elected amount below the amount of Health Care Expenses submitted for reimbursement during the Plan Year.

SECTION 6

NONDISCRIMINATION REQUIREMENTS

- 6.1 Committee Discretion. The Committee may in its sole and absolute discretion take any actions that it deems appropriate to assure compliance with all applicable Code nondiscrimination requirements and all applicable Code limitations on Qualified Benefits provided to Highly Compensated Individuals and Key Employees. These actions include the reduction of Contributions made by Highly Compensated Individuals or Key Employees, based on a uniform and consistent method applicable to all Highly Compensated Individuals or Key Employees.
- 6.2 Aggregation with Other Plans. For purposes of the applicable Code nondiscrimination requirements, this Plan and the Utica College Limited-Purpose Flexible Spending Account shall be considered a single plan.

SECTION 7

PLAN ADMINISTRATION

- 7.1 Committee. The Employer may appoint one or more persons to serve as members of the Committee to control and manage the operation and administration of the Plan, and may remove any member of the Committee at any time. Any such appointment or removal shall be in writing. If no appointment is made, the Plan Administrator shall be the Committee.
- 7.2 Powers. The Committee has full authority and responsibility to control and manage the operation and administration of the Plan. The Committee shall have the exclusive right to interpret the Plan (but not to modify or amend the Plan) and to decide any and all questions arising in the administration, interpretation, and

application of the Plan. The Committee shall establish whatever rules it finds necessary for the operation and administration of the Plan and shall endeavor to apply such rules in its decisions so as not to discriminate in favor of any person. The decisions of the Committee or its action with respect to the Plan shall be conclusive and binding upon the Employer and all persons having or claiming to have any right or interest in or under the Plan.

- 7.3 Delegation of Responsibilities. The members of the Committee may elect from their number a chairman, who need not be an Employee, and may appoint a secretary, who need not be an Employee or a member of the Committee. They may appoint from their number such subcommittees with such powers as they shall determine. They may allocate responsibility among themselves or delegate any of their duties or responsibilities to other persons, including the Employer or any of its officers or employees. Any such allocation or delegation of responsibilities shall be by an instrument in writing, setting forth specifically the delegated duties, signed by or on behalf of the Committee and the delegated person and shall be exercised in a reasonable manner taking into account the discretionary or ministerial nature of the responsibility allocated or delegated and the capabilities of such person or persons to whom the responsibility is allocated or delegated. A member of the Committee may resign at any time by delivering a written resignation to the Employer.
- 7.4 Agents and Contractors. The Committee or any person or persons to whom the Committee has delegated responsibilities may employ, with the approval of the Committee, one or more accountants, legal counsel or other persons as shall be deemed necessary for the effective control and management of the operation and administration of the Plan. The members of the Committee, the Employer and its officers and directors, and any person to whom any duty or responsibility has been delegated by the Committee shall be entitled to rely upon all tables, certificates, opinions and reports furnished by any duly appointed accountant, legal counsel or other person and shall be fully protected in respect of any action taken or permitted by them in good faith in reliance upon any such tables, certificates, opinions or reports.
- 7.5 Meetings. The Committee may hold meetings upon such notice, at such place or places, and at such time or times as it may determine. A majority of the members of the Committee shall constitute a quorum for the transaction of business. All resolutions or other actions taken by the Committee shall be by vote of a majority of those present at a meeting of the Committee at which a quorum shall be present or, if they act without a meeting, in writing by all the members of the Committee.

- 7.6 Expenses. No Committee member shall receive any compensation for his services, but the Employer may reimburse a Committee member for any necessary expenses incurred.
- 7.7 Records. The Committee shall maintain records showing the fiscal transactions of the Plan.
- 7.8 Plan Administrator. The Employer may appoint one or more persons to act as Plan Administrator within the meaning of Section 3(16)(A) of ERISA and may remove the Plan Administrator from office at any time. Any such appointment or removal shall be in writing signed by the Plan Administrator and acknowledging the appointment. If no appointment is made, the Employer shall be the Plan Administrator. The Plan Administrator shall file such documents and shall have such duties as are required by applicable law, and as may be delegated in the instrument of appointment.
- 7.9 Indemnification. Each person who is or has been a member of the Committee or the Plan Administrator shall be indemnified by the Employer against expenses (including amounts paid in settlement with the approval of the Employer) reasonably incurred by him in connection with any action, suit, or proceeding to which he may be a party or with which he shall be threatened by reason of his being, or having been, a member of the Committee or the Plan Administrator, except in relation to matters as to which he shall be adjudged in such action, suit, or proceeding to be liable for a breach of any fiduciary responsibility under ERISA. The foregoing right of indemnification shall be in addition to any other rights to which any member of the Committee or Plan Administrator may be entitled as a matter of law.
- 7.10 Claims Procedures. Qualified Benefits shall be paid in accordance with the terms of the Plan. A Participant who disagrees with a decision concerning his right to participate in the Plan or wishes to make a claim for a Qualified Benefit may file a claim in writing with the Committee. Any claim for payment or reimbursement for Health Care Expenses incurred in a Plan Year must be filed no later than 120 days following the end of the Plan Year or any earlier date specified in the Plan. Any claim for payment or reimbursement for Dependent Care Expenses incurred in a Plan Year must be filed no later than 120 days following the end of the Plan Year or any earlier date specified in the Plan. Any other claim must be filed no later than 120 days following the end of the Plan Year to which the Qualified Benefit relates, or if earlier 90 days after he ceases participation in the Plan. The Employer or the Committee shall establish and maintain claims procedures in accordance with ERISA, which shall include: (i) a procedure for advising claimants on how to make claims for benefits; (ii) a procedure for the review of such claims and giving timely written notice to the claimant concerning the

determination made on the claim; and (iii) a procedure for requesting a review of any claim that is denied in whole or part and giving timely written notice to the claimant concerning the decision on review.

SECTION 8

AMENDMENT AND TERMINATION OF THE PLAN

- 8.1 Amendment. The Employer may amend the Plan at any time or from time to time by an instrument in writing executed with the same formality as this instrument. However, no amendment shall affect the rights of Participants under the Plan with respect to the payment of Premiums, Health Care Expenses or Dependent Care Expenses incurred prior to the effective date of the amendment.
- 8.2 Termination. The Plan is intended by the Employer to be a permanent program for the provision of Qualified Benefits for its Employees. The Employer nevertheless reserves the right to terminate the Plan at any time and for any reason. Such termination shall be effected by a written instrument executed by the Employer with the same formality as this instrument. Termination of the Plan shall not affect the rights of Participants under the Plan with respect to the payment of Premiums, Health Care Expenses or Dependent Care Expenses incurred prior to the effective date of the termination.

SECTION 9

HIPAA PRIVACY RULES

- 9.1 Definitions. For purposes of this Section:
- A) “Authorization” means a valid written authorization to disclose Protected Health Information by the person to whom such Protected Health Information pertains and which is made in accordance with Section 164.508 of the Privacy Rules.
 - B) “Electronic Protected Health Information” means Protected Health Information that is transmitted by or maintained in electronic media.
 - C) “Plan Administration Functions” means the administration functions performed by the Plan Sponsor on behalf of this Plan. It excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.
 - D) “Privacy Rules” means the health privacy regulations promulgated by the United States Department of Health and Human Services, found at 45 CFR, Parts 160-164.

- E) “Protected Health Information” means individually identifiable health information as described at Section 160.103 of the Privacy Rules.
- F) “Summary Health Information” means information that may be individually identifiable health information, which:
 - (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and
 - (b) from which identifying information described in Section 164.514 of the Privacy Rules (such as name, address, age, telephone number, fax number, electronic mail address, social security number, medical records number, health plan beneficiary number, photograph, etc.) has been deleted, except that addresses may be aggregated to the level of a five-digit zip code.

9.2 Disclosure of Summary Health, Enrollment and Disenrollment Information. The Plan may disclose, or allow a Plan health insurance issuer or HMO to disclose, the following information to the Plan Sponsor:

- A) Summary Health Information, provided the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan, or for the purpose of modifying, amending or terminating the Plan.
- B) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the health insurance issuer or HMO offered by the Plan.

9.3 Disclosure of Protected Health Information. The Plan may disclose, or allow a Plan health insurance issuer or HMO to disclose, Protected Health Information only:

- A) for the purposes and in accordance with the requirements of section 164.512 of the Privacy Rules (such as disclosures required by law, and disclosures for public health activities or law enforcement purposes); or
- B) directly to the individual to whom the Protected Health Information pertains; or

- C) pursuant to a valid Authorization signed by the individual to whom the Protected Health Information pertains; or
- D) without the Authorization of the individual to whom the Protected Health Information pertains, provided such individual is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the disclosure in accordance with the requirements of Section 164.510 of the Privacy Rules; or
- E) to the Plan Sponsor for purpose of Plan Administration functions only, but only: (i) if any notice of privacy practices required to be given by the Plan under Section 164.520 of the Privacy Rules contains a separate statement that the Plan, or a Plan health insurance issuer or HMO, may disclose Protected Health Information to the Plan Sponsor; and (ii) after the Plan Sponsor certifies in writing that the Plan has been amended to incorporate this Section and agrees to:
 - (a) not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law;
 - (b) ensure that any agent, including any subcontractor to whom the Plan Sponsor provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to the Protected Health Information;
 - (c) not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, unless pursuant to an Authorization from the individual to whom the Protected Health Information pertains;
 - (d) report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for, whenever it becomes aware of such use or disclosure;
 - (e) make available Protected Health Information to the individual to whom it pertains in accordance with the access provisions of Section 164.524 of the Privacy Rules;
 - (f) make available Protected Health Information for amendment, and incorporate any amendments to Protected Health Information, in accordance with the amendment provisions of Section 164.526 of the Privacy Rules;

- (g) make available Protected Health Information as required to provide an accounting of disclosures in accordance with the accounting provisions of Section 164.528 of the Privacy Rules;
- (h) make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rules;
- (i) if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information, when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor will limit further use and disclosure to those purposes that make the return or destruction of the information infeasible;
- (j) ensure that adequate separation occurs between the Plan and the Plan Sponsor, as described below;
- (k) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;
- (l) ensure that the adequate separation between the Plan and the Plan Sponsor is supported by reasonable and appropriate security measures for any Electronic Protected Health Information;
- (m) ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures;
- (n) report to the Plan any security incident of which it becomes aware; and
- (o) make its policies, procedures and documentation relating to safeguards for Electronic Protected Health Information available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance.

9.4 Plan Sponsor's Use of Protected Health Information. The Plan Sponsor shall use or disclose Protected Health Information only if it has properly received the

Protected Health Information from the Plan, or a Plan health insurance issuer or HMO, and such use and disclosure complies with the requirements of the Privacy Rules and this Section. The Plan Sponsor will notify the Plan of any misuses or impermissible disclosures of Protected Health Information of which it becomes aware.

9.5 Adequate Separation Between Plan and Plan Sponsor. The following classes of employees, or other persons under the control of the Plan Sponsor, shall have access to Protected Health Information solely for the purposes specified below, and only for Plan Administration Functions. No other employees of the Plan Sponsor, or other persons under the control of the Plan Sponsor, shall have access to Protected Health Information.

Third party administrators, and their employees, retained by the Plan Sponsor to assist with Plan Administration Functions, such as processing claims, keeping Plan records, and preparing Plan reports, will have access to Protected Health Information.

Employees who work in the Plan Sponsor's Benefits or Human Resources Department will have access to Protected Health Information:

- A) to the extent necessary to assist Plan participants and their family members with getting benefit claims resolved;
- B) that is the result of pre-employment physicals requested or required by the Plan Sponsor before hiring prospective employees;
- C) to the extent necessary to fulfill any responsibility they may have to review and determine claims and appeals of denied claims under this Plan;
- D) to the extent necessary to determine whether stop-loss payments from the Plan's stop-loss carrier are appropriate and accurately determined;
- E) to the extent necessary to monitor and enforce the subrogation provisions of the Plan, and work with the Plan Sponsor's subrogation entity to help the Plan obtain reimbursement when appropriate;
- F) for activities related to ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance); and
- G) to the extent necessary to correspond with other group health plans on coordination of benefits issues.

Employees who work in the Plan Sponsor's Legal Department will have access to Protected Health Information to the extent necessary to: (i) enforce the provisions of the Plan; and (ii) respond to, defend against, and provide necessary information to outside counsel for responding to and defending against, lawsuits against the Plan, Plan Sponsor or Plan fiduciaries, or other lawsuits that require benefits information or Protected Health Information.

Employees who work in the Plan Sponsor's Finance Department will have access to Protected Health Information to the extent necessary to conduct an internal audit of the Plan's expenses and payments of claims.

- 9.6 Non-Compliance. A Plan participant who believes the Plan has unlawfully used or disclosed his or her Protected Health Information may file a complaint with Ms. Lisa Green, VP of Human Resources, Utica College, 1600 Burrstone Road, Utica, New York, 13502.

If any employee or other individual under the control of the Plan or the Plan Sponsor fails to comply with the provisions of this Section regarding use or disclosure of Protected Health Information, the Plan or Plan Sponsor, as the case may be, shall impose reasonable sanctions on such individual as necessary, in its discretion, to end such non-compliance. If appropriate, such sanctions shall be imposed progressively (for example, an oral warning, written warning, transfer to another department, and termination); or, in the discretion of the Plan or Plan Sponsor, the employment or other relationship between the Plan or Plan Sponsor and such individual could be immediately terminated.

- 9.7 Individuals' Rights With Respect to Protected Health Information. An individual may request restrictions on certain uses and disclosures of his or her Protected Health Information, as provided in Section 164.522(a) of the Privacy Rules (although the Plan is not required to agree to a requested restriction). An individual has the right to receive confidential communications of Protected Health Information, as provided in Section 164.522(b) of the Privacy Rules, if the individual believes the Plan's usual method of communicating Protected Health Information could endanger him or her. An individual also has the right to inspect and copy his or her Protected Health Information, as provided in Section 164.524 of the Privacy Rules.

The Plan will track disclosures of Protected Health Information for a period of six years (but not prior to April 14, 2003), and will provide to an individual upon request an accounting of disclosures of his or her Protected Health Information, to the extent required and in accordance with Sections 164.528 and 164.530 of the Privacy Rules. An individual has the right to amend his or her Protected Health

Information maintained by the Plan in accordance with Section 164.526 of the Privacy Rules.

SECTION 10

MISCELLANEOUS

- 10.1 No Employment Rights Conferred. The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and any Participant or to be a consideration for, or an inducement to or condition of, the employment of any person. Nothing herein contained shall be deemed to: (i) give to any Participant the right to be retained in the employment of the Employer; (ii) interfere with the right of the Employer to discharge any Participant at any time; (iii) give to the Employer the right to require any Participant to remain in its employment; or (iv) interfere with any Participant's right to terminate his employment with the Employer at any time.
- 10.2 No Compensation for Other Purposes. Qualified Benefits paid under the terms of this Plan shall not be treated as additional compensation to the Participant for purposes of determining contributions or benefits under any qualified retirement plan maintained by the Employer or for purposes of any other benefit obligations of the Employer, unless otherwise provided under the terms of the retirement plan or other benefit program.
- 10.3 Tax Effects. Neither the Employer, Plan Administrator nor the Committee makes any warranty or other representations as to whether any Contributions, coverage or benefit payments to or on behalf of a Participant will be excluded from the Participant's gross income for federal or state tax purposes.
- 10.4 General Assets. Payment of Qualified Benefits shall be made out of the assets of the Employer generally available for payment of its obligations. There shall be no trust fund for payment of Qualified Benefits. Except as provided in a qualified medical child support order (within the meaning of Section 609 of ERISA), and except to the extent that this provision may be contrary to other law, Qualified Benefits payable from the Plan shall not be subject to assignment or transfer or otherwise alienable, either by voluntary or involuntary act of a Participant or by operation of law, nor subject to attachment, execution, garnishment, or other seizure under any legal or equitable process.
- 10.5 Impossibility of Performance. In the event that it becomes impossible for the Employer to perform any act under the Plan, that act shall be performed which in the judgment of the Employer shall most nearly carry out the intent and purposes of the Plan.

10.6 Gender. For purposes of this Plan, unless the context requires otherwise, whenever the masculine gender is used, it shall also be deemed to include the feminine gender.

10.7 Governing Law. All legal questions pertaining to the Plan shall be determined in accordance with the laws of the State of New York except when those laws are preempted by the laws of the United States.

By signing this instrument, the Employer(s) approves and adopts the terms of the Flexible Spending Account Plan as stated herein.

Utica College
(Employer Name)

By: Linda Madde

Title: Director of Human Resources

Date: December 12, 2016

UTICA COLLEGE

FLEXIBLE SPENDING ACCOUNT PLAN (With Pre-Tax Insurance Premiums)

SUMMARY PLAN DESCRIPTION

DISCLAIMER

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

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

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

UTICA COLLEGE

FLEXIBLE SPENDING ACCOUNT PLAN (With Pre-Tax Insurance Premiums)

SUMMARY PLAN DESCRIPTION

*Of the Provisions of the Plan
in Effect on January 1, 2016*

INTRODUCTION

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

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM"). Check to see if there are any SMM's attached when you refer to this SPD.

IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name: Utica College
Flexible Spending Account

Plan Number: 510

Plan Type: Cafeteria (Section 125) Plan

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

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

Employer Identification Number: 16-1476258

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

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

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

Legal process may also be served upon the Plan Administrator.

1. What is the purpose of the Plan?

Eligible employees can make pre-tax contributions to the Plan that are credited to their Plan account(s) and may be used to pay or reimburse them for the following types of expenses, provided the expenses are not payable or reimbursable from any other source:

- dependent care expenses that would otherwise qualify for a dependent care credit on your federal income tax return if they were not paid or reimbursed under the Plan. You must designate the amount you wish to contribute for dependent care expenses. These contributions will be credited to an account that can be used only for dependent care expenses.
- health care expenses (other than insurance premiums and expenses for long-term care services) that would otherwise be deductible on your federal income tax return if they were not paid or reimbursed under the Plan (but without regard to any minimum amount of health care expenses required to take a deduction), incurred for you, your spouse, any person who qualifies as your dependent for federal income tax purposes, or your child even if he or she does not qualify as your dependent for federal income tax purposes but only through the end of the calendar year in which the child reaches age 26. Health care expenses also include the cost of over-the-counter medicines and drugs (such as antacid, allergy medicine, pain reliever and cold medicine) provided, the over-the-counter medicine or drug is either insulin or is prescribed (without regard to whether such medicine or drug is available without a prescription). Whether a medicine or drug is a prescribed medicine or drug is determined in accordance with regulations and other guidance issued by the Internal Revenue Service. Health care expenses do not include toiletries, cosmetics, sundry items, dietary supplements, vitamins and other items that are merely beneficial to a person's general health. You must designate the amount you wish to contribute for health care expenses. These contributions will be credited to an account that can be used only for health care expenses.

These contributions are deducted from employees' pay and are not reported as taxable income on their W-2 forms, so they do not pay federal income tax or Social Security taxes on them, if the Plan continues to satisfy certain tax requirements. Before you can participate in the Plan, and before the beginning of each Plan Year, you will be notified of the minimum and maximum amount you can contribute for these expenses for that Plan Year. (For the Plan Year, see **IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.**)

Notwithstanding the above, the maximum amount a participant can elect on a pre-tax basis for payment or reimbursement of health care expenses for any Plan Year is \$2,550.00. This limit may be adjusted in the future to reflect cost-of-living changes.

Eligible employees can also pay their premiums through the Plan, on a pre-tax basis, for the following group health coverage sponsored by the Employer:

- dental coverage
- medical coverage
- vision coverage

as well as the following other group coverage sponsored by the Employer:

- accidental death and dismemberment coverage

(An employee's cost for coverage is referred to in this SPD as his "premium" whether the coverage is provided through an insurer or is self-insured by the Employer.) The premiums employees pay through the Plan are deducted from their pay and are not reported as taxable income on their W-2 forms, so they do not pay federal income tax or Social Security taxes on them, provided the Plan satisfies certain tax requirements.

Alternatively, an eligible employee will receive additional amount(s) in his paycheck if he is eligible for, but declines and does not receive, the following group coverage sponsored by the Employer:

- medical coverage

The Employer will provide written notice to eligible employees before the beginning of each Plan Year of any change to the amount of additional cash compensation paid to participants who decline and do not receive coverage. (For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.) The additional amounts an employee receives in his paycheck are subject to income tax and Social Security taxes, and are reported as taxable income on his W-2 form.

2. Who is eligible to participate in the Plan?

To participate, you must be: (i) an employee of the Employer or an Affiliated Employer that has adopted the Plan (both are referred to herein as Employer); (ii)

among the employees to whom the Employer makes available group health plan coverage which meets certain requirements under the Affordable Care Act; and (iii) satisfy any other eligibility requirements described below. Notwithstanding the above, the following persons are not eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation (“LLC”), any member of the LLC; and (iv) if the Employer is a Subchapter S corporation, and any person who owns directly or indirectly more than 2% of the Employer. In addition, any employee participating in another Flexible Spending Account Plan maintained by the Employer which has health flexible spending accounts compatible with the tax requirements to be eligible to contribute to a health savings account cannot also participate in this Plan at the same time.

- An employee is eligible to participate in the Plan and make contributions for the following types of expenses, and/or pay premiums for the following group coverage sponsored by the Employer, through the Plan -
 - dependent care expenses
 - health care expenses
 - accidental death and dismemberment coverage
 - dental coverage
 - medical coverage
 - vision coverage

if he is expected to work at least thirty (30) hours per week for the Employer (the “hours requirement”).

Note: If he was hired prior to 1/1/14, if he is expected to work at least seventeen and a half (17 ½) hours per week for the Employer (the “hours requirement”).

Such employee can participate in the Plan, and make such contributions and/or pay such premiums, through the Plan on the date he satisfies the requirement(s) above; provided he has completed and filed all of the forms required for participation by the Committee.

The following rules apply to an employee whose work schedule is such that it is not certain whether he will be reasonably expected to satisfy the hours requirement but who satisfies the Plan's other substantive eligibility requirements.

- 1) If he is a newly hired employee and he works an average of at least thirty (30) hours per week for the Employer during the twelve (12) consecutive month period commencing on the first day of the month coinciding with or immediately following his date of hire (his "initial measurement period"), he can participate in the Plan during the twelve (12) consecutive months beginning with the second month following his initial measurement period (if he continues to satisfy the Plan's other substantive eligibility requirements).
- 2) Whether or not he is a newly hired employee, if he works an average of at least thirty (30) hours per week for the Employer during the twelve (12) consecutive months beginning on the first day of any November (the "standard measurement period"), he can participate in the Plan during the twelve (12) consecutive month period beginning on the first day of the Plan Year following that standard measurement period (if he continues to satisfy the Plan's other substantive eligibility requirements).
- 3) If his employment changes during his initial measurement period or a standard measurement period such that, thereafter, he is reasonably expected to satisfy the hours requirement, he can participate in the Plan on the first day of the month following the change (and until he no longer satisfies the Plan's substantive eligibility requirements).
- 4) An employee will not be considered a newly hired employee once he has been an employee for a full standard measurement period, unless he: (i) stops providing services to the Employer for a period of at least 26 consecutive weeks; and (ii) later starts providing services for the Employer again (in which case he will be considered a newly hired employee when he starts providing services for the Employer again).
- 5) All hours for which an employee is paid are considered hours worked. If an employee is on an unpaid leave during a measurement period on account of jury duty or an unpaid leave subject to the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act of 1994

(USERRA), the period of unpaid leave will be excluded when determining whether he averaged the required number of hours during that measurement period.

The Employer will notify an employee before, or as soon as administratively practical after, the Employee satisfies the requirements for eligibility.

3. Are there any other requirements to participate in the Plan?

If you are eligible to participate in the Plan, your premiums will automatically be deducted from your pay and paid through the Plan throughout the Plan Year, unless you elect otherwise in writing signed by you and filed with the Committee. (For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.) If you file this election, you will not be able to pay your premiums through the Plan until the next Plan Year, unless a change in status occurs that allows you to change this election (see Question & Answer 4). To make contributions to the Plan for other expenses you must complete an enrollment process, and elect the amount of your contributions to the Plan for the Plan Year. Contributions for these expenses are also deducted from your pay throughout the Plan Year. Failure to complete enrollment by the date specified by the Committee will be considered an election not to make contributions for the Plan Year for these expenses. In that case, you will not be able to make contributions for these expenses until the next Plan Year, unless a change in status occurs that allows you to change your election (see Question & Answer 4).

4. When can I change the amount I put into the Plan?

You can change the premiums you pay through the Plan, and your contributions for other expenses, before the beginning of each new Plan Year. Once the Plan Year has started, federal tax laws permit you to change these amounts only when one of the following “changes in status” occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or special enrollment or disenrollment rights under a state Children’s Health Insurance Program (CHIP). (This applies only to elections for group health coverage premiums.)
- You, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law under a group health plan sponsored by your Employer. (This applies only to elections for group health coverage premiums.)

- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage. (This applies only to group health coverage premium elections and health care expense elections.)
- You, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines). (This applies only to elections for group health coverage premiums.)
- Your premiums increase significantly. (However, if there is an ordinary increase or decrease in premiums, the premiums you pay through the Plan will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or your contributions for other expenses.
- There is a significant curtailment in, or cessation of, group coverage for employees generally. Note, that a significant curtailment in, or cessation of, your coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan.
- A new group coverage option is added or a group coverage option you have selected is eliminated. Note, that the addition or elimination of a coverage option allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or your contributions for other expenses.
- Your legal marital status changes (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).
- The number of your dependents changes (including a change resulting from a birth, death, adoption or placement for adoption of a child).
- There is a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes

you, your spouse or dependent to become or cease to be eligible for coverage under the Plan or the same type of coverage under another employer plan. However, if your employment terminates and resumes in the same Plan Year within a period of 30 days or less, the amount of premiums you paid through the Plan before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in the premiums you pay through the Plan.

- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for group coverage at the new place of residence. Note, a change in residence allows you to change the amount of the premiums you pay through the Plan for group coverage for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Plan or your contributions for other expenses.
- Your dependent's eligibility for group health coverage changes due to the dependent's age, student status or marital status or similar circumstance.
- Your spouse, former spouse or dependent makes a change under another plan which is either (i) consistent with one of the events described above, or (ii) for the normal election period under the other plan and that election period is different from the Plan Year of this Plan.
- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan. (This applies only to elections for group health coverage premiums.)
- There is a change in your dependent care provider or a change in the cost of services provided by a dependent care provider who is not a relative.
- A person's status as a dependent for purposes of your dependent care election changes.
- You: (i) have been reasonably expected to average at least thirty (30) hours of service per week for the Employer and there is a change in your

employment status such that you will no longer reasonably be expected to average at least thirty (30) hours of service per week for the Employer after the change; and (ii) you represent to the Employer or Committee that you and related individuals who cease medical coverage due to the revocation, have enrolled (or intend to enroll) in other group health plan coverage which satisfies the requirements for minimum essential coverage under the Patient Protection and Affordable Care Act, effective no later than the first day of the second month following the month that includes the date the medical coverage is revoked. (This applies only to a prospective revocation of a Contribution election to pay for medical coverage through the Plan (even if the change does not result in you ceasing to be eligible for medical coverage).)

- You: (i) are eligible to enroll in a qualified health plan through an exchange established under the Patient Protection and Affordable Care Act during an exchange's special enrollment period or annual open enrollment period; and (ii) you represent to the Employer or Committee that you, and any related individuals who cease coverage due to such revocation, have enrolled (or intend to enroll) in a qualified health plan through the exchange effective no later than the day immediately following the last day of your medical coverage. This applies only to a prospective revocation of a Contribution election to pay for medical coverage through the Plan.)

Note that any election to change the amount of premiums you pay through the Plan or your contributions for other expenses must be made within 30 days after, and must be consistent with, an event described above. Also, even if you are allowed to change your contribution for health care expenses, you may not reduce the annual contribution elected to less than the amount of health care expenses already reimbursed to you for the Plan Year.

5. How do I receive my benefits from the Plan?

Amounts are deducted directly from your pay and used to pay your premiums. Your employer may make arrangements for automatic payment or reimbursement of other expenses covered under the Plan. Otherwise, these expenses will be paid/reimbursed at least monthly, provided you file a written claim for payment or reimbursement at least five business days before a scheduled payment/reimbursement date. The Committee will inform participants of the scheduled payment/reimbursement dates. Claims for payment or reimbursement must be made on forms provided by the Committee. You may request forms from Human Resources, Utica College, 1600 Burrstone Road, Utica, New York 13502.

The Employer may also make arrangements for expenses to be paid and processed using a pre-paid “debit” card. Expenses paid or reimbursed in this manner must be substantiated as an expense qualifying for payment or reimbursement under the Plan in accordance with federal tax law. If an expense cannot be substantiated, the Employer will take action consistent with tax regulations to require the participant to repay the unsubstantiated amount, including: (i) denying the participant access to a pre-paid card (and requiring him to submit written forms for future claims) until the unsubstantiated amount is recovered; (ii) demanding that the participant repay the unsubstantiated amount; (iii) deducting the unsubstantiated amount from the participant’s wages; and (iv) offsetting payment of other claims for expenses incurred in the same Plan Year by the unsubstantiated amount. If these efforts are unsuccessful, the participant will remain indebted to the Employer for the unsubstantiated amount. The Employer or Plan Administrator may adopt other rules for the use of pre-paid cards, such as suspending or terminating participation in the Plan for misuse of a pre-paid card, canceling a person’s pre-paid card when he ceases participation in the Plan, establishing transaction limits or restrictions on the pre-paid card, and charging fees for the use of pre-paid cards.

If a participant attempts to have an expense paid through a pre-paid card but, for any reason, it is not successfully processed, he should submit a written claim for the expense. A claim for the expense is not considered denied until he submits a written claim and the written claim is denied in accordance with the claims procedures described in the Answer to Question 12.

Note:

- The amount of dependent care expenses paid or reimbursed cannot exceed the contributions you have made to the Plan for dependent care expenses, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.
- The amount of health care expenses paid or reimbursed cannot exceed the amount of your health care expense contribution election for the Plan Year, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.
- Only expenses incurred on or after the date you begin participating in the Plan, and before the date you stop participating in the Plan, are covered under the Plan. Generally, you stop participating in the Plan when you are no longer an eligible employee of the Employer. (See Question and Answer 2.) In addition, any expenses incurred after you stop making Plan contributions for those expenses are not covered.

- If you are employed through the end of the Plan Year, you have until 120 days after the end of each Plan Year to submit a claim for payment or reimbursement for expenses that you incurred during the Plan Year. (Question & Answer 7 explains rules that apply when you terminate employment before the end of a Plan Year.)
- Amounts paid under the Plan are not treated as additional compensation to an employee for purposes of determining contributions or benefits under any qualified retirement plan maintained by the Employer, or for purposes of any other benefit obligations of the Employer, unless otherwise provided under the terms of the retirement plan or other benefit program.

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

6. What happens if I am employed by the Employer through the end of a Plan Year but my contributions are greater than my actual expenses during the Plan Year?

Contributions for health care expenses that remain credited to you as of the end of a Plan Year (after payment of all timely and valid claims) are carried over and are available for payment or reimbursement of health care expenses incurred in the following Plan Year; provided that: (i) you elect to participate in this Plan the following Plan Year; and (ii) no more than \$500.00 may be carried over into the following Plan Year. If you are not a participant in this Plan the following Plan Year, but immediately after the end of the Plan Year in which health care expense contributions remain credited you elect to participate in another flexible spending account plan maintained by the Employer (or an Affiliated Employer that has adopted this Plan) and which has health flexible spending accounts that are compatible with the tax requirements to be eligible to make contributions to a health savings account, then the amount described above will be carried over and credited to your health flexible spending account under that other cafeteria plan.

If the amount you contribute for dependent care expenses exceeds the amount of dependent care expenses you actually incur during the Plan Year, you will forfeit the excess contributions.

Therefore, you should be careful to contribute only the amount you think will be needed to cover your anticipated expenses for the Plan Year.

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

You may claim payment or reimbursement for expenses incurred before your termination, provided you submit your claim for payment or reimbursement no later than **90** days after your termination. You may also have a right to COBRA continuation coverage. (See “COBRA Continuation Coverage” in Question and Answer 13.)

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

A paid leave of absence is not itself a change in family status, so your elections will stay in place unless you have another reason to change them. However, a leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act is a change in status, so you may change your elections as explained in Question & Answer 4. Also, see Question & Answer 13 for special rules applicable to a leave under the Family and Medical Leave Act and the Uniform Services Employment and Reemployment Rights Act.

9. Can the Employer amend or terminate the Plan?

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

10. Can a person’s coverage under the Plan ever be rescinded?

A person’s coverage under the Plan may be rescinded (i.e., retroactively cancelled or discontinued) if the person (or a person who sought coverage for the covered person) performed an act, practice, or omission that constitutes fraud, or made an intentional misrepresentation of fact, to get the Plan coverage. Any person whose coverage is rescinded will receive at least 30 days advance written notice before his coverage is rescinded. Rescission of a person’s coverage is considered an adverse benefit determination for purposes of the Plan’s claims procedures described in the Answer to Question 12.

11. Who controls the operation of the Plan?

A Committee appointed by the Employer controls and manages the operation of

the Plan. The Committee decides all questions arising in the interpretation and application of the Plan, and may establish rules for the operation of the Plan.

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

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

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

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

If a claim is denied in whole or in part, you will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan's review procedures and time limits; and (v) a statement that you have a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review. In the case of a health claim, the notice will also state the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the

determination. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If a claim is denied and you want a review, you must notify the Committee in writing within 180 days after you receive the written notice of denial of health claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) a statement that you have a right to sue under the Employee Retirement Income Security Act; and (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.” If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request.

If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

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

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

COBRA Continuation Coverage

You may have a right under “COBRA” to continue to participate in the health care expense portion of the Plan only after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose 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:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

- (5) You become divorced or legally separated from your spouse.

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

Uniformed Services Employment and Reemployment Rights Act Continuation Coverage

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 continue to participate in the health care expense portion of the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. 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.

The procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage rules and deadlines described in the SPD, 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).

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

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Information concerning your HIPAA and USERRA rights is available from Ms. Lisa Green, VP of Human Resources, Utica College, 1600 Burrstone Road, Utica, New York, 13502, phone (315) 792-3276, fax (315) 792-3386.

Family and Medical Leave Act

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

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

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act (“HIPAA”) regarding the use and disclosure of your protected health information (“PHI”). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan’s privacy notice or more information about the Plan’s privacy practices, or you want to file a privacy violation complaint, please contact Ms. Lisa Green, VP of Human Resources, Utica College, 1600 Burrstone Road, Utica, New York, 13502, phone (315) 792-3276, fax (315) 792-3386.

Qualified Medical Child Support Order

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

Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

This includes the ability to:

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone

directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.