IMPORTANT NOTICE TO EMPLOYERS CONCERNING CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS

The form plan document and summary plan description provided by Lifetime Benefit Solutions, Inc. provides for contributions to employees' Health Savings Accounts ("HSAs"). Please read this notice before allowing or making such contributions.

- An employee is not eligible to make HSA contributions (or to have contributions made to his HSA) unless he satisfies specific requirements under tax law and regulations. For example, he can have only high deductible health coverage and certain other "permitted" group and individual health coverage, and must not be claimed as a dependent on someone else's federal tax return or be entitled to Medicare benefits.

- Employee HSA contribution elections and changes (i.e., increases, decreases or revocations) cannot apply to compensation that would otherwise be paid before the first day of the month following the date the election form (or changed election form) is filed.

- An employee may elect to have his compensation for a month reduced for HSA contributions only if on the first day of that month:

  - he has high deductible medical coverage maintained by an employer sponsoring the Plan, and the employer reasonably believes he satisfies the tax requirements to make HSA contributions; and

  - he does not have a "health FSA" under any cafeteria plan which allows payment or reimbursement of medical expenses other than dental and vision care expenses.

- In addition, an employee may not elect to have his compensation reduced for HSA contributions for any month (or portion of a month) which is part of a "grace period" under a cafeteria plan if the employee had a health FSA under that cafeteria plan during the cafeteria plan year preceding the grace period, unless: (i) the health FSA allowed payment or reimbursement of only dental and vision care expenses; or (ii) he had a zero health FSA balance as of the last day of the cafeteria plan year preceding the grace period. For purposes of this rule, an employee's health FSA balance as of the last day of the cafeteria plan year is determined by disregarding any expenses which are not actually paid or reimbursed by that day.

- The Plan provides that all HSA contributions made through the Plan must stop when the employee no longer satisfies the eligibility requirements for HSA contributions or for participation in the Plan.

- Generally, the total contribution to an employee's HSA for a calendar year may not exceed the maximum contribution applicable to him under tax law and regulations for that year (which depends on whether he has single or family high deductible health plan coverage); reduced on a proportional basis for the number of months in that year less than twelve (12) that he does not satisfy the eligibility requirements for making HSA contributions (determined as of the first day of each month). However, an employee who is age 55 or older and satisfies the eligibility requirements for making HSA contributions may make additional "catch-up" contributions as permitted under tax law and regulations if he certifies to the employer that he has reached age 55.

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

- HSA contributions in excess of the maximum contribution limit, and HSA contributions for an employee who is not eligible for HSA contributions, are treated as taxable income to the employee and may also result in excise taxes.

Lifetime Benefit Solutions, Inc. is not a law firm and does not give legal or tax advice. It is the employer's sole responsibility to:

- understand all HSA tax rules, including rules regarding when an employee is eligible to make HSA contributions, the maximum amount of HSA contributions that can be made in a calendar year, and what corrective action must or should be taken if it learns that an employee's HSA contributions exceed the maximum amount; and

- consult with its own legal counsel if it has any concerns regarding these or any other matters relating to HSA contributions.

UTICA COLLEGE

LIMITED PURPOSE
FLEXIBLE SPENDING ACCOUNT PLAN
(With Pre-Tax Insurance Premiums and
Health Savings Account Contributions)

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. U.S. Department of Labor (DOL) Technical Release 92-01 explains this 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 trust requirement applies and, if it does, complying with it.

UTICA COLLEGE

LIMITED PURPOSE
FLEXIBLE SPENDING ACCOUNT PLAN
(With Pre-Tax Insurance Premiums and
Health Savings Account Contributions)

PLAN DOCUMENT

SECTION 1
PRELIMINARY MATTERS

1.1 Form. The Utica College Limited-Purpose 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 other than Contributions to a Participant's Health Savings Account. The term "Account" does not refer to a Health Savings Account.

2.2 "Code" means the Internal Revenue Code of 1986, as amended.

2.3 "Committee" means the person or persons appointed by the Employer as members of the Committee to administer the Plan in accordance with Section 8 hereof.

2.4 "Contributions" means amounts a Participant contributes to or through the Plan for a Plan Year on a pre-tax basis (or, in the limited circumstances described in Sections 4.11(B) and 5.3(H), on an after-tax basis) and, if Qualified Benefits include Contributions to an Employee's Health Savings Account, amounts the Employer contributes to an Employee's Health Savings Account.

2.5 "Contribution Election" means an election by a Participant to have Contributions credited to his Account(s) in accordance with Section 5, or to have Contributions forwarded to his Health Savings Account in accordance with Section 6. An Employee's failure to affirmatively make such election shall be deemed an election to not have Contributions credited to any such Account or forwarded to his Health Savings Account, as the case may be.

2.6 "Coverage" means Group Coverage or Personal Coverage.

2.7 "Dental and Vision Care Expense Account" means an Account established for a Participant under the Plan for payment or reimbursement of Dental and Vision Care Expenses.

2.8 "Dental Care Expense" means an expense which: (i) is for "medical care" as that term is used for purposes of Section 105(b) of the Code (excluding non-prescription medicines, drugs and other expenses that are not allowable as a deduction under Section 213 of the Code); (ii) is for treatment of the mouth (as described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(A)); (iii) is incurred by a Participant for himself, his Spouse or his Dependent; and (iv) coverage for which is "permitted" coverage within the meaning of Section 223 of the Code. However, expenses for a medicine or drug shall be included in Dental Care Expenses covered by this Plan only if such medicine or drug is 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 Dental Care Expenses covered by this Plan) shall be determined in accordance with regulations and other guidance issued by the Internal Revenue Service.

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 Dental and Vision Care Expenses from a Participant's Dental and Vision Care Expense Account, "Dependent" means: (i) a person who is Participant's dependent (as determined for purposes of Section 105(b) of the Code) at the time the Dental or Vision 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 Dental or Vision 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 this 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 this 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; and (iv) if an election is made under the Code for the Employer to be a Subchapter S corporation, any 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 8 (Plan Administration) and Section 9 (Amendment and Termination of the Plan), "Employer" shall mean only the first Employer identified below.

Employer: Utica College

Address: 1600 Burrstone Road

Utica, New York 13502

Effective Date: 01/01/2010

Affiliated Employer: NA

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 "Group 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 and is "permitted" coverage or insurance within the meaning of Section 223 of the Code.

2.17 "Group Coverage" means Group Accidental Death and Dismemberment Coverage, Group Health Coverage, Group Life Coverage, Group Long-Term Disability Coverage, and/or Group Short-Term Disability Coverage.

2.18 "Group Dental Coverage" means group coverage: (i) maintained for Employees by the Employer under a separate plan, program, insurance policy or contract; (ii) which satisfies the requirements of Sections 105 and 106 of the Code; (iii) substantially all of which is for treatment of the mouth (as described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(A)); and (iii) is "permitted" coverage within the meaning of Section 223 of the Code.

2.19 "Group Health Coverage" means Group Dental Coverage, Group High Deductible Medical Coverage, and/or Group Vision Coverage.

2.20 "Group High Deductible Medical Coverage" means group medical coverage maintained for Employees by the Employer under a separate plan, program, insurance policy or contract, is described in Section 213 of the Code (except long-term care insurance), satisfies the requirements of Sections 105 and 106 of the Code and is a high deductible health plan as described in Section 223 of the Code.

2.21 "Group Life Coverage" means group term life insurance coverage maintained for Employees by the Employer under a separate plan, program, group insurance policy or contract, or set of individual insurance policies or contracts, satisfying the group term life insurance requirements of Section 79 of the Code.

2.22 "Group 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.

2.23 "Group 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.

2.24 "Group Vision Coverage" means group coverage: (i) maintained for Employees by the Employer under a separate plan, program, insurance policy or contract; (ii) which satisfies the requirements of Sections 105 and 106 of the Code; (iii)

substantially all of which is for treatment of the eye (as described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(B)); and (iii) is "permitted" coverage within the meaning of Section 223 of the Code.

2.25 "Health Savings Account" means an account: (i) the tax treatment of which is governed by Section 223 of the Code; (ii) used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Section 223(d)(2) of the Code; (iii) maintained outside the Plan by a trustee or custodian; and (iv) to which the Employer may forward Contributions in accordance with Section 6.

2.26 "Highly Compensated Individual" means a highly compensated individual within the meaning of Section 125 of the Code.

2.27 "Key Employee" means a person who is a key employee within the meaning of Section 416 of the Code.

2.28 "Participant" means an Employee who meets the requirements for participation specified in Section 3.

2.29 "Personal Accident Coverage" means personal accident insurance coverage provided under an individual policy owned by a Participant and issued by **,** and which satisfies the requirements of Section 106 of the Code and is "permitted" coverage or insurance within the meaning of Section 223 of the Code.

2.30 "Personal Cancer Coverage" means personal cancer coverage provided under an individual policy owned by a Participant and issued by , and which satisfies the requirements of Section 106 of the Code and is "permitted" coverage or insurance within the meaning of Section 223 of the Code.

2.31 "Personal Coverage" means Personal Accident Coverage, Personal Cancer Coverage, Personal Dental Coverage, Personal Hospital Indemnity Coverage, and/or Personal Vision Coverage.

2.32 "Personal Dental Coverage" means personal coverage: (i) provided under an individual policy owned by a Participant and issued by for medical care; (ii) substantially all of which is for treatment of the mouth (as described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(A)); (iii) which satisfies the requirements of Section 106 of the Code; and (iv) is "permitted" coverage or insurance within the meaning of Section 223 of the Code.

2.33 "Personal Health Coverage" means Personal Cancer Coverage, Personal Dental Coverage, Personal Hospital Indemnity Coverage and/or Personal Vision Coverage.

2.34 "Personal Hospital Indemnity Coverage" means personal hospital indemnity coverage provided under an individual policy owned by a Participant and issued by , and which satisfies the requirements of Section 106 of the Code and is "permitted" coverage or insurance within the meaning of Section 223 of the Code.

2.35 "Personal Vision Coverage" means personal coverage: (i) provided under an individual policy owned by a Participant and issued by for medical care; (ii) substantially all of which is for treatment of the eye (as described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(B)); (iii) which satisfies the requirements of Section 106 of the Code; and (iv) is "permitted" coverage or insurance within the meaning of Section 223 of the Code.

2.36 "Plan" means this Limited Purpose Flexible Spending Account Plan as set forth in this document and as amended from time to time.

2.37 "Plan Administrator" means the Employer or other person(s) appointed by the Employer to serve as Plan Administrator in accordance with Section 8 hereof.

2.38 "Plan Year" means:

each 12-consecutive month period beginning January 1 and ending the following December 31.

However, if the Employer terminates this Plan pursuant to Section 9, the last Plan Year shall end on the effective date of termination. If an Affiliated Employer discontinues its participation in this Plan, Participants who are Employees of the Affiliated Employer shall be treated as having participated in this Plan for a short Plan Year ending on the effective date of such discontinuation.

2.39 "Premium" means the premium, or portion thereof, that a Participant is required to pay for any Coverage indicated in Section 2.40(A). (For purposes of the Plan, "Premium" includes a Participant's cost for any such Group Coverage that is self-insured by the Employer.)

2.40 "Qualified Benefit" means:

X (A) payment of Premiums for any of the Coverage indicated below:

- X Group Accidental Death and Dismemberment Coverage
- X Group Dental Coverage
- X Group High Deductible Medical Coverage
- ____ Group Life Coverage
- ____ Group Long-Term Disability Coverage

____ Group Short-Term Disability Coverage

_X_ Group Vision Coverage

____ Personal Accident Coverage

____ Personal Cancer Coverage

____ Personal Dental Coverage

____ Personal Hospital Indemnity Coverage

____ Personal Vision Coverage

_X_ (B) payment or reimbursement from a Participant's:

_X_ Dental and Vision Care Expense Account for Dental and Vision Care Expenses incurred during a Plan Year not payable or reimbursable, under insurance or any other health plan coverage; provided, however, that if such a Dental or Vision Care Expense is eligible for reimbursement under both this Plan and a participant's Health Savings Account, the participant can seek payment or reimbursement from either this Plan or the Health Savings Account, but not both.

_X_ Dependent Care Expense Account for Dependent Care Expenses incurred during a Plan Year not payable or reimbursable, from any other source.

_X_ (C) Contributions to a Participant's Health Savings Account.

2.41 "Qualifying Individual" means a qualifying individual as defined for purposes of Section 21(b) of the Code.

2.42 "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.

2.43 "Statutory Leave" means an unpaid leave of absence under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act.

2.44 "Vision Care Expense" means an expense which: (i) constitutes "medical care" as that term is used for purposes of Section 105(b) of the Code (excluding non-prescription medicines, drugs and other expenses that are not allowable as a deduction under Section 213 of the Code); (ii) is for treatment of the eye (as

described in Treas. Reg. Section 54.9831-1(c)(3)(iii)(B)); (iii) iv) is incurred by a Participant for himself, his Spouse or his Dependent; and (iv) coverage for which is "permitted" coverage within the meaning of Section 223 of the Code. However, expenses for a medicine or drug shall be included in Vision Care Expenses covered by this Plan only if such medicine or drug is 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 Vision Care Expenses covered by this Plan) shall be determined in accordance with regulations and other guidance issued by the Internal Revenue Service.

SECTION 3
PARTICIPATION

3.1 Eligibility and Participation Date.

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

X	Group Accidental Death and Dismemberment Coverage
X	Group Dental Coverage
X	Group High Deductible Medical Coverage
	Group Life Coverage
	Group Long-Term Disability Coverage
	Group Short-Term Disability Coverage
X	Group Vision Coverage
	Personal Coverage
X	Dental and Vision Care Expenses
X	Dependent Care Expenses
X	a Health Savings Account

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 the 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 TO AND BENEFITS FROM ACCOUNTS
(NOT APPLICABLE TO HEALTH SAVINGS ACCOUNT CONTRIBUTIONS)

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 Group Coverage indicated below, shall receive additional cash compensation for:

____ Accidental Death and Dismemberment Coverage

____ Dental Coverage

_X_ High Deductible Medical Coverage

____ Life Insurance Coverage

____ Long-Term Disability 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 the Plan, the maximum amount of pre-tax Contributions a Participant can elect to make for any Plan Year for his Dental and Vision Care Expense Account shall not exceed $2,500.00 (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 Premiums, and Dental, Vision and Dependent Care Expenses. Payment of Premiums shall be made automatically by the Employer. No Participant shall be entitled to payment or reimbursement for Dental or Vision 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 Dental and Vision 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 Dental or Vision 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 Dental, Vision 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 Dental, Vision or Dependent Care Expense has not been reimbursed, and is not reimbursable, from any other source. The amount credited to a Participant's Dental and Vision Care Expense Account and Dependent Care Expense Account shall be reduced by the amount paid from such Accounts.

Notwithstanding the above, Dental and Vision Care Expenses and Dependent Care Expenses may be automatically paid and processed using a "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 a Dental, Vision or Dependent Care Expense paid via a debit 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 8.10.

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; provided, however, the amount available for payment or reimbursement for Dental and Vision Care Expenses incurred during a Plan Year shall equal the amount of his Contribution Election for his Dental and Vision Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Dental or Vision Care Expenses incurred during the Plan Year.

4.6 Cessation of Contributions. If Contributions to a Participant's Dental and Vision Care Expense or Dependent Care Expense Account cease during a Plan Year, he may submit claims only for payment or reimbursement of Dental and Vision 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 Dental, Vision and Dependent Care Expenses) 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 Dental, Vision and Dependent 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 Dental, Vision 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 Dental and Vision Expense Account Carry Over. Any Contributions that remain credited to a Participant's Dental and Vision Expense Account as of the end of any Plan Year (after payment of all timely and valid claims) shall be carried over into his Dental and Vision Expense Account for the following Plan Year (and shall be available for payment or reimbursement of Dental and Vision 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 Dental and Vision 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 not 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 under this Plan 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 the amount of 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 Dental, Vision 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 Dental and Vision 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 Dental and Vision 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 Dental and Vision Expenses shall equal the amount of his Contribution Election for his Dental and Vision Care Expense Account for the Plan Year, less the amount already paid or reimbursed from such Account for Dental and Vision 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 Dental and Vision 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 Dental and Vision 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 Dental and Vision 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 8.10.

4.15 Changes in Premiums. The Employer or Committee shall provide advance written notice to each Participant of 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.

4.17 Section Not Applicable to HSA Contributions. None of the provisions of this Section 4 shall apply to Contributions to Health Savings Accounts.

SECTION 5
ELECTION PROCEDURES FOR ACCOUNT CONTRIBUTIONS
(NOT APPLICABLE TO HEALTH SAVINGS ACCOUNT CONTRIBUTIONS)

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 Group Premiums shall automatically be paid through Contributions to this 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 make such Contributions.

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 Group Health 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 Group Health Coverage Premiums to pay for the continuation coverage.

C) Court Judgment, Decree or Order. A Participant's Contribution Election for Group Health Coverage Premiums or Personal Health Coverage Premiums may be increased to pay for a Dependent child's or foster child's Group Health Coverage or Personal Health 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 Group Health Coverage Premiums or Personal Health Coverage Premiums if such judgment, decree or order requires someone else to provide such Coverage for such child. A Participant's Contribution Election for his Dental and Vision 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 Group Health 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 Group Health 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 Dental and Vision 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 Group Health 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 Dental, Vision 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' Group Coverage Premiums change during a Plan Year, there shall be an automatic corresponding change to the Participants' Contributions for such Premiums. Similarly, if a Participant's Personal Coverage Premiums are unilaterally changed by the insurer (and not due to any action on the part of the Participant) there shall be an automatic corresponding change to the Participant's Contributions for such Premiums. Notwithstanding the above, if there is a significant increase in the Premium for a Group Coverage option, an affected Participant may revoke his election of that option and elect another option providing similar Group 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 Section 152(a) of the Code.

K) Significant Curtailment or Cessation of Coverage. If there is a significant curtailment in or cessation of Participants' Group Coverage, an affected Participant may revoke the election of that Group Coverage and may elect another option providing similar Group Coverage (if available) with a corresponding change to the Contribution Election for the Group Coverage Premiums; provided, however, any curtailment of Group Health Coverage must constitute reduced Coverage for Participants generally.

L) Change in Coverage Options. If a Group Coverage option is added, the Contribution Election for the Group Coverage Premium for a Participant who elects the new Group Coverage option shall be changed to correspond

to the Participant's Premium for that Group Coverage. If a Group 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 Group Coverage.

M) Change in Coverage under Other Employer's Plan. A Participant may change his Contribution Elections (other than his Contribution for his Dental and Vision Care Expense Account or for Personal Coverage Premiums) 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 a 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 Group Health Coverage 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 group high deductible medical coverage, and his Contribution Election for group high deductible 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 group high deductible medical coverage); (ii) he represents to the Employer or Committee that he, and related individuals who cease group high deductible 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 group high deductible 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 group high deductible medical coverage, and his Contribution Election for group high deductible 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 group high deductible 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 Dental and Vision Care Expense Account during a Plan Year may not reduce his elected amount below the amount of Dental and Vision Care Expenses submitted for reimbursement during the Plan Year.

5.5 Section Not Applicable to HSA Contributions. None of the provisions of this Section 5 shall apply to Contributions to Health Savings Accounts.

SECTION 6
CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS

6.1 Employee's Eligibility to Make Contributions Elections. Subject to Sections 6.2 and 6.4 below, an Employee who satisfies the eligibility requirements of Section 3 and has Group High Deductible Medical Coverage may elect to have a portion of his compensation forwarded by the Employer as Contributions to his Health Savings Account, provided the Employee certifies to the Employer, and the Committee reasonably believes, the Employee satisfies all tax requirements to make such Contributions. The Committee shall provide an election form to each

such Employee which must be completed and filed with the Committee on or before the date specified by the Committee, must indicate the Contributions to be forwarded to the Employee's Health Savings Account, and must contain sufficient identifying information about the Employee's Health Savings Account to facilitate forwarding of his Contributions to his Health Savings Account trustee or custodian. An Employee's failure to submit an election form by the date specified by the Committee shall be deemed an election to not make any Contributions to a Health Savings Account. Changes to Contribution Elections (i.e., increases, decreases or revocations) shall be effective (and shall apply to compensation that would otherwise be paid) no earlier than the first day of the calendar month following the date the Contribution Election (or changed Contribution Election) is filed. An Employee's Contributions to his Health Savings Account shall cease when he ceases to satisfy the eligibility requirements in Section 3 or this Section 6.

The Employer shall forward an Employee's Contributions to his Health Savings Account trustee or custodian within a reasonable time after the pay period from which they are made, but not later than the date prescribed by applicable tax laws and regulations.

An Employee's Contributions to his Health Savings Accounts shall be made through equal payroll reductions. The amount of reduction for each pay period shall be the Employee's Contribution Election for the Plan Year (or remainder of the Plan Year) divided by the number of pay periods in the Plan Year (or remainder of the Plan Year).

6.2 Prohibition on Contribution Elections in Certain Months. Notwithstanding Section 6.1 above:

(A) an Employee may elect to have his compensation for a calendar month reduced for Contributions to his Health Savings Account only if as of the first day of that month he: (i) has Group High Deductible Medical Coverage; and (ii) is not covered under another cafeteria plan (as defined in Section 125 of the Code) maintained by the Employer; and

(B) an Employee may not elect to have his compensation reduced for Contributions to his Health Savings Account for any calendar month (or portion thereof) which is part of a "grace period" (as described in IRS Notice 2005-42) under a cafeteria plan (as described in Section 125 of the Code) maintained by the Employer if the Employee had a health flexible spending account (as described in IRS Revenue Ruling 2004-45) under that cafeteria plan during the plan year preceding the grace period, unless: (i) such health flexible spending account provided only "permitted" dental, vision or preventive care coverage (within the meaning of Section 223 of

the Code); or (ii) he had no balance remaining in such health flexible spending account as of the last day of the plan year preceding the grace period (disregarding any claims incurred as of that day but not yet submitted, or not yet paid or reimbursed).

6.3 Employer Contributions. Subject to Section 6.3(D), the Employer shall make Contributions to Employees' Health Savings Accounts for each calendar quarter in accordance with this Section 6.3.

(A) Employer Contributions to an Employee's Health Savings account shall be made on or as soon as practical after the first day of each calendar quarter ("Quarterly Contribution Dates") if the Employee is eligible to make Contributions to his Health Savings Account for the month in which the Quarterly Contribution Date occurs (whether or not he actually makes any such Contributions), but in no event later than the date prescribed by applicable tax laws and regulations. The Employer's Contribution with respect to each Quarterly Contribution Date shall equal an amount based on the level of the Employee's Group High Deductible Medical Coverage in effect as of that Quarterly Contribution Date and in accordance with the following schedule:

GROUP HIGH DEDUCTIBLE MEDICAL COVERAGE	JANUARY 1ST CONTRIBUTION DATE	APRIL 1ST CONTRIBUTION DATE	JULY 1ST CONTRIBUTION DATE	OCTOBER 1ST CONTRIBUTION DATE
ONE PERSON (EMPLOYEE ONLY	**$720.00**	**$240.00**	**$240.00**	**$240.00**
TWO PERSONS (EMPLOYEE, SPOUSE OR ONE DEPENDENT	**$1,440.00**	**$480.00**	**$480.00**	**$480.00**
FAMILY (EMPLOYEE, SPOUSE + DEPENDENTS	**$1,440.00**	**$480.00**	**$480.00**	**$480.00**

(B) If an Employee first becomes eligible to make Contributions to his Health Savings Account for a month which does not begin on a Quarterly Contribution Date, the Employer shall make a Contribution to his Health Savings Account on or as soon as practical after the first day of the month the Employee first becomes eligible to make such Contributions, but in no event later than the date prescribed by applicable tax laws and regulations. This Employer Contribution shall equal a portion of the Contribution the Employer would have made on the preceding Quarterly Employer Contribution Date if: (i) the Employee had been eligible to make

Contributions to his Health Savings Account for the month in which the preceding Quarterly Contribution Date occurred; and (ii) the Employee had the same level of Group High Deductible Medical Coverage in effect for that month as he when did he first became eligible to make such Contributions. Such portion shall be determined by multiplying the full Employer Contribution described in the preceding sentence by a fraction. The denominator of the fraction shall be three (3), and the numerator of the fraction shall be the number of months between the first month the Employee became eligible to make Contributions to his Health Savings Account and the next Quarterly Contribution Date. Thereafter, any Employer Contributions to his Health Savings Account shall be made and determined in accordance with Subsection (A) above.

(C) Prior to the beginning of each Plan Year, the Employer shall provide written notice to Participants of any changes to the amount of the quarterly Contribution the Employer shall make pursuant to this Section 6.3.

(D) All Employer Contributions made to an Employee's Health Savings Account in accordance with this Section 6.3 shall be conditioned upon the Employee providing to the Employer sufficient identifying information about the Employee's Health Savings Account to facilitate the forwarding such Contributions to his Health Savings Account trustee or custodian.

6.4 Maximum Amount of Contributions. The Employer shall cease Contributions to an Employee's Health Savings Account for a calendar year, and take any other corrective action required under the Code and applicable Internal Revenue Service guidance, if the Employer becomes aware that the total Contributions to the Employee's Health Savings Account for such calendar year exceeds (or otherwise will exceed) the maximum Health Savings Account contribution under Section 223(b)(2)(A) of the Code based on the Employee's High Deductible Medical Coverage (i.e., single or family) and reduced on a proportional basis for the number of months less than twelve (12) that he does not satisfy the eligibility requirements under the Code for contributions to his Health Savings Account; provided, however, that an Employee age 55 or older and who satisfies such requirements may make additional "catch-up" Contributions as permitted under Section 223(b)(3) of the Code if he certifies to the Employer that he has attained age 55.

6.5 Status of Health Savings Accounts. A Health Savings Account is not an employer-sponsored employee benefit plan, and neither the Employer nor the Plan Administrator shall have any authority or control over the funds deposited in any Health Savings Account. Each Health Savings Account shall be an individual trust or custodial account separately established and maintained by a trustee or

custodian (not the Employer or Plan Administrator) outside the Plan. The Health Savings Account trustee or custodian shall be chosen by the Participant (not the Employer or Plan Administrator). Although the Employer or Plan Administrator may limit the number of Health Savings Account providers to whom it will forward Contributions, they shall not endorse any Health Savings Account trustee or custodian. The Employer or Plan Administrator will maintain records of each Employee's Health Savings Account Contributions, but neither the Employer nor the Plan Administrator shall create a separate fund or otherwise segregate assets for this purpose. All terms and conditions of Health Savings Account coverage and benefits (e.g., eligible medical expenses, claims, procedures, etc.) will be provided by and are set forth in documents creating or related to the Health Savings Account, which are not part of this Plan.

6.6 Section Applicable Only to Health Savings Account Contributions. The provisions of this Section 6 shall apply only to Contributions to Health Savings Accounts.

SECTION 7
NONDISCRIMINATION REQUIREMENTS

7.1 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.

7.2 Aggregation with Other Plans. For purposes of the applicable Code nondiscrimination requirements, this Plan and the Utica College Flexible Spending Account shall be considered a single plan.

SECTION 8
PLAN ADMINISTRATION

8.1 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 this 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.

8.2 Powers. The Committee has full authority and responsibility to control and manage the operation and administration of this Plan. The Committee shall have

the exclusive right to interpret this Plan (but not to modify or amend this Plan) and to decide any and all questions arising in the administration, interpretation, and application of this Plan. The Committee shall establish whatever rules it finds necessary for the operation and administration of this 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 this Plan shall be conclusive and binding upon the Employer and all persons having or claiming to have any right or interest in or under this Plan.

8.3 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.

8.4 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 this 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.

8.5 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.

8.6 Expenses. No Committee member shall receive any compensation for his services, but the Employer may reimburse a Committee member for any necessary expenses incurred.

8.7 Records. The Committee shall maintain records showing the fiscal transactions of this Plan.

8.8 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.

8.9 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.

8.10 Claims Procedures. Qualified Benefits shall be paid in accordance with the terms of this Plan. A Participant who disagrees with a decision concerning his right to participate in this 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 a Dental or Vision Care Expense 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 this 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 9
AMENDMENT AND TERMINATION OF THE PLAN

9.1 Amendment. The Employer may amend this 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 this Plan with respect to the payment of Premiums, or Dental, Vision or Dependent Care Expenses incurred prior to the effective date of the amendment.

9.2 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 this 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 this Plan shall not affect the rights of Participants under this Plan with respect to the payment of Premiums, or Dental, Vision or Dependent Care Expenses incurred prior to the effective date of the termination.

SECTION 10
HIPAA PRIVACY RULES

10.1 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 the 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:

(i) 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

(ii) 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.

10.2 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.

10.3 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.

10.4 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.

10.5 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 the Plan;

D) 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;

E) 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.

10.6 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.

10.7 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 11
MISCELLANEOUS

11.1 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.

11.2 No Compensation for Other Purposes. Qualified Benefits paid under the terms of the 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.

11.3 Tax Effects. Neither the Employer, Plan Administrator nor the Committee makes any warranty or other representations as to whether any Plan 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.

11.4 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.

11.5 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.

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

11.7 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 this Limited Purpose Flexible Spending Account Plan as stated herein.

Utica College
(Employer Name)

By: Linda Madore

Title: Director of Human Resources

Date: December 12, 2016

UTICA COLLEGE

LIMITED PURPOSE
FLEXIBLE SPENDING ACCOUNT PLAN
(With Pre-Tax Insurance Premiums and Health Savings Account Contributions)

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. U.S. Department of Labor (DOL) Technical Release 92-01 explains this 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 trust requirement applies and, if it does, complying with it.

UTICA COLLEGE

LIMITED PURPOSE
FLEXIBLE SPENDING ACCOUNT PLAN
(With Pre-Tax Insurance Premiums and
Health Savings Account Contributions)

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 Limited Purpose Flexible Spending Account
Plan Number:	511
Plan Type:	Cafeteria (Section 125) Plan
Plan Year:	The Plan Year begins on January 1 and ends on December 31
Employer and Plan Sponsor:	Utica College 1600 Burrstone Road Utica, New York 13502 (315) 792-3276
Employer Identification Number:	16-1476258
Plan Administrator:	Utica College 1600 Burrstone Road Utica, New York 13502 (315) 792-3276
Type of Plan Administration:	The Plan is administered by the Employer through a Committee appointed by the Employer. All benefits are paid from the general assets of the Employer. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the amount of Employer and participant contributions. 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. The contributions will be credited to an account that can be used only for dependent care expenses.

- dental and vision expenses (other than insurance premiums) that would otherwise be deductible on your federal income tax return if they were not paid or reimbursed under the Plan (but without regard to any minimum amount of expenses required to take a deduction), 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. Dental and vision care expenses also include the cost of over-the-counter medicines and drugs provided, the over-the-counter medicine or drug 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. Dental and vision 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 dental and vision care expenses. The contributions will be credited to an account that can be used only for dental or vision 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 dental and vision care expenses for any Plan Year is $2,500.00. 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
- high deductible 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:

- high deductible 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 are subject to income tax and Social Security taxes, and are reported as taxable income on his W-2 form.

Finally, if you are enrolled in group high deductible medical coverage sponsored by the Employer, you may be able to make pre-tax contributions through the Plan to your "health savings account" or "HSA" and the Employer may make additional contributions to your HSA. However, it is important that you keep in

mind that to be eligible for HSA contributions you must also satisfy certain requirements under tax law. For example, you must not have any other health coverage, except for certain "permitted" coverage, and must not be claimed as a dependent on someone else's federal tax return or be entitled to Medicare. There can be negative tax consequences if contributions are made to your HSA when you do not satisfy the HSA eligibility requirements, and the HSA eligibility rules and the limits on HSA contributions can be complicated. ***The Employer is not responsible for determining whether you are eligible for HSA contributions or the maximum contribution that can be made to your HSA. You should contact your own tax advisor to make certain you understand all HSA rules and requirements***.

SEE QUESTIONS AND ANSWERS 10 THROUGH 14 FOR REQUIREMENTS TO MAKE HSA CONTRIBUTIONS AND SPECIAL RULES REGARDING THE TIMING AND MAXIMUM AMOUNT OF HSA CONTRIBUTIONS.

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); and (ii) 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.

An employee is eligible to participate in the Plan and make contributions for the following -

- dependent care expenses
- dental and vision care expenses
- group accidental death and dismemberment coverage premiums
- group dental coverage premiums
- group high deductible medical coverage premiums
- group vision coverage premiums

- health savings account contributions

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?

An eligible employee's group coverage premiums are automatically paid through the Plan, unless the employee elects otherwise in a signed writing filed with the Committee by the date specified by the Committee. If an employee files this election, he will not be able to pay group coverage premiums through the Plan until the next Plan Year, unless a change in status occurs that allows him to change his election (see Question & Answer 4). Before an eligible employee can pay individual policy premiums through the Plan or make contributions to the Plan for other expenses, he must complete and file an enrollment/election form by the date specified by the Committee. Failure to complete and return the form by that date will be considered an election not to pay individual policy premiums through the Plan or make contributions to the Plan for other expenses. In that case, the employee will not be able to pay individual policy premiums through the Plan or make contributions to the Plan for other expenses until the next Plan Year, unless a change in status occurs that allows him to change his election (For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.)

SEE QUESTIONS AND ANSWERS 10 AND 11 FOR REQUIREMENTS TO MAKE HSA CONTRIBUTIONS AND SPECIAL RULES REGARDING THE TIMING AND MAXIMUM AMOUNT OF HSA CONTRIBUTIONS.

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

There are special rules for changes to an election for HSA contributions. Those rules are discussed in the Answer to Question 12. You can change your other elections before the beginning of each new Plan Year and, once the Plan Year has started, federal tax laws permit you to change your other elections only when one of the following "changes in status" occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 and individual health coverage premium elections and dental and vision 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 premium for group coverage increases significantly or the insurer unilaterally increases your premium for your individual insurance coverage (not due to any action on your part). (However, if there is an ordinary increase or decrease in premiums, your contributions will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- There is a significant curtailment in, or cessation of, group coverage for employees generally. Note, that a significant curtailment in, or cessation

of, your group coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

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

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

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

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

- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for group coverage at the new place of residence. Note, 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.

- 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.

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

- 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 group high deductible 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 group high deductible medical coverage is revoked. (This applies only to a prospective revocation of a Contribution election to pay for group high deductible medical coverage through the Plan (even if the change does not result in you ceasing to be eligible for group high deductible 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 group high deductible medical coverage. This applies only to a prospective revocation of a Contribution election to pay for group high deductible medical coverage through the Plan.)

Note that an election change must be made within 30 days of an event described above, and must conform to and be consistent with that event. Also, even if you are allowed to change your dental and vision care expense reimbursement election, you may not reduce the annual contribution elected to less than the amount of dental and vision 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. The 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 19.

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 dental and vision care expenses paid or reimbursed cannot exceed the amount of your dental and vision 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 dental and vision 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 dental and vision 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 dental and vision 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 not 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 20.)

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, an unpaid leave, and a leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act is a change in status, so you may change your elections as explained in Question and Answer 4. Also, see

Question and Answer 20 for special rules applicable to a leave under the Family and Medical Leave Act.

9. What is an HSA?

An HSA is an individual trust or custodial account that you establish with a trustee or custodian (which you choose) and is used primarily to reimburse you for reimbursement "eligible medical expenses." It is not an employer-sponsored employee benefit plan, and the Employer has no authority or control over the funds deposited in your HSA. An HSA is administered by the HSA trustee or custodian, and the Employer's role, if any, is limited to forwarding contributions to your HSA through this Plan if you satisfy the eligibility requirements described in the Answers to Questions 10 & 11. All terms and conditions of HSA coverage and benefits (e.g., eligible medical expenses, claims, procedures, etc.) should be set forth in documents provided by the HSA trustee or custodian. Those documents are not part of this Plan.

10. Can I make HSA contributions?

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

11. Who can make HSA contributions through the Plan?

An employee who is eligible to pay premiums through the Plan for high deductible medical coverage sponsored by the Employer (see Question and Answer 2) and has that coverage may elect to have a portion of his compensation forwarded by the Employer as contributions to his HSA, provided he certifies to the Employer, and the Committee reasonably believes, the employee satisfies all of the tax requirements to make HSA contributions.

12. How does an employee elect to make HSA contributions?

The Committee will provide an election form to each employee who provides this certification and who the Committee reasonably believes satisfies all of the requirements to make HSA contributions. The form must be completed and filed with the Committee on or before the date specified by the Committee, must

indicate the contributions to be forwarded to the employee's HSA, and must contain sufficient identifying information about the employee's HSA to facilitate the forwarding of his contributions to the HSA trustee or custodian. An employee's failure to submit election form(s) by the date specified by the Committee will be deemed an election to not make any contributions to his HSA.

HSA contribution elections and changes to HSA contributions elections (i.e., increases, decreases or revocations) will be effective (and apply to compensation that would otherwise be paid) no earlier than the first day of the calendar month following the date the election form (or changed election form) is filed. An employee's contributions to his HSA will stop when he no longer satisfies the eligibility requirements referenced in the Answer to Question 10 or he is no longer eligible to pay premiums through the Plan for group high deductible medical coverage sponsored by the Employer (see the Answer to Question 2). In addition, the following rules also apply to HSA contribution elections:

- An employee may elect to have his compensation for a calendar month reduced for HSA contributions only if he has group high deductible medical coverage sponsored by the Employer as of the first day of that month.

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

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

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

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

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

Yes. If you are eligible to make HSA contributions to your HSA for the month of January, April, July or October, the Employer will make contributions to your HSA on or as soon as practical after the first day of that month (the "Quarterly Contribution Date"), provided you furnish the Employer with information sufficient to facilitate the forwarding of these contributions to your HSA trustee or custodian. The amount of the contribution for each Quarterly Contribution Date will equal an amount based on the level of your group high deductible medical coverage in effect as of that month and in accordance with the following table:

GROUP HIGH DEDUCTIBLE MEDICAL COVERAGE	JANUARY 1ST CONTRIBUTION DATE	APRIL 1ST CONTRIBUTION DATE	JULY 1ST CONTRIBUTION DATE	DECEMBER 1ST CONTRIBUTION DATE
ONE PERSON (EMPLOYEE ONLY	$720.00	$240.00	$240.00	$240.00
TWO PERSONS (EMPLOYEE, SPOUSE OR ONE DEPENDENT	$1,440.00	$480.00	$480.00	$480.00
FAMILY (EMPLOYEE, SPOUSE + DEPENDENTS	$1,440.00	$480.00	$480.00	$480.00

If you first become eligible to make HSA contributions to your HSA for any month other than January 1st, April 1st, July 1st and October 1st, the Employer will make a contribution to your HSA on or as soon as practical after the first day of the month you become eligible to make HSA contributions, provided you furnish the Employer with information sufficient to facilitate the forwarding of these contributions to your HSA trustee or custodian. The amount of this contribution will equal a portion of the contribution the Employer would have made the preceding if you had been eligible to make HSA contributions for the month in which the preceding Quarterly Contribution Date occurred and you had the same group high deductible medical coverage in effect for that month as you did when you first became eligible to make HSA contributions. The portion is determined by multiplying the full Employer contribution for that preceding Quarterly Contribution Date by a fraction. The denominator of the fraction is three (3), and

the numerator of the fraction is the number of months between the first month you became eligible to make HSA contributions and the next Quarterly Contribution Date. Thereafter, any Employer contributions to your HSA will be determined and made as described in the first paragraph in the Answer to this Question. Thereafter, any Employer contributions to your HSA will be determined and made quarterly, as described in the first paragraph in the Answer to this Question.

Prior to the beginning of each Plan Year, the Employer will provide written notice to participants of any changes to the amount of Employer HSA contributions.

Notwithstanding the above, the Employer may stop or reduce the amount of contributions it makes to your HSA if the Employer becomes aware that the total contributions made (or that would otherwise be made) to your HSA exceed (or will exceed) the maximum contribution permitted under federal tax law for a calendar year.

14. Are there circumstances where the Employer can stop HSA contributions?

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

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

15. What tax rules apply to HSAs?

The tax rules that apply to HSA contributions and distributions are very different

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

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

16. 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.

17. 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 19.

18. 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.

19. 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 dental or vision care expense or is any other type of claim. If any part of the claim is denied, the Committee will provide you with a written notice, within 30 days after the receipt of a dental or vision expense claim or 90 days after the receipt of any other type of claim. However, if an extension is necessary due to reasons beyond the Committee's control, the time to make the determination may be extended for up to another 15 days for a dental or vision expense claim or 90 days for any other type of claim. (If an extension for a dental or vision expense claim is necessary because additional information is needed from you, then you will be given 45 days from the date you receive the notice to provide the information.) In any case, you will receive written notice of the reasons for the extension, any additional information required for the Committee to make the determination, and the date the determination is expected.

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

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

If a claim is denied and you want a review, you must notify the Committee in writing within 180 days after you receive the written notice of denial of dental or vision expense claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) a statement that you have a right to sue under the Employee Retirement Income Security Act; and (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 dental or vision expense claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a dental or vision expense claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

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

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

COBRA Continuation Coverage

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

What is COBRA Continuation Coverage?

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

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

(1) Your hours of employment are reduced; or
(2) Your employment ends for any reason other than your gross misconduct.

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: 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 dental or vision care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Plan for the remainder of that Plan Year.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from 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 dental and vision 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.