Daemen College Employee Health and Welfare Plan

Wrap Plan Document and Summary Plan Description

June 1, 2020

INTRODUCTION

Daemen College (the "Company") provides group insurance benefits for eligible employees of the Company and certain affiliated employers, and their eligible family members, under the Daemen College Employee Health and Welfare Plan (the "Plan"). This is a restatement of the Plan, effective November 4, 2020.

This document, together with the insurance contracts, subscriber contracts, coverage certificates, booklets and other documents provided by the insurance companies, HMOs and third party administrators – which are sometimes called simply "Insurance Company Documents" in this document – in addition to separate benefit specific Program summaries, the annual open enrollment materials provided each year, and similar documents used to provide and describe the Plan's benefits constitutes the summary plan description of the Plan as in effect as of [TBD], 2020. **The Insurance Company Documents for the Plan contain important information particular to the program that is not in this document, and are available free of charge upon request.**

This document, together with the Insurance Company Documents, is also the plan document for the Plan for purposes of Section 402 of the Employee Retirement Income Security Act of 1974 ("ERISA"). All insured benefits under the Plan are provided by the insurance companies and HMOs in accordance with the insurance contracts, subscriber contracts or coverage certificates they issue to the Company or to Plan Participants. **The Company does not guarantee any of the insured benefits under the Plan.**

ADOPTION

The Company hereby adopts this restatement of the Plan effective June 1, 2020.

Daemen College

By: _____
Robert E. Rood, Vice President for Business Affairs & Treasurer

Date: November 4, 2020

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BASIC PLAN INFORMATION

Plan	Daemen College Employee Health and Welfare Plan
Component Plan Numbers	501 (*Daemen College Health Insurance Plan*, which includes Medical, Prescription Drugs, Business Travel Accident, Dental, Voluntary Vision, and Health Flexible Spending Account) 503 (*Daemen College Long-Term Disability Plan*, which includes Voluntary Term Life Insurance, Short Term Disability (NYS DBL) and Long Term Disability Insurance)
Plan Sponsor	Daemen College
Employer ID Number	16-0759798
Participating Affiliated Employers	N/A
Plan Administrator	Director of Employee Engagement Daemen College 4380 Main Street Amherst, NY 14226
Type of Administration	As Plan Administrator, the Company has the responsibility and discretionary authority to administer and interpret the Plan, other than those provisions of the Plan described below over which the insurance companies and HMOs that provide benefits under the Plan have responsibility and discretionary authority. For example, the Company has discretionary authority to interpret the Plan to determine the eligibility of Employees to participate in the Plan. All decisions of the Company under the Plan will be final and binding on all affected parties. The Company may delegate some or all of its responsibilities and authority with respect to the Plan. The insurance companies and HMOs that provide insured benefits under the Plan have the responsibility and discretionary authority to interpret their insurance contracts, subscriber contracts, coverage certificates and other relevant documents with respect to the processing and appeal of claims for benefits, including determining the amount of and entitlement to benefits under the relevant insurance contracts, subscriber contracts or coverage certificates.

Agent for Service of Legal Process	Director of Employee Engagement Daemen College 4380 Main Street Amherst, NY 14226
Amendment or Termination of the Group Health Plan	**The Company reserves the right to change or terminate coverage under the Plan at any time.** If the Plan is terminated, you will have no further rights to the type of benefits formerly provided under the Plan.
Plan Year	The plan year for the Daemen College Health Insurance Plan (Plan 501) begins June 1st and ends May 31st. The plan year for the Daemen College Long-Term Disability Plan (Plan 503) begins on January 1st and ends on December 31st.

MEANING OF CERTAIN IMPORTANT TERMS

When capitalized and used in this document, these terms have the following meanings:

Claims Administrator – the company, committee or person designated by the Plan Administrator to administer claims under the Plan. The Claims Administrator (if any) for each Program is identified in Exhibit A.

Code – the Internal Revenue Code, as amended from time to time.

Company – Daemen College

Coverage Option – A health or welfare insurance Coverage Option provided under the Plan. The current Coverage Options are listed in Exhibit A.

Domestic Partner— an Eligible Employee's same or opposite sex partner who is at least 18 years of age, not related to the Eligible Employee by blood (or married to another person), and in a committed relationship with the Eligible Employee (intending to remain so indefinitely). An Eligible Employee must complete and sign an affidavit of domestic partnership and provide evidence of cohabitation as required by the affidavit of domestic partnership.

Eligible Employee – a Full-Time Employee of the Employer who meets any other eligibility requirements specified in the Insurance Company Documents.

Eligible Family Member – the spouse to whom an Eligible Employee is legally married (and otherwise meets the definition of a spouse under federal law), a Domestic Partner, or a biological, adopted or step-child of the Eligible Employee or the Eligible Employee's Domestic Partner who (in either case) meets any other eligibility requirements (including but not limited to any age limit) specified in the Insurance Company Documents or by the Company.

Eligible Retiree—an Eligible Employee who fully retires after age 55 with fifteen years of employment with the Employer. Eligible Retirees are only eligible to continue participation in medical/prescription drug coverage after retirement. However, such coverage shall be fully paid by the Eligible Retiree. Retirees over age 65 are required to enroll in the Medicare Advantage Plan offered by the College. The Employer reserves the right to terminate retiree coverage at any time.

Employee – a person who is employed by the Employer and who is treated by the Employer as an Employee for employment tax purposes. An individual who is a leased employee, is on the payroll of another company, or is treated as an independent contractor by the Employer for employment tax purposes is not an Employee for purposes of the Plan.

Employer – the Company, and any other affiliate of the Company who adopts the Plan with the consent of the Company.

FMLA – the Family and Medical Leave Act of 1993. "FMLA Leave" means a paid or unpaid leave of absence that is treated as leave under the FMLA.

Full-Time Employee – an Employee of the Employer who regularly works at least 30 hours per week. The Company may use initial and look-back measurement periods to determine who qualifies as a Full-Time Employee, in accordance with IRS regulations and other applicable guidance.

Insurance Company Documents – means and includes (1) the insurance contracts, subscriber contracts or coverage certificates identified in Exhibit A, (2) any similar contracts or certificates for any other Coverage Options offered under the Plan, now or in the future, (3) any other documents provided to Participants by the insurance companies and HMOs that provide insured benefits under the Plan. In the event of any conflict between a contract or certificate described in clause (1) or (2), and any other document described in clause (3), the contract or certificate described in clause (1) or (2) shall be controlling.

Participant – an Eligible Employee or an Eligible Family Member who is covered under the Plan.

Period of Coverage – means the applicable Plan Year, except when a Participant elects to enroll in coverage mid-year due to a special enrollment right or change in status event pursuant to the Section of this document titled "Mid-Year Enrollment Rights," in which case the Period of Coverage shall be the fractional period commencing on the effective date of such election and ending at the end of the current Plan Year.

Plan – the Daemen College Employee Health and Welfare Plan.

Plan Administrator – The Director of Employee Engagement of Daemen College or such other person, committee or company that Daemen College designates as the Plan Administrator.

Plan Year(s) – the 12-month period beginning June 1st and ending May 31st for Medical, Prescription Drugs, Business Travel Accident, Dental, Voluntary Vision, and the Health Flexible Spending Account, and the 12-month period beginning January 1st and ending December 31st for Voluntary Term Life Insurance, Short Term Disability (NYS DBL) and Long Term Disability Insurance.

Programs – the specific benefits covered by this Plan, which includes medical and prescription drug insurance, dental insurance, vision insurance, voluntary life insurance, supplemental short-term disability insurance, long-term disability insurance, business travel accident insurance, an employee assistance program, and a health flexible spending account. The current Programs provided under this Plan are listed in Exhibit A. The Employer separately maintains a Cafeteria Plan outside of this Plan, which permits Eligible Employees to pay for insurance premiums, health flexible spending account, and dependent care flexible spending account benefits on a pre-tax basis.

ELIGIBILITY AND ENROLLMENT

Eligibility – Employees

You are generally eligible to participate in the Plan if you are a Full-Time Employee of the Employer. In general, a Full-Time Employee is an Employee of the Employer who regularly works at least 30 hours per week. Notwithstanding the foregoing, the Company may use initial and look-back measurement periods for purposes of determining whether an Employee qualifies as a Full-Time Employee, in accordance with IRS regulations and other applicable guidance. Accordingly, it is possible that you will not be an Eligible Employee even though you are currently working 30 or more hours per week. Your ability to participate in each of the Programs under the Plan is described in Exhibit A.

> Note: An individual who is not on the regular payroll of the Employer for employment tax purposes whether because the individual's services are provided to the Employer through a temporary agency or leasing organization or because the Employer treats the individual as an independent contractor for employment tax purposes or because of any other reason, is not eligible to participate in the Plan.

Notwithstanding the above, the following persons are not eligible to participate: (1) leased or temporary employees; (2) union employees, unless the relevant collective bargaining agreement provides for participation; (3) independent contractors (including persons treated by an Employer as independent contractors) even if a court or agency should determine such persons to be "employees"; (4) contract employees and per diem employees; (5) individuals whose employment contract or other relevant document setting forth the individual's terms of employment states that the individual is not covered by one or more Programs; and (6) adjunct faculty members. Additionally, a Program does not cover an individual who has executed an agreement pursuant to which the individual has waived his/her right to participate in the Program or has acknowledged that he/she is not entitled to participate in the Program.

Eligibility – Family Members

An Eligible Employee can enroll for Plan coverage for the Eligible Employee alone, or for the Eligible Employee and one or more of the Employee's Eligible Family Members as permitted by the Plan Programs (detailed in Exhibit A). Additional information about Eligible Family Members can be found in the Insurance Company Documents or from the applicable Claims Administrator, including a description of which children are eligible for dependent coverage, the age at which a child's dependent status ends, the conditions that apply to dependent coverage, and the time

dependent coverage becomes effective. In addition, your children generally can be covered under the Plan (subject to any applicable age limits, such as age 26 for medical/prescription drug coverage), regardless of their student or marital status and regardless of whether your home is their principal place of abode or whether you support them.

An unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the child's coverage would otherwise terminate and who is chiefly dependent upon the covered Eligible Employee for support and maintenance, will remain covered while the covered Eligible Employee's coverage continues and the child remains in such condition. The covered Eligible Employee has 31 days from the date of the child's attainment of the termination age to submit an application to request that the child continue to be covered and proof of the child's incapacity. The insurer has the right to check whether a child is and continues to qualify under this rule.

Eligibility for coverage under the Plan may be subject to additional conditions contained in the Insurance Company Documents. The insurance company or HMO has the right to request and be furnished with such proof as may be needed to determine the eligible status of any individual at any time.

Initial Enrollment and Coverage Entry Dates

An eligible Full-Time Employee can enroll in medical, prescription drug, voluntary vision, dental, health flexible spending account, dependent care flexible spending account, business travel accident, and the employee assistance program coverage beginning on the first day of the month following the month of hire or, if later, the first day of the month following the Employee's transfer to eligible Full-Time Employee status.

For purposes of supplemental short-term disability insurance, coverage begins on the completion of six months of employment as a Full-Time Employee (statutory short-term disability coverage is fully-paid by the College and is effective after 30 days of employment)

For purposes of voluntary term life insurance and long-term disability insurance, coverage begins on the first day of the month following 90-days of continuous employment.

Full-Time Employees are automatically enrolled in the basic life insurance, business travel accident, and the employee assistance program effective the date of hire or, if later, the date the Employee transfers to eligible Full-Time Employee status.

In order to participate, such Eligible Employee must complete and deliver to his or her Employer, a benefit enrollment form and, if applicable, a salary reduction agreement during such period. If the Employee waives coverage at that time or does not return a completed enrollment form to the Plan Administrator within 30 days of the date coverage could first begin, the Employee will not be eligible to enroll for coverage until the next open enrollment period unless the Employee experiences a mid-year special enrollment or change in status event (see "Open Enrollment Period," and "Mid-Year Enrollment Rights," below).

Open Enrollment Period

An eligible Employee may change benefit elections each year under the Plan during the open enrollment period. The Plan Administrator will provide you with information on Plan Coverage Options and elections each year before or during the open enrollment period, including information on how to make pre-tax elections under the Cafeteria Plan offered outside of this Plan. The open enrollment period for the Plan is usually a period of approximately four weeks before the start of the Plan Year(s), with all elections effective as of the first day of the Plan Year(s).

Mid-Year Enrollment Rights

Once you enroll for Plan coverage you can change your election only during an open enrollment period unless:

1. you have a special enrollment event described below, or
2. you have a "Change in Status", as described below.

Special Enrollment Events

You may enroll yourself or an eligible family member for group health plan coverage under the Plan at a time other than during your initial enrollment period or an open enrollment period, if you or your Eligible Family Member experiences one or more of the following special enrollment events.

Loss of Other Coverage. A special enrollment event occurs if you lose, or your spouse or dependent child loses, existing group health plan coverage from a source other than the Plan. You, your spouse, or dependent child will be allowed to enroll due to a loss of coverage if:

- you, your spouse, or dependent child has a loss of other coverage due to:
    - exhaustion of COBRA coverage under another group health plan, or
    - termination of another employer's contribution to the other coverage, or
    - a loss of eligibility due to such causes as legal separation, divorce, death,
    - termination of employment or reduction in the number of hours of employment,
- you had previously declined coverage under this Plan because you, your spouse, or your dependent had other coverage; and
- the loss of the other coverage is not due to a failure to pay premiums or termination for cause (such as making fraudulent claims or intentional misrepresentation).

New Dependent. A special enrollment event also occurs, and you may enroll yourself, your spouse, and a new dependent child for group health plan coverage under the Plan, if you gain a new dependent through marriage, birth, adoption, or placement for adoption of a child.

To enroll or elect additional group health plan coverage under the Plan because of a special enrollment event, you must submit a completed election change to the Plan Administrator within 30 days of the date on which the special enrollment event occurs.

If you do not submit the required completed enrollment form within the 30-day special enrollment period, you will not be eligible to enroll yourself or your spouse or dependent child for group health plan coverage under the Plan until the next open enrollment period, unless you have another special enrollment or change in status event, or unless the Insurance Company Documents provide an exception.

Note: Even if you are enrolled under a family Coverage Option, in order to add a newborn or newly adopted child, you must complete and return the appropriate enrollment form within 30 days from the date of birth, adoption, or placement for adoption.

Children's Health Insurance Program Reauthorization Act. If you and your dependent child are eligible but not enrolled in coverage under a group health plan component of the Plan, you may enroll in coverage if you or your dependent child's Medicaid or CHIP coverage is terminated as a result of loss of eligibility, or you or your dependent child becomes eligible for a subsidy under Medicaid or CHIP. You must request coverage within 60 days after you or your dependent child is terminated from Medicaid or CHIP coverage, or determined to be eligible for assistance for Medicaid or CHIP coverage.

Change in Status Events

A Participant may revoke an election to participate in the Plan during a Period of Coverage and make a new election for the remaining portion of the Period of Coverage if, under the facts and circumstances, the Participant has had a Change in Status and the election change satisfies the consistency requirements set forth herein and applicable Code regulations. The determination of whether a Participant has had a Change in Status shall be made by the Plan Administrator in its sole discretion. A mid-year election change must be made within thirty (30) days following the Change in Status event. A newly Eligible Employee or spouse or dependent will become a Participant, or, for revoked elections, coverage shall end, as soon as administratively practicable following the date of the election or revocation.

A "Change in Status" means any of the following events:

- Legal Marital Status. Any event that changes a Participant's legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment.

- Number of Dependents. Any event that changes the number of a Participant's dependents (as defined under federal tax law), including birth, death, adoption and placement for adoption.

- Employment Status. Any event that changes the employment status of a Participant, his spouse or dependents, including (i) termination or commencement of employment, (ii) strike or lockout, (iii) commencement of (or return from) an unpaid leave of absence,

and (iv) change in worksite. For this purpose, a change in status that affects an individual's eligibility under the Plan shall constitute a change in employment status.

- Dependent Coverage. Any event that causes a Participant's dependent to satisfy, or cease to satisfy, eligibility requirements for coverage under a Program benefit on account of attainment of age, student status, or any similar circumstance.

- Residence. Any change in the place of residence of a Participant, his spouse or dependents.

- Miscellaneous Other. Any other events included under Code Section 125, the regulations thereunder or other official guidance promulgated by the Secretary of the Treasury.

Consistency Rules for Election Changes

An election change satisfies the requirements of this Section only if the election change is on account of and corresponds with the Change in Status that affects eligibility under the Plan, or under another employer's plan.

Qualified Medical Child Support Orders

In accordance with Section 609(a) of ERISA, the Plan will provide health coverage to a child of an Eligible Employee in accordance with the terms of any medical child support order that the Plan Administrator determines to be a "qualified medical child support order." A qualified medical child support order is a judgment, decree, or order issued by a court that provides for child support or health benefit coverage relating to benefits under the Plan or a national medical support notice that in either case meets certain requirements regarding substance and form. You must submit medical child support orders and national medical support notices to the Plan Administrator. The Plan Administrator will notify the involved individuals of its receipt of the order or notice and of the Plan's procedure for determining whether it is a qualified order. You may request a copy of the Plan's procedure for determining whether an order or notice is a qualified medical child support order from the Plan Administrator.

BENEFITS UNDER THE PLAN

Plan Benefits – In General

The subscriber contracts and coverage certificates issued to a Participant describe the benefits provided under the Plan. If any of the information in a subscriber contract or coverage certificate regarding benefits conflicts with the information in this document, the information in the subscriber contract or coverage certificate will be controlling. However, in the event of conflict this document shall control for purposes of satisfying the Company's compliance with the disclosure requirements under ERISA, the Internal Revenue Code, HIPAA, and other applicable federal laws governing employee benefit plans.

Plan Funding

The Company and Employee Participants share the cost of health coverage under the Plan.

The Company will determine, in its sole discretion, how much an Employee Participant must pay toward the cost of coverage, and the Company reserves the right to change the amount to be paid by Employee Participants at any time.

The Company will periodically notify participating Employee Participants of the amounts that Employee Participants must pay for Plan coverage.

Certain plan benefits, such as dental insurance, the employee assistance program, and the health flexible spending account are self-funded by the Company, meaning the Company pays benefit claims from its general assets (after collecting any required Employee contributions). Other plan benefits, such as medical and prescription drug coverage, voluntary vision, short-term disability, long-term disability, and business travel accident are fully-insured by the applicable insurance carrier.

Medicare Entitlement

If you are actively employed and covered under the Plan and become entitled to Medicare, this Plan will pay benefits on a primary basis with Medicare paying on a secondary basis while you are actively employed unless you elect Medicare as your primary coverage and decline coverage under this Plan. If you elect Medicare as your primary coverage and decline coverage under this Plan, Federal law prohibits this Plan from making any benefit payments on your behalf, even secondary payments.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

All group health plans and their insurance companies or health maintenance organizations that provide coverage for medical and surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Group health plans, insurance companies, and HMOs may impose deductible or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductible and coinsurance are consistent with those established for other benefits under the plan or coverage.

Insurance Dividends or Rebates

Any dividend or rebate paid by an insurance company or HMO that provides benefits under the Plan will be the property of the Company, regardless of how the Plan is funded, unless otherwise determined by the Company in its sole discretion.

Statute of Limitations

All claims for benefits must be submitted by the claims filing deadline specified under the rules for a particular Program. If the Program does not specify a filing deadline, then claims must be submitted within one year from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred. This requirement may be waived by the Plan if, through no fault of the claimant, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late claims will not be accepted if they are filed more than one year from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred.

Except as noted in the claims procedures, a claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, or any other person, with respect to a claim for disability, medical, or other claims for benefits without first exhausting the claims procedures set forth above. A claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the Plan Administrator's decision on appeal but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal. No legal action may be commenced or maintained to recover benefits under the Plan more than one year after the Plan's final decision on appeal.

Lifetime Limits

The medical and prescription drug benefits provided under the Plan does not impose a lifetime limit on essential health benefits (as defined in guidance and regulations issued by the Department of Health and Human Services).

Anti-assignment Provision

Except for voluntary assignments to health care providers as may be required by law or as may be provided in applicable Programs, the right to receive benefits under any of the Programs covered by this document may not be assigned, voluntarily or involuntarily, to any other person other than the Participant. A direct payment by the Plan to a person or entity that provides medical services to a Plan Participant is not a waiver of this provision. Additionally, a medical service provider may not bring a claim for benefits against the Plan, a Plan fiduciary, the Plan Administrator, or an Employer with respect to the services it provides to a Plan Participant.

CIRCUMSTANCES THAT MAY RESULT IN THE DENIAL OR LOSS OF BENEFITS

In General

Various circumstances can result in the termination, reduction, denial, or loss of Plan benefits. Some of these circumstances are described in this Section. For additional information, refer to the Insurance Company Documents.

Coordination of Benefits

When a Participant is also covered under another group health plan or policy, this Plan will coordinate benefit payments with any payments made under the other plan or policy. One plan or policy will pay the benefit as a primary benefit. The other plan or policy will pay secondary benefits, to the level covered by that plan or policy, if necessary to cover the Participant's expenses. The coordination of benefits rules in this Plan and the other plan or policy will determine which plan or policy is primary. The Insurance Company Documents state the coordination of benefit rules for health and dental benefits under this Plan.

Subrogation and Reimbursement

If a third party is responsible for any injury or illness covered by the Plan, the Plan has the right to all or part of any amount that the Participant or another person recovers or might recover from the third party. For more information, refer to the Insurance Company Documents.

Fraudulent Claims

If any person is found to have falsified any document in support of a claim for Plan benefits, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such false information to the attention of the insurance company or Plan Administrator, the Plan Administrator may, without the consent of any person, terminate the Plan coverage of such person or of any person whose coverage is attributable to such person, including retroactively as permitted by law. Any Employee who submits falsified documents in support of a claim for Plan benefits, or fails to correct information which such person knows or should have known to be incorrect, or fails to bring such false information to the attention of the insurance company or Plan Administrator may be subject to disciplinary action up to and including termination of employment. In addition, the insurance company may refuse to honor any benefit claim made by such person or by any person whose coverage is attributable to such person, such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

Right to Recover Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount that was properly payable under the Plan to a Participant, the Participant shall be responsible for repaying the overpayment to the Plan. If the plan makes any payment that, under the terms of the Plan, should not have been made, the Plan Administrator, the Company or the insurance company can recover that incorrect payment from the person(s) to whom it was paid or from any other

appropriate person, whether or not the wrongful payment resulted from the insurance company's or Plan Administrator's own error. The repayment or refund may be made in any one or more of the following methods: (1) a lump sum payment, (2) a reduction in future benefit payments otherwise payable under the Plan, (3) automatic deductions from the pay of an Employee, or (4) any other method designated by the Plan Administrator or insurance company in its sole discretion.

HEALTH SAVINGS ACCOUNTS

Note: Your health savings account is not part of this Plan and is not subject to ERISA. The following information is provided for convenience.

Health Savings Accounts

A health savings account is trust or custodial account that qualifies as a "health savings account" under the Code. Very generally, an individual who has high deductible health plan coverage under a high deductible coverage option sponsored by the Company, and who meets other Code requirements, can make pre-tax or deductible contributions to a health savings account and then take distributions from the account tax free to pay for qualifying medical expenses incurred after the establishment of the account by the individual or the individual's spouse or certain dependents. The individual may take distributions for other purposes, subject to income tax and, in certain cases, penalties. Funds in a health savings account are not subject to forfeiture and remain available for distribution to the owner even if he or she is no longer eligible to contribute to the account, and for distribution after the owner's death to his or her estate or beneficiary.

To establish a health savings account, an individual must make arrangements with a trustee or custodian (outside of the Plan).

The Cafeteria Plan offered outside of this Plan allows certain Participants to elect to make pre-tax contributions to his or her health savings account, if applicable, through payroll deduction.

You may establish your health savings account with the Company's elected health savings account custodian. The custodian will administer your health savings account. The Company's and your Employer's only responsibility with respect to your health savings account is to send your contributions to the custodian.

Who is Eligible to Contribute to an HSA

A Participant can contribute to an HSA if he or she has high deductible coverage under the Plan and is not covered by any health coverage that is considered disqualifying coverage under Code rules. Disqualifying coverage includes the following:

- Coverage under another health insurance contract or health benefit plan, including family coverage under your spouse's employer's health plan (unless the other coverage is a limited type permitted under Code rules).

- Coverage under a general-purpose health care flexible spending account or health reimbursement account (either under this Plan or under your spouse's employer's plan).

You may, however, contribute to a limited purpose or post-deductible health care flexible spending account.

- Medicaid coverage

- Enrollment in Medicare Part A or B (note that you are automatically enrolled in Medicare Part A if you are age 65 or older and receiving Social Security benefits).

- TRICARE coverage and certain VA medical benefits.

The IRS imposes a statutory limit on health savings account contributions. Both your contributions and any Employer contributions made for you will count against the limit.

The IRS may change these statutory limits each year as needed to reflect cost of living adjustments, and will publish them annually.

The limits apply on a calendar year basis. They are reduced proportionately for the months a Participant is not HSA eligible. (Eligibility is determined monthly.)

As described above, you may make health savings account contributions through pre-tax payroll deduction. You may also contribute to your health savings account (subject to the IRS limits) by depositing or transferring funds to the trustee or custodian of your account.

For a highly-compensated Employee, the Company may limit the amount of contributions that the Employee may make through payroll deduction, but the Employee may still make contributions by depositing or transferring funds to the trustee or custodian of his or her account.

Additional Information about HSAs

You should review the documents establishing your health savings account and contact the trustee or custodian of your account for information about the operation and investment of the account, how to obtain distributions from your account, and the expenses that may be charged against your account. You may not rely on this document or other information from the Company or the Employer for tax advice regarding health savings accounts. The tax rules are complicated, and failure to follow them may result in tax penalties. You should consult your own tax adviser and IRS Publication 969 for information about:

- Whether you are eligible to contribute to a health savings account.

- The amount of deductible or pre-tax contributions you may make to a health savings account, and how a partial calendar year of eligibility will affect that amount, and the deadline for making contributions for a calendar year.

- What and whose medical expenses you can pay from your health savings account on a tax free basis.

- What tax penalties apply if contributions to your account exceed the limit, or if you take distributions from the account that are not eligible for tax free treatment.

Neither the Company nor your Employer guarantees the tax consequences of contributions to your health savings account or distributions from that account. The Company does, however, strongly recommend that you keep receipts and records for the medical expenses you pay (or for which you obtain reimbursement) from your health savings account. You will need these receipts and records to prove to the IRS that payments from your account should not taxed.

LEAVES OF ABSENCE

Family Medical Leave Act

Under Federal law, eligible Employees may take up to 12 weeks of unpaid leave each year because of the birth of a child or the placement of a child for adoption or foster care, to care for an immediate family member who has a serious health condition, or because of their own serious health condition.

Plan coverage will be maintained for an Employee on FMLA leave on the same terms and conditions as if the Employee had continued to work to the extent required by FMLA, and as described in Employer's handbook. To continue Plan coverage during FMLA, an Employee must pay the Employee premium on a monthly basis on an after-tax basis. For additional information on FMLA, contact the Plan Administrator.

USERRA Leaves

If an Employee is absent from work because of active military service, the Employee has the right under Federal law to continue his or her Plan coverage for up to 24 months. For more information, refer to the Insurance Company Documents.

Other Leaves of Absence

If an Employee takes any other leave of absence or is absent from work for any reason other than FMLA, New York State Paid Family Leave, USERRA leave, paid time-off, or approved unpaid personal leave, Plan coverage will end on the Employee's last day of work (unless COBRA is offered and elected, as described below).

TERMINATION OF COVERAGE UNDER THE PLAN

Employee

Your coverage under the Plan as an Employee will end on the earliest of the following dates:

- the date you die;
- the last day of the month in which your active employment ends, or your hours of employment are reduced so that you are no longer an Eligible Employee (but see "Leaves of Absence" above) for medical, prescription drug, dental, and voluntary vision insurance, and the last day of active employment for voluntary life insurance, short and long-term disability insurance, business travel accident insurance, and the employee assistance

program (note you must pay all premiums due for the month in order for coverage to continue through the last day of the month);

- the last day of the period for which required contributions are paid, if you stop paying your required share of the cost of coverage;
- if you are on a leave of absence, the last day of the extended coverage period described under "Leaves of Absence" above;
- the date the Plan terminates.

Spouse

The coverage under the Plan of the spouse of an Employee who has enrolled for a family Coverage Option covering the spouse will end on the earliest of:

- the date on which the Employee and spouse are legally divorced or their marriage is annulled;
- the last day of the month in which the Employee dies;
- the date on which the Employee's coverage under the Plan ends for any other reason;
- the date on which the Employee switches to a Coverage Option that does not cover the spouse; or
- the date the Plan terminates.

Domestic Partner

The coverage under the Plan of the Domestic Partner of an Employee who has enrolled for a family Coverage Option covering the Domestic Partner will end on the earliest of:

- the date on which the Employee and Domestic Partner dissolve their domestic partnership;
- the last day of the month in which the Employee dies;
- the date on which the Employee's coverage under the Plan ends for any other reason;
- the date on which the Employee switches to a Coverage Option that does not cover the Domestic Partner; or
- the date the Plan terminates

Dependent Children

The coverage under the Plan of a dependent child of an Employee who has enrolled for a family Coverage Option covering the child will end on the earliest of:

- the last day of the month in which a covered dependent child reached age 26;
- the date on which the child ceases to be eligible for coverage as a dependent child for any other reason (under the rules of the relevant subscriber contract, coverage certificate, or Insurance Company Documents);
- the last day of the month in which the Employee dies;
- the date on which the Employee's coverage under the Plan ends for any other reason;
- the date on which the Employee switches to a Coverage Option that does not cover the child; or
- the date the Plan terminates.

Refer to the subscriber contract, coverage certificate, and applicable Insurance Company Documents for additional information on circumstances under which coverage may be lost.

CONTINUING HEALTH CARE COVERAGE UNDER COBRA

Introduction to COBRA Coverage

Under certain circumstances, if your medical or dental coverage terminates you may be eligible to continue coverage under a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when such coverage under the Plan would otherwise end.

This section of the document has important information about your right to COBRA continuation coverage, which is a temporary extension of medical and/or dental coverage under the Plan. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other health coverage options that may cost less than COBRA continuation coverage.

You may have other options available to you when you lose medical and/or dental coverage under the Plan. For example, you may be eligible to buy an individual policy through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

The Plan provides no greater COBRA rights than what COBRA requires, and nothing in this document is intended to expand your rights beyond COBRA's requirements.

What is COBRA coverage?

COBRA continuation coverage is a continuation of medical and/or dental Plan coverage when it would otherwise end because of a life event. These life events are called "qualifying events" in this document. Specific qualifying events are listed later in this document. 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 medical or dental coverage under the Plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualifying Events

1) *Termination of Employment/Reduction of Hours.* One qualifying event is the termination of your employment with an Employer, or the reduction in your hours of employment to the point where you are no longer an Eligible Employee. If this qualifying event occurs, you will have the right to elect COBRA coverage for up to 18 months following the date your coverage would otherwise terminate. If your spouse or any of your dependents are covered under this Plan through one of the family Coverage Options, the covered individual will have the right to elect COBRA coverage individually. If you elect COBRA coverage under a family Coverage Option, the individuals covered by the Coverage Option will not need to elect to continue their COBRA coverage individually.

   If you are (or, if covered under the Plan, your spouse or dependent is) determined to be disabled for purposes of Social Security at any time during the first 60 days of your COBRA coverage period, coverage may be continued for an additional 11 months, for a total of 29 months of COBRA coverage. To qualify to elect the additional 11 months of COBRA coverage, you must notify the Plan Administrator within 60 days of the date the Social Security Administration makes its disability determination, but in no case later than the last day of the 18th month of COBRA coverage. The cost of coverage may be up to 150 percent of the full monthly premium. Each qualified beneficiary in your family who is not disabled is also entitled to the disability extension. Coverage may be terminated due to a cessation of the disabled qualified beneficiary's disability.

2) *Child Ceases to be Eligible Dependent.* If your child ceases to qualify as a dependent eligible for Plan coverage (see your subscriber contract or coverage certificate), he or she may elect COBRA coverage for 36 months from the date his or her coverage would otherwise terminate under the Plan. There are specific notice requirements you, your spouse or dependent must satisfy in order for your dependent to be eligible for COBRA coverage under this provision (see "Notice Requirements" below).

3) *Death of Employee.* If your spouse or dependent is covered under the Plan at the time of your death, the covered individual will have the right to elect COBRA coverage for 36 months from the date his or her coverage would otherwise terminate under the Plan as a result of your death.

4) *Divorce*. If your spouse or dependent is covered under the Plan, and you become divorced from your spouse, your spouse and any covered dependents who will lose coverage as a result of the divorce will have the right to elect COBRA coverage for 36 months from the date their coverage would otherwise terminate under the Plan as a result of the divorce. There are specific notice requirements you or your spouse or dependents must satisfy in order for your spouse and dependents to be eligible for COBRA coverage under this provision (see "Notice Requirements" below).

5) *Multiple Qualifying Events*. If you elect to continue under one of the family Coverage Options due to the termination of employment/reduction of hours qualifying event, and one of the other qualifying events listed above occurs, your covered family member or dependent(s) may elect to continue coverage for an additional period (but not beyond the date that is 36 months from the date coverage was originally lost due to the termination of employment/ reduction of hours of qualifying event. There are specific notice requirements you or your spouse or dependents must satisfy in order for your spouse or dependents to be eligible for COBRA coverage under this provision (see "Notice Requirements" below).

Electing COBRA coverage

Each individual who is eligible to elect COBRA coverage must make written election for COBRA coverage no later than the date that is 60 days after the later of the date coverage would otherwise end or the date the Plan Administrator provides written notice of the right to elect COBRA coverage. The election form must be hand delivered to the Plan Administrator or postmarked on or before the 60th day; if it is not, the individual will not be eligible to elect COBRA coverage.

Notice Requirements

You or your spouse or dependents must notify the Plan Administrator as soon as possible (but not later than 60 days) after you and your spouse are divorced, your covered child ceases to be eligible for coverage as a dependent child under the Plan, or one of you receives a Social Security disability determination. If written notice is not provided to the Plan Administrator within 60 days after one of these events occurs, COBRA coverage will not be available (in the case of a disabled individual, extended COBRA coverage will not be available). Written notice must be provided to the Plan Administrator.

If the Qualifying Event is termination of employment or reduction in hours of employment, the Plan Administrator will notify you (and your spouse and dependent children covered under one of the family Coverage Options) of your right to elect COBRA coverage. The Plan Administrator will provide you with written notice of your rights within 44 days after the date your coverage would terminate due to your termination of employment or reduction in hours.

If the Qualifying Event is your death and your spouse or any of your dependents is covered under one of the family Coverage Options, the Plan Administrator will notify your spouse and dependent children of their right to elect COBRA coverage. The Plan Administrator will provide them with written notice of their rights within 44 days after the date their coverage would terminate due to your death.

If the Qualifying Event is divorce or loss of dependent child status and you or a family member have notified the Plan Administrator within 60 days after the occurrence, the Plan Administrator will provide your spouse or dependent child with written notice of his or her rights within 14 days of the date of notice to the Plan Administrator.

Cost of COBRA Coverage

The monthly premium for COBRA coverage is up to 102 percent of the normal full monthly premium for the elected coverage under the Plan and up to 150 percent of the normal full monthly premium for coverage during the 19th through 29th months of COBRA coverage for disabled individuals who are eligible for 11 additional months of COBRA coverage. COBRA premiums are due by the first day of each month; except that the initial premium payment can be made at any time within 45 days after COBRA coverage is elected. Premium payments for COBRA coverage must be mailed to the Plan Administrator.

Continuation Coverage under State Law

New York State law may also provide continuation and/or conversion coverage once your continuation rights under federal COBRA expire. Please contact the Plan Administrator or the applicable insurer for more information regarding any continuation or conversion right you may have with respect to fully insured benefits under the Plan.

Termination of COBRA coverage

COBRA coverage will end on the date of any of the following events:

- The required premiums are not paid on time (taking into account any permitted grace periods).
- The maximum (18 month, 29 month, or 36 month) COBRA coverage period expires.
- The Company ceases to provide any group health coverage to any Employees.
- You become, or your spouse or child (as applicable) becomes, covered under another group health plan that does not contain any exclusion or limitation with respect to a preexisting condition of the individual who becomes covered.
- You become or, your spouse, or child (as applicable) becomes, entitled to Medicare.
- If you are, or your spouse or your child is, in the extended 19th through 29th month of COBRA coverage as a result of a Social Security disability determination, coverage will terminate on the first day of the month that begins more than 30 days after the date of a final determination that you are, or your spouse is, or your child is (as applicable) no longer disabled for purposes of Social Security.

CLAIMS PROCEDURES

The benefit claim procedures under the Plan are described in detail in the subscriber contract or coverage certificate (or other Insurance Company Documents) for the Plan. You should carefully review the claims sections of your subscriber contract or coverage certificate. Exhibit B "Claim Procedures" describes the general claims procedure rules for claims under ERISA. If there is any conflict between the claims procedures in Exhibit B and the procedures stated in the Insurance Company Documents, the procedures in the Insurance Company Documents will be controlling. However, if the procedures stated in the Insurance Company Documents do not comply with ERISA, then the claims procedures in Exhibit B shall apply and control.

PLAN ADMINISTRATION

Discretionary Authority

The Plan Administrator determines, in its sole discretion, your eligibility to participate in this Plan and its benefit Programs, and, for benefits managed internally (if any), whether benefits are payable for a claim. For insured Programs, the insurer determines whether benefits are payable under its policy or contract for a claim in its sole discretion. For self-insured Programs, the third party administrator determines whether benefits are payable under the Program in its sole discretion. The Plan Administrator has the discretionary authority to administer and interpret all aspects of the Plan not set forth in an insurance policy. The Plan Administrator may delegate its authority to one or more persons or organizations and such delegation will include full discretion unless such discretion is restricted by the delegation.

How to Deliver Forms and Notices

This Plan and the Insurance Company Documents require you to return or deliver various election and enrollment forms and notices to the Plan Administrator or the applicable insurance company or HMO by specified due dates. It is most important that you make certain the Plan Administrator actually receives the form or notice on a regular business day on or before the due date, at the address stated in this document, with enough time to relay the form to the applicable insurance company or HMO by the due date. **Failure to do so will result in no coverage or a loss of coverage for yourself or your dependents or both.**

Eligible Employee's Responsibility to Furnish Current Address(es)

Each Eligible Employee is responsible for providing the Plan Administrator and each insurance company with the Eligible Employee's current address and the current address of each other person covered through the Eligible Employee. Any notices required or permitted to be given to a Participant shall be deemed to have been properly given if directed to the address most recently provided by the Eligible Employee and sent by first class U.S. mail.

PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION

The portion of the Plan relating to medical and dental Programs is subject to privacy and security requirements under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

The Plan and any "business associate" (as this term is defined in the HIPAA privacy requirements) of the medical and dental Programs under the Plan will disclose Protected Health Information ("PHI") related to those Programs to the Company only in accordance with the provisions in this section. For the purposes of this section, PHI is defined according to the HIPAA privacy requirements but limited to protected health information that is received by or on behalf of the Plan or created by or on behalf of the Plan.

Disclosure of PHI will only be made for the following purposes:

1) claims management and related healthcare data processing, including auditing payments, investigating and resolving payment disputes, and responding to inquiries about payments;

2) deciding appeals of denied claims;

3) conducting or arranging for legal services and auditing functions, including fraud abuse and detection; and

4) business planning and development, such as conducting cost management and planning related analysis relating to managing and operating the Plan.

The disclosure of PHI is subject to the following:

1) The Company may only use or further disclose PHI as permitted or required under the Plan or as required by law.

2) The Company will ensure that any of its agents, including any subcontractor, to whom the Company provides any PHI agrees to the restrictions of this section.

3) The Company will not use or disclose PHI for employment–related actions or decisions or in connection with any other benefit or benefit plan sponsored by or adopted by the Company.

4) The Company will make any PHI disclosed to it available to the individual who is the subject of the PHI for inspection and amendment in accordance with the HIPAA privacy requirements, and will provide an accounting of any disclosures for which an accounting is required under the HIPAA privacy requirements.

5) The Company will make its internal practices, books and records relating to the use or disclosure of PHI available to the Department of Health and Human Services.

6) The Company will return to the Plan or destroy all PHI, and will retain no copies, when the PHI is no longer needed for the purpose for which it was obtained. In the event the return or destruction is not feasible, the Company will limit any further uses or disclosures of the PHI to those purposes which make the return or destruction not feasible.

7) The Company will not use or disclose PHI that is genetic information for underwriting purposes.

8) The Company will report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware.

9) The Company will make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA.

With respect to PHI that is transmitted by electronic media or maintained in any electronic medium (Electronic Protected Health Information, or "Electronic PHI"), The Company agrees to:

1) 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;

2) Ensure that the adequate separation between the Plan and Company is supported by reasonable and appropriate security measures;

3) Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

4) Report to the Plan any security incident of which it becomes aware. For purposes of this section, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the Electronic PHI; and

5) Upon request from the Plan, Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the Electronic PHI to the extent such information is available to Company.

6) Notwithstanding the foregoing, these limitations shall not apply to enrollment, disenrollment, and summary health information provided to Plan Sponsor pursuant to 45 CFR 164.504(f)(l)(ii) or (iii); of Electronic PHI released pursuant to an authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

Company will ensure that the adequate separation between the Plan and Company is supported by reasonable and appropriate security measures. In accordance with HIPAA, only the following Employees, classes of Employees or other persons under the Company's control (or acting on behalf of the Company) may have access to PHI in order to carry out their duties with respect to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business:

- Employee Engagement Department
- Business Department

These individuals may only have access to and use and disclose PHI to the extent necessary to perform plan administration functions that the Company performs for the Plan.

Neither the Plan, nor any business associate of the Plan, will disclose any PHI to the Company prior to the receipt by the Plan of a written certification by the Company that the Company agrees to the provisions of this section. The Company will restrict access to PHI and the use of PHI by Employees of the Company to Plan administrative functions that the Company performs for the Plan. If an Employee of the Company receives PHI and discloses it in a manner which does not comply with the provisions of the Plan, the Company will take appropriate actions which may include disciplinary actions.

AMENDMENT OR TERMINATION OF PLAN

The Company reserves the right to amend or terminate the Plan at any time. In particular, the Company reserves the right to change at any time the share of the premium Plan coverage required from Employees at any time, and to terminate retiree coverage at any time.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specific locations, such as worksites, all documents governing the Plan including insurance contracts and copies of the latest annual reports (Form 5500) 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 copies of the latest annual reports (Form 5500) and updated summary plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report(s). The Plan Administrator is required by law to furnish you with a copy of the summary annual report(s).

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA coverage rights

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants of the Plan, 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 Participants and beneficiaries of the Plan. No one, including your Employer 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, 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 $112 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, provided that you have exhausted all your administrative appeal rights. 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 Area 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.

Address Changes

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

EXHIBIT A
PROGRAMS, INSURANCE COMPANIES AND CLAIMS ADMINISTRATORS

Program	Eligible	Carrier/Administrator
Medical (includes prescription drug coverage)	Full-Time Employees, Eligible Family Members Limited Full-Time Employees **Start Date:** Staff: 1st of the month following date of hire Faculty: Date of hire **End Date:** Last day of the month the employee's status changed to ineligible	Univera 205 Park Club Lane Buffalo, NY 14221 1-800-499-1275 www.univerahealthcare.com Plan #: 00130563
Retiree Medical (includes prescription drug coverage)	Eligible Retirees	Blue Cross Blue Shield 257 W. Genesee Street Buffalo, NY 14202 1-800-329-2792
Dental	Full-Time Employees, Eligible Family Members Limited Full-Time Employees **Start Date:** Staff: 1st of the month following date of hire Faculty: Date of hire **End Date:** Last day of the month the employee's status changed to ineligible	MetLife Metropolitan Life Insurance Company 200 Park Ave, New York NY 10166 1-800-942-0854 www.metlife.com Plan#: 5958869 PDP Plus
Vision	Full-Time Employees, Eligible Family Members Limited Full-Time Employees **Start Date:** Staff: 1st of the month	Guardian The Guardian Life Insurance Company of America 10 Hudson Yards, New York NY 10001 1-888-482-7342 www.guardiananytime.com

	following date of hire Faculty: Date of hire **End Date:** Last day of the month the employee's status changed to ineligible	Plan#: 00324707
Voluntary Term Life Insurance	Full-Time Employees, Eligible Family Members Limited Full-Time Employees **Start Date:** Staff: 1st of the month following date of hire Faculty: Date of hire **End Date:** Staff: Last day of employment Faculty: Last day of employment	Lincoln Financial Group Lincoln Life & Annuity Company of New York Group Insurance Service Office P.O. Box 2616, Omaha NE 68103 www.LincolnFinancial.com 800-423-2765
Health and Dependent Day Care Flexible Spending Account	Full-Time Employees Limited Full-Time Employees **Start Date:** Staff: 1st of the month following date of hire Faculty: Date of hire **End Date:** Last day of the month the employee's status changed to ineligible; Contributions cease with last paycheck	ProFlex Administrators 8321 Main Street Williamsville, NY 14221 www.proflextpa.com 716-633-2073
Supplemental Short-Term Disability	Full-Time Employees Limited Full-Time Employees (offered after 6 months of employment)	Daemen College 4380 Main Street Amherst, NY 14226 716-839-8325
Long-Term Disability	Full-Time Employees	Lincoln Financial Group

	(offered after 3 months/90 days of employment) Limited Full-Time Employees	Lincoln Life & Annuity Company of New York Group Insurance Service Office P.O. Box 2609, Omaha NE 68103 800-423-2765 www.LincolnFinancial.com Plan#: 10252700
Business Travel Accident	Employees working 20 or more hours per week **Start Date:** Staff: Date of hire Faculty: Date of hire **End Date:** Staff: Last day of employment Faculty: Last day of employment	Chubb 202B Hall's Mill Road, P.O. Box 1650 Whitehouse Station, NJ 08889 Customer Service (USA): 1-800-243-6124 International Customer Service: 1-202-659-7803 Plan#: 9908-56-44
Employee Assistance Program	Full-Time Employees, Eligible Family Members Limited Full-Time Employees **Start Date:** Staff: Date of hire Faculty: Date of hire **End Date:** Staff: Last day of employment Faculty: Last day of employment	Lincoln Financial Group Lincoln Life & Annuity Company of New York Group Insurance Service Office P.O. Box 2616, Omaha NE 68103 888-628-4824 www.LincolnFinancial.com Plan#: 10252700

Part Time employment is defined as working less than 30 hours or more per week.

Full Time employment is defined as working 30 hours or more per week over the course of 12 months.

Limited Full Time employment includes employees who work 35 hours or more per week over the academic calendar only.

EXHIBIT B
DAEMEN COLLEGE HEALTH AND WELFARE PLAN CLAIMS PROCEDURES

Any participant (Employee) or beneficiary (dependent), or an authorized representative acting on behalf of a participant or beneficiary, may assert a claim for benefits. Throughout this section, any of these individuals are referred to generically as "the Claimant."

All claims for benefits under a Program shall be submitted in accordance with the terms of that Program and shall be subject to the claims review procedure established for that Program. However, if the particular issue on which a claim is based does not relate to any Program, or if the Program lacks a claims procedure that satisfies any then-applicable ERISA claims procedure requirements, the relevant following claims procedures (health, disability, or other) shall apply or supplement the defective procedures to bring them into compliance. Where a Program's materials with a defective claims procedure specify that claims can be filed or must be responded to in a time period more generous than the procedures below, then these procedures shall also be read to require the more generous time period for submission or response.

The "Claims Reviewer" is the individual or entity assigned to review claims or appeals for a Program. Where a Program's materials specify that claims be sent to an insurer or third party administrator, then the insurer or third party administrator shall be the Claims Reviewer for purposes of the procedures that follow. Where a Program's materials do not contain any claims procedure, then the following procedures shall apply, with the Plan Administrator (or its delegate) acting as the Claims Reviewer for all internal claims and appeals.

GROUP HEALTH PLAN CLAIMS PROCEDURES

This procedure applies only to claims submitted for group health plan benefits under a Program. In addition, it applies to any rescission (as defined under the Patient Protection and Affordable Care Act (PPACA) and guidance thereunder) of coverage that is not attributable to a failure to timely pay required premiums or contributions toward the cost of coverage. You will be provided with 30 days' advance written notice of any rescission.

If you need assistance with your claim, appeal of a denied claim, or the external review process, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All claims and appeals under the Plan will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a benefit decision. Decisions regarding the hiring, compensation, termination, promotion, incentives or other similar matters regarding any individual or organization making decisions in the claims an appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of benefits.

Certain aspects of the claims procedures apply only to Plans that are not grandfathered medical plans under 26 CFR § 54.9815-1251T and that are subject to the expanded claims procedure requirements under the Patient Protection and Affordable Care Act (PPACA). Those sections are indicated throughout the procedures that follow. In cases where the Department of

Labor has indicated that there is a delayed enforcement deadline for a particular PPACA requirement described in this section, the Claims Reviewer may delay implementation of the particular delayed provision until the enforcement deadline.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by PPACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

I. Internal Review

A. Definitions.

The following terms are defined for purposes of this subsection:

1. ***Post-Service Claim*** means any claim for a benefit which is not a Pre-Service Claim as defined below.

2. ***Pre-Service Claim*** means any claim for benefits whereby the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care.

3. ***Urgent Care Claim*** means a claim for health care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

   a. Could seriously jeopardize the Claimant's life or health or the ability of the Claimant to regain maximum function, or

   b. In the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The determination of whether a claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that a claim shall automatically be treated as an Urgent Care claim if a physician with knowledge of the Claimant's medical condition determines that the claim involves Urgent Care.

4. ***Plan*** means, for purposes of this claims procedure, any Program listed in Exhibit A that provides benefits for health care or treatment.

5. ***Claims Reviewer*** means the person or entity responsible for the relevant claims determination under the Plan.

B. Determination of Benefits

The amount of time that the Claims Reviewer has to respond to a claim for benefits will depend upon the type of claim for benefits being made, as provided below.

1. **Post-Service Claims.** The Claims Reviewer will notify the Claimant of the benefits determination within a reasonable period of time after receiving the claim, but not later than 30 days after the claim is received. This period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Plan expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making a benefit determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

2. **Pre-Service Claims.** The Claims Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not more than 15 days after receiving the claim. This period may be extended by the Plan for up to 15 days, provided that the Claims Reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 15-day period explaining the reason for the additional extension and when the Plan expects to decide the claim. If the initial 15-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making benefits determination is tolled from the date the Claims Reviewer sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information is received by the Plan.

In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within five days after the Plan initially receives the claim so that the Claimant can make proper adjustments.

3. **Urgent Care Claims.** The Claims Reviewer will notify the Claimant of its benefit determination (whether adverse or not) as soon as reasonably possible, taking into consideration the medical circumstances involved. The Claims Reviewer will always respond to an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no more than 72 hours after receipt of the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim), unless the Claimant fails to submit information necessary to decide a claim. In this situation, the Claimant will be informed

within 24 hours after submitting the claim the specific information necessary to complete the claim. Notification may be oral, unless the Claimant requests written notification. The Claimant will be given at least 48 hours to provide the requested information. The Claims Reviewer will notify the Claimant of the benefit determination no later than 48 hours after the earlier of the Plan's receipt of the requested information or the end of the period the Claimant was given to supply the additional information.

In the event the Claimant fails to follow proper Plan procedures in submitting a claim, the Claimant will be notified within 24 hours after the Plan initially receives the claim so that the Claimant can make proper adjustments.

4. Concurrent Care Decisions. In certain situations, the Plan may approve an ongoing course of treatment. For example, treatment provided over a period of time or approval of a certain number of treatments. If the Plan reduces or terminates the course of treatment before its completion, except in the case where the Plan is amended or terminated in its entirety, this shall constitute an adverse benefit determination. The Claims Reviewer will notify the Claimant of this adverse benefit determination within sufficient time to allow the Claimant to appeal the decision and obtain a determination on review before the benefit is reduced or terminated.

If the Claimant requests to extend the course of treatment and the claim involves an Urgent Care situation, the Claims Reviewer will notify the Claimant of the claim determination (whether adverse or not) as soon as possible, but in no case more than 24 hours after the Claimant requests an extension, provided that the Claimant submits such claim at least 24 hours prior to the expiration of the initial treatment period.

C. Notification of Adverse Claim Determination

If the Claimant's claim for benefits is denied, in whole or in part, the Claimant or the Claimant's authorized representative will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the denial;

2. Sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

3. references to the specific Plan provisions on which the benefit determination was based;

4. a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;

5. A statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

6. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;

7. a description of the Plan's internal appeals procedures, any applicable the external review process, information regarding how to file an appeal, and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;

8. if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;

9. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;

10. identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;

11. the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

12. the contact information for the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA); and

13. in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In order to expedite the process in a situation involving an Urgent Care Claim, the Claimant may initially be notified of an adverse claim determination orally, but a written notification providing the information set forth above shall follow within three days.

D. Appeal of Adverse Claim Determination

If a claim for benefits is denied, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days after receiving the written notice of denial. The Claimant may submit with this appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant to the claim free of charge. In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Claimant is entitled to review the Plan's claim file and to present evidence and testimony in support of his or her claim.

If the situation involves an Urgent Care Claim, the Claimant can request an expedited review process whereby the Claimant may submit the appeal orally or in writing, and all necessary information, including the Plan's benefit determination on review, shall be relayed to the Claimant by telephone, fax, or other similarly expeditious method.

A full review of the information in the claim file and any new information submitted to support the appeal, including all comments, documents, records, and other information will be conducted. The claim determination will be made by the Claims Reviewer of the Plan. The Claims Reviewer will not have been involved in the initial benefit determination nor is the subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult a healthcare professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination. If a healthcare professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

E. Interim Notification of New Evidence or Rationale during pendency of Internal Appeal

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, if during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Claims Reviewer

must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

F. Notification of Final Internal Decision on Appeal

After an appeal is filed, the Claims Reviewer will respond to the claim within a certain period of time. The amount of time that the Claims Reviewer has to respond is based on the underlying claim for benefits as set forth below:

Post-Service Claims:	Within a reasonable period, but no more than 60 days after receiving Claimant's appeal request
Pre-Service Claims:	Within a reasonable time appropriate to medical circumstances, but no more than 30 days after receiving Claimant's appeal request
Urgent Care Claims:	As soon as possible, taking into account the medical exigencies, but no more than 72 hours after receiving Claimant's appeal request (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will defer to the attending provider with respect to the decision as to whether a claim is an Urgent Care Claim)

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the denial;

2. Sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

3. references to the specific Plan provisions on which the benefit determination was based;

4. A statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

5. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;

6. a description of any voluntary review procedures, internal appeals and the external review process, including information on how to initiate an appeal and applicable time limits;

7. if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request.

8. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;

9. identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;

10. the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

11. a discussion of the decision to deny the claim (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA);

12. disclosure of the availability of, and the contact information for, the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793 (in the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA); and

13. a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, the Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

II. External Review

The following review procedures apply to non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA. Specifically, they apply to such plans that are self-insured. Fully-insured group health Plans subject to external review requirements are generally subject to applicable state external review procedures, as outlined in each Plan. However, in the event those state external review procedures do not comply with PPACA requirements by the enforcement deadline imposed by the Departments of Labor and Health and Human Services, then such fully-insured Plans will be governed by these procedures to the extent necessary to comply with PPACA.

These procedures are intended to comply with the interim safe harbor contained in U.S. Department of Labor Technical Release 2010-01, as modified by Department of Labor Technical Release 2011-01, Department of Labor Technical Release 2011-02, and 76 Fed. Reg. 37208-37234 (June 24, 2011). At such time that guidance is revised or replaced by the Department, the new guidance shall be incorporated by reference herein and these procedures will be superseded by such new guidance to the extent necessary to comply with PPACA.

A. Standard External Review

This Section II.A. describes the procedures for standard external review. Standard external review is external review that is not considered expedited (as described in Section II.B., below).

1. Requests for External Review. A Claimant may file a request for external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. Except for requests for external review initiated before September 20, 2011, external review is only available for:

a. A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and

b. An adverse benefit determination (including a final adverse benefit determination) that involves medical judgment, as determined by the external reviewer. An adverse benefit determination that involves medical judgment includes, but is not limited to, an adverse benefit determination based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or the Plan's determination that a treatment is experimental or investigational. Additional examples of situations where a claim is considered to involve medical judgment include adverse benefit determinations based on:

i. The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);

ii. Whether treatment by a specialist is medically necessary or appropriate (pursuant to the Plan's standard for medical necessity or appropriateness);

iii. Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;

iv. A determination that a medical condition is a preexisting condition;

v. The Plan's general exclusion of an item or service, if the Plan covers the item or service in certain circumstances based on a medical condition;

vi. Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the Plan's wellness program, if any;

vii. The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations); and

viii. Whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.

2. **Preliminary Review.** Within five (5) business days after the date of receipt of the external review request, the Claims Reviewer will review the request to determine whether:

a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

b. The adverse benefit determination or the final adverse benefit determination does not relate to the Claimant's failure to meet the requirements for eligibility to participate under the terms of the Plan (eligibility claims are not subject to external review);

c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the final internal appeals process; and

d. The Claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Claims Reviewer will issue a written notification to the Claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and the toll-free (if available) contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. The Plan will allow a Claimant to perfect the request for external review within the later of: (a) the four-month filing period, or (b) the 48 hour period after the receipt of notification.

3. Referral to Independent Review Organization. The Claims Reviewer will assign an independent review organization (IRO) accredited by a nationally-recognized accrediting organization to conduct the external review. The Claims Reviewer will contract for assignments under the Plan with at least two IROs by January 1, 2012, and with at least three IROs by July 1, 2012. The Plan will rotate claim assignments among the IROs or incorporate other independent, unbiased methods for selection of IROs, such as random selection. The contract between the Plan and an IRO will provide the following:

a. The IRO will use legal experts where appropriate to make coverage determinations under the Plan.

b. The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the Claimant may submit in writing to the assigned IRO within ten (10) business days after the date of receipt of the notice that the IRO must consider when conducting external review. The IRO is not required to, but may, accept and consider additional information submitted after ten (10) business days.

c. Within five (5) business days after the date of assignment of the IRO, the Plan will provide the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review. If the Plan does not timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making such a decision, the IRO must notify the Claimant and the Plan.

d. Upon receipt of any information submitted by the Claimant, the IRO must within one (1) business day forward the information to the Plan. The Claims Reviewer may, but is not required to, reconsider its adverse benefit

determination or final internal adverse benefit determination. Reconsideration by the Plan will not delay the external review. If the Claims Reviewer decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Claims Reviewer will provide written notice of its decision to the Claimant and the IRO within one (1) business day after making its decision. The IRO will terminate the external review upon receiving this notice from the Claims Reviewer.

e. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

    i. The Claimant's medical records;

    ii. The attending health care professional's recommendation;

    iii. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating provider;

    iv. The terms of the Plan to ensure that the IRO's decision is not contrary to the Plan's terms, unless the terms are inconsistent with applicable law;

    v. Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

    vi. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the Plan's terms or with applicable law; and

    vii. The opinion of the IRO's clinical reviewer or reviewers after considering the available information or documents to the extent the clinical reviewer or reviewers consider appropriate.

f. The IRO will provide written notice to the Claimant and the Plan of the final external review decision within 45 days after the IRO receives the request for the external review. The notice will contain:

    i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, and if applicable, the claim amount, the diagnosis code and its corresponding meaning, the

treatment code and its corresponding meaning, and the reason for the previous denial);

ii. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the decision;

iv. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

v. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the Claimant;

vi. A statement that judicial review may be available to the Claimant; and

vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

B. Expedited External Review

1. Request for Expedited External Review. When external review is otherwise available, the Plan will allow a Claimant to make a request for an expedited external review at the time the Claimant receives:

a. An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or

would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal, or

b. A final internal adverse benefit determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant receive emergency services, but has not been discharged from a facility.

2. **Preliminary Review.** Immediately upon receipt of the request for expedited external review, the Claims Reviewer will review the request to determine whether the request meets the reviewability requirements described in Section II.A.2. above for Standard External Review. The Plan must immediately send a notice that meets the requirements set forth in Section II.A.2. for Standard External Review to the Claimant of its eligibility determination.

3. **Referral to Independent Review Organization.** Upon determination that a request is eligible for expedited external review following preliminary review described in Section II.B.2. above, the **Claims** Reviewer will assign an independent review organization (IRO) in accordance with the requirements described in Section II.A.3. above for Standard External Review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefits determination to the assigned IRO electronically or by telephone or fax or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for Standard External Review. In reaching a decision, the IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. **Notice of Final External Review Decision.** The IRO will provide written notice to the Claimant and the Plan of the final external review decision, in accordance with the requirements of Section II.A.3.f. above for Standard External Review, except that the notice will be provided as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, then within 48 hours after the date of providing that notice, the IRO must provide written confirmation of that decision to the Claimant and the Plan.

5. **Reversal of Plan's decision.**

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim. The final external review decision is binding on the Plan and the Claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the Plan from making payment on the claim or otherwise

providing benefits at any time, including after a final external review decision that denied the claim or otherwise fails to require such payment or benefits. For this purpose, the Plan must provide any benefits, including by making payment on the claim, pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. IRO Recordkeeping Requirements

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six (6) years. An IRO must make such records available for examination by the Claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

DISABILITY PLAN CLAIMS PROCEDURES

If the Claimant submits a claim for disability benefits provided under an insurance policy or any other contract for disability benefits administered by an outside provider, the claims and appeals procedures set forth in the insurer's or other third-party administrator's policy or contract must be followed. If the disability Program is administered by the Employer or if an outside provider has failed to establish a claims and appeals procedure, the following procedures must be followed:

A. Determination of Benefits

For the purposes of this disability benefit claims procedure, the term Claims Reviewer means the person or entity responsible for the relevant determination under a disability Program and the term Plan means any Program that provides benefits in the event of a disability. The Claims Reviewer will notify the Claimant of the claim determination within 45 days of the receipt of the claim. This period may be extended by 30 days if an extension is necessary to process the claim due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and when the Plan expects to decide the claim, will be furnished to the Claimant within the initial 45-day period. This period may be extended for an additional 30 days beyond the original extension. A written notice of the additional extension, the reason for the additional extension and when the Plan expects to decide the claim, will be furnished within the first 30-day extension period if an additional extension of time is needed. All notices of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and that the Claimant will have at least 45 days to provide the requested information. If a period of time is extended due to the Claimant's failure to submit information necessary to decide the claim, the period for making the benefit determination by the Claims Reviewer will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information received by the Plan.

B. Notification of Adverse Claim Determination

If the claim for benefits is denied, in whole or in part, the Claimant will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the denial;

2. references to the specific Plan provisions on which the benefit determination was based;

3. a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;

4. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;

5. a description of the Plan's appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;

6. a discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following:

   i. the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

   ii. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

   iii. the Claimant's disability determination by the Social Security Administration that the Claimant presented to the Plan;

7. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim or, alternatively, a statement that these sorts of rules, guidelines, protocols, standards or criteria of the Plan do not exist; and

8. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances; or a statement that this will be provided free of charge upon request.

C. Appeal of Adverse Determination

If a claim for benefits is denied, the Claimant may appeal the denied claim in writing to the Claims Reviewer within 180 days of the receipt of the written notice of denial. The Claimant may

submit with the appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant the claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted. The claim determination will be made by the Claims Reviewer of the Plan. The Claims Reviewer will not have been involved in the initial benefit determination nor will the Claims Reviewer be the subordinate of any individual involved in the initial claim for benefits. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Claims Reviewer will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, was not consulted in the initial adverse benefit determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse benefit determination.

D. Notification of Decision on Appeal

The Claims Reviewer will make a determination on the appeal within 45 days of the receipt of the appeal request. This period may be extended for an additional 45 days if the Claims Reviewer determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that the Claims Reviewer expects to render a decision will be furnished to the Claimant within the initial 45-day period. However, if the period of time is extended due to the Claimant's failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which the Claimant responds to the request for additional information.

In connection with the appeal, a Claimant may submit written comments, documents, records, and other information relating to the claim. In addition, the Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The review of the appeal will take into account all comments, documents, records, and other information that the Claimant submits, whether or not the Claimant first raised the issues or first submitted that information when the claim was originally considered.

The claim will be reviewed independently of the original claim and will be conducted by a named fiduciary of the Plan other than the Claims Reviewer.

In deciding an appeal of a claim denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same person who was consulted in connection with the original claim or any of his or her employees.

The Claims Reviewer will provide the Claimant with the name(s) of the health care professional(s) who was/were consulted in connection with the original claim, even if the claim denial was not based on his/her/their advice.

Before the Plan can deny the Claimant's appeal, the Claims Reviewer will provide the Claimant, free of charge, with:

- Any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; and

- Any new or additional rationale on which the denial of the appeal will be based.

This evidence and rationale will be provided as soon as possible and sufficiently in advance of the expiration of the 45-day period discussed above in order to give the Claimant a reasonable opportunity to respond prior to that date.

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a culturally and linguistically appropriate manner calculated to be understood by the Claimant and will include:

1. the specific reason(s) for the adverse determination;

2. references to the specific Plan provisions on which the determination was based;

3. a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the Claimant's benefit claim upon request;

4. a description of any voluntary review procedures and applicable time limits, the Claimant's right to obtain the information about those procedures, a statement of the Claimant's right to bring an action under Section 502(a) of ERISA, and a description of any applicable contractual limitations period that applies to the Claimant's right to bring the action, including the calendar date on which the contractual limitations period expires for the claim;

5. a discussion of the decision, including an explanation of the Plan's basis for disagreeing with or not following;

    a. the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

    b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

c. the Claimant's disability determination by the Social Security Administration that the Claimant presented to the Plan;

6. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in denying the claim on appeal or, alternatively, a statement that those sorts of rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

7. if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that an explanation will be provided free of charge upon request.

OTHER CLAIMS FOR BENEFITS

The Claims Reviewer shall maintain a procedure under which any participant or beneficiary (or an authorized representative acting on behalf of a participant or beneficiary) may assert a claim for benefits not covered by the claims procedures for health or disability plans set forth above. Any such claim shall be submitted to the Claims Reviewer in writing. The Claims Reviewer will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Claims Reviewer determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 90 days to decide the claim. Before obtaining this extension, the Claims Reviewer will notify the Claimant in writing, and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Claims Reviewer expects to render a decision.

If the claim is denied in whole or in part, the Claims Reviewer will provide the Claimant with a written notice which explains the reason or reasons for the decision, includes specific references to Plan provisions upon which the decision is based, provides a description of any additional material or information which might be helpful to decide the claim (including an explanation of why that information may be necessary), and describes the appeals procedures and applicable filing deadlines, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review. It will also include a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits. If the Claimant disagrees with the decision reached by the Claims Reviewer, the Claimant may submit a written appeal requesting a review of the decision. The written appeal must be submitted within 60 days of receiving the initial adverse decision. The appeal should clearly state the reason or reasons why the Claimant disagrees with the Claims Reviewer's decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the claim. The Claims Reviewer will generally notify the Claimant of its decision on appeal within 60 days after the appeal is received, unless special circumstances require an extension of time for processing, in which event a decision should be rendered as soon as possible, but in no event later than 120 days after such receipt. The decision will be in writing

and will include specific reasons for the decision, with specific references to the pertinent Plan provisions on which the decision is based; and a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. It will also describe any voluntary appeal procedures and applicable time limits, a statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

STATUTE OF LIMITATIONS AND EXHAUSTION OF ADMINISTRATIVE REMEDIES

All claims for benefits must be submitted by the claims filing deadline specified under the rules for a particular Program. If the Program does not specify a filing deadline, then claims must be submitted within one year from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred. This requirement may be waived by the Plan if, through no fault of the Participant or Beneficiary, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late claims will not be accepted if they are filed more than two years from the date the services relating to the claim were performed or the event that gave rise to the benefit occurred.

The Claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Claims Reviewer, the Plan Sponsor, or any other person, with respect to a claim for disability, medical, or other claims for benefits without first exhausting the claims procedures set forth above. A Claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the Claims Reviewer's or Plan Administrator's decision on appeal, but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal.

A. Failure to Follow the Claims Procedure for Health Plan Claims or Rescissions of Health Plan Coverage

In the case of non-grandfathered health plans subject to the expanded claims procedure requirements under PPACA, then notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by PPACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Claims Reviewer's decision on appeal. However, the Claimant cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

1. *De minimis*;

2. Not likely to cause, prejudice or harm to the Claimant;

3. Attributable to good cause or matters beyond the Plan's control;

4. In the context of an ongoing good-faith exchange of information; and

5. Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

B. Failure to Follow the Claims Procedure for Disability Benefits Claims

Notwithstanding the above, if the Plan fails to strictly adhere to the claims procedures for disability benefits claims, the Claimant will be deemed to have "exhausted" all administrative remedies available under the Plan. The Claimant will then be entitled to bring an action under Section 502(a) of ERISA on the basis that the Plan failed to provide the Claimant with a reasonable claims procedure that would yield a decision on the merits of the Claimant's claim. If the Claimant chooses to bring an action under Section 502(a) of ERISA in these circumstances, the Claimant's claim or the Claimant's appeal of the Claimant's claim denial will be deemed to have been denied by the Plan on review.

Notwithstanding the above paragraph, the administrative remedies available under the Plan will not be deemed to have been "exhausted" based on minor violations that do not cause and are not likely to cause the Claimant to be prejudiced or harmed in any way, provided the Plan shows that the violation was for a good cause or due to matters beyond its control, and that the violation occurred in the context of an ongoing, good faith exchange of information between the Claimant and the Plan. This exception is not available to the Plan if the violation is part of a pattern or practice of violations by the Plan.

The Claimant may request a written explanation of the violation from the Plan. The Plan must provide the requested explanation within 10 days, including a specific description of the bases, if any, for asserting that the violation should not cause the administrative remedies available under the Plan to be deemed exhausted.

If a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception, the claim will be considered to be re-filed on appeal upon the Plan's receipt of the decision of the court. The Plan will provide a notice of the resubmission to the Claimant within a reasonable time after the receipt of the decision.