ST. JOHN FISHER COLLEGE

FLEXIBLE BENEFITS PROGRAM

AND

PRE-TAX PREMIUM BENEFITS PROGRAM

SUMMARY PLAN DESCRIPTION

Of the Provisions of the Plan
in Effect on January 1, 2011

INTRODUCTION

This document, together with the Summary Plan Description for the St. John Fisher College Welfare Benefits Plan, constitutes the Summary Plan Description ("SPD") and presents a brief description of the Flexible Benefits Program and Pre-Tax Premium Benefits Program. It is not meant to extend or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection at the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, during regular business hours.

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

IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name:	St. John Fisher College Flexible Benefits Program and Pre-Tax Premium Benefits Program
Plan Number:	506
Plan Type:	Cafeteria (Section 125) Plan and Health Care and Dependent Care Flexible Spending Accounts
Plan Year:	The Plan Year begins on January 1 and ends on December 31
Employer and Plan Sponsor:	St. John Fisher College 3690 East Avenue Rochester, New York 14618 (585) 385-8048
Employer Identification Number:	16-0746864
Plan Administrator:	St. John Fisher College Welfare Benefits Plan Committee 3690 East Avenue Rochester, New York 14618 (585) 385-8048
Contributions and Plan Administration:	The Plan is administered by the Employer through a Committee appointed by the Employer and claims are adjudicated by a third party claims administrator, EBS Benefit Solutions, Inc. All benefits are paid from the general assets of the Employer and participant contributions. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the amount of Employer and participant contributions. The Human Resources Department is the primary source for information about these aspects of the Plan.
Plan Agent for Service of Legal Process:	St. John Fisher College 3690 East Avenue Rochester, New York 14618 Legal process may also be served upon the Plan Administrator.
Claims Administrator/ Fiduciary:	EBS Benefit Solutions, Inc. P.O. Box 22999 Rochester, NY 14692 Phone: 1-800-327-7130 or 585-232-2632 Fax: 1-877-256-7228 www.myebsaccount.com

1. What is the advantage to me of the Flexible Benefits Program and Pre-Tax Premium Benefits Program?

You can use the Plan to pay your premiums on a pre-tax basis for the group coverage sponsored by your Employer and listed in Question & Answer 5. (Your cost for the group coverage listed is referred to in this SPD as your "premium" whether the coverage is provided through an insured plan or is self-insured by your Employer.) You can also use the Plan to make pre-tax contributions that can be used to pay or reimburse you for expenses described in Question & Answer 6. These amounts are deducted from your pay and are not reported as taxable income on your W-2 form, so you do not pay income tax or Social Security taxes on them.

Alternatively, under the Plan you will receive an additional amount in your paycheck per payroll period if you are eligible for, but decline and do not receive, group medical coverage. The additional amounts you receive in your paycheck are subject to income tax and Social Security taxes, and are reported as taxable income on your W-2 form.

2. Who is eligible to participate in the Plan?

You are eligible to participate in the Plan if you are a full-time employee of the Employer. Full-time is defined as:

- For hourly, professional, administrative and supervisory staff: a weekly work schedule of 35 or 40 hours or more per week throughout the year, as determined by departmental requirements;

- For faculty: by appointment letters in conjunction with the Faculty Statutes.

You must also be in an eligible employment status. A description of employment status eligibility rules is available at http://www.sjfc.edu/dotAsset/130803.pdf. Also see Question & Answers 12 through 16 for more information about employment statuses.

Notwithstanding the above, any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court, are not eligible to participate in the Plan.

You may also cover eligible dependents under the Plan. Due to tax laws and insurance company requirements, each component Program (i.e., medical, dental, life insurance, General Health Care Flexible Spending Account, etc.) maintains different eligibility criteria. Employees should carefully review the dependent eligibility criteria in the official brochure prepared by the insurance company or Claims Administrator before enrolling a dependent in benefits under a Program.

A summary of dependent eligibility for each Program is available at http://www.sjfc.edu/dotAsset/130805.pdf. See the Summary Plan Descriptions for the various Programs, contact Human Resources, and/or visit the St. John Fisher College Welfare Benefits Plan website (http://www.sjfc.edu/campus-services/hr/benefits/legal.dot#benefits) for more information regarding eligible dependents. You can also contact the Plan Administrator to obtain a paper copy of this information.

For purposes of Pre-Tax Premium Benefits, the General Health Care FSA, and the Limited Purpose Health Care FSA, an eligible dependent is:

- your legal spouse if recognized by state and Federal law (i.e., current opposite-sex spouses only);
- your biological child, stepchild, legally adopted child, or eligible foster child who has not attained age 27 as of the end of the calendar year; and
- your tax dependent under Section 152 of the Internal Revenue Code ("Code"), except that an individual's status as a Dependent is determined without regard to the gross income limitation for a qualifying relative, and certain other provisions of the Code's definition that don't apply for purposes of pre-tax health benefits under Code Section 105(b). If you provide more than half of the financial support to a relative, or to another individual living in your home for the entire calendar year, then you should confer with a tax adviser to determine whether the individual qualifies as your dependent for this purpose.

It is important to note that because this Plan is governed by Federal tax law, same-sex spouses and domestic partners are not considered spouses eligible for benefits under this Plan. In other words, same-sex spouses and domestic partners and their children who are eligible for benefits under the Health Benefits Program and the Dental Benefits Program are not eligible as dependents under this Plan (for purposes of Pre-Tax Premium Benefits or FSA eligibility), unless the individual also qualifies as your Federal tax dependent under Code Section 152 as modified by Code Sections 105(b) and 125. See Question & Answer 4 for more information.

For purposes of the Dependent Care FSA, the following are eligible dependents:

- Your biological child, stepchild, adopted child, child placed for adoption, or foster child (or a descendant of your child), or your brother, sister, half-brother, half-sister, stepbrother or stepsister (or a descendant of any such relative), whose primary residence is your household for more than half of the calendar year, who is under age 13, and who has not provided more than one-half of his or her own support that year. In the case of divorced or separated parents, a child is treated as a dependent only of the parent who has custody for the greater portion of the calendar year.
- Your spouse or other relative you claim as a dependent on your taxes (or could have claimed as a dependent except for the fact that his or her gross income exceeds the personal exemption for that tax year) including relatives such as a

parent, parent in-law, or sibling, who lives with you for more than half the year (or someone other than a spouse whose primary residence is your household for more than half of the calendar year), spends at least eight hours a day in your household, and is physically or mentally incapable of caring for himself or herself.

3. When can I begin participating in the Plan?

If you meet the eligibility requirements listed above, you may begin participating in the Plan on the first of the month following the date of hire. If you are hired on the first of the month, then you become eligible on your hire date.

If you are a new hire, you must enroll online within 30 days of your hire date. Your coverage will be effective as of the first day of the month following your date of hire. Failure to enroll within 30 days may result in no coverage until the next open enrollment, or until you experience a qualifying event.

If you are not a new hire but are becoming eligible for benefits under the Plan due to a change in status (e.g., if you have a qualifying change in family status, or are changing from an ineligible to an eligible benefits status), then you generally have 30 days from your qualifying event to enroll or make coverage changes. The effective date of your coverage and the amount of time you have to make changes will depend on the type of qualifying event. See Question & Answer 8 for more information.

Once you are eligible to participate, your premiums will automatically be paid through the Plan unless you elect otherwise in writing signed by you and filed with Human Resources. If you file this election you will not be able to pay your premiums through the Plan until the next Plan Year, unless a change in status occurs that allows you to change this election (see Question & Answer 8). To make contributions to a General Health Care Flexible Spending Account (General Health Care FSA), Limited Purpose Health Care Flexible Spending Account (Limited Purpose Health Care FSA), or Dependent Care Flexible Spending Account (Dependent Care FSA), you must complete the enrollment process.

Failure to complete enrollment by the date specified by Human Resources will be considered an election not to make contributions for the Plan Year for other expenses. In that case, you will not be able to make contributions for other expenses until the next Plan Year, unless a change in status occurs that allows you to change your election (see Question & Answer 8).

Your premiums and contributions to the Plan are deducted from your pay throughout the Plan Year. For the Plan Year, see IMPORTANT PLAN INFORMATION YOU SHOULD KNOW.

4. How do I know if my same-sex spouse or domestic partner is a tax dependent eligible for Plan benefits?

You should consult with a tax advisor to determine if such an individual qualifies as your tax dependent. You may be required provide the College with a signed affidavit attesting to the dependent's tax status in order to receive Plan benefits for such individuals.

In general, the requirements for a same-sex spouse, domestic partner, or the child of such an individual to be your tax dependent for purposes of the benefits available under the Plan are:

- The individual has the same principal place of abode as you for the entire calendar year;
- The individual is a member of your household for the entire calendar year (and the relationship must not violate local law);
- During the calendar year, you must provide more than half of the total support (as described below) for the individual;
- The individual must not be claimed as a child on anyone else's tax return; and
- The individual must be a U.S. citizen, a U.S. national, or a resident of the U.S.

To determine whether you provide more than half of the total support for your same-sex spouse, domestic partner, or the child of such an individual, you must compare the amount of support you provide with the amount of support your same-sex spouse, domestic partner, or the child of such an individual receives from all sources, including Social Security, welfare payments, the support you provide, and the support your same-sex spouse, domestic partner, or the child of such an individual provides from his or her own funds. Support includes food, shelter, clothing, medical and dental care, education, and similar expenses. If you believe you might provide more than half of the support for your same-sex spouse, domestic partner, or the child of such an individual, you should complete the support worksheet in IRS Publication 501 (Exemptions, Standard Deduction, and Filing Information). Please note that an individual could qualify as a tax dependent for purposes of the benefits available under the Plan, but not on your tax return, if that individual earns more than $3,650 (the exemption amount as defined in Code Section151(d) for 2011), but still receives more than half of his or her support from you.

If you submit a signed affidavit certifying that your same-sex spouse, domestic partner, or the child of such individual is your tax dependent, and it is later determined that the value of those benefits should have been taxable to you, then you will be required to reimburse the Company for any liability it may incur for failure to withhold Federal, state, or local income taxes, Social Security taxes, or other taxes related to such benefits.

Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant or eligible dependent under

this Plan will be excludable from the Participant's or eligible dependent's gross income for Federal, state, or local income tax purposes.

5. What premiums can I pay through the Plan?

You can pay your premiums for the following types of group coverage sponsored by your Employer:

- medical coverage through the Health Benefits Program (on a pre-tax basis for you, your spouse or any person who qualifies as your dependent for Federal income tax purposes, as modified by Code Section 105(b), which governs taxation of health benefits)

- dental coverage through the Dental Benefits Program (on a pre-tax basis for you, your spouse or any person who qualifies as your dependent for Federal income tax purposes, as modified by Code Section 105(b), which governs taxation of health benefits)

- supplemental life insurance coverage and accidental death & dismemberment coverage (on an after-tax basis for you and your eligible dependents).

6. What other expenses can be paid under the Plan?

You can also make contributions to the following accounts available under the Plan that can be used to pay or reimburse you for the following types of expenses on a pre-tax basis, provided they are not payable or reimbursable from any other source:

- General Health Care FSA: health care expenses (other than insurance premiums) that would otherwise be deductible on your Federal income tax return if they were not paid or reimbursed under any other plan or Program (but without regard to any minimum amount of heath care expenses required to take a deduction) for you, your spouse or any person who qualifies as your dependent for Federal income tax purposes. Plan contributions cannot be used to pay or reimburse you for over-the-counter drugs (other than a prescribed drug or insulin), toiletries, cosmetics, sundry items, dietary supplements, vitamins and other items that are merely beneficial to a person's general health. A list of eligible medical and dental expenses is available via the Flexible Spending Account link on the St. John Fisher College Insurances website (http://www.sjfc.edu/campus-services/hr/benefits/insurances/index.dot#flex). You can also refer to IRS Publication 502 for more information.

- Limited Purpose Health Care FSA: if you have high deductible health plan coverage and contribute to an HSA, the Limited Purpose Health Care FSA can be used for dental and vision care expenses (other than insurance premiums) that would otherwise be deductible on your Federal income tax return if they were not paid or reimbursed under any other plan or Program (but without regard to any minimum amount of heath care expenses required to take a deduction) for you, your spouse or any person who qualifies as your dependent for Federal income tax purposes.

- Dependent Care FSA: work-related dependent care expenses that would otherwise qualify for a dependent care credit on your Federal income tax return if they were not paid or reimbursed under any other plan or Program. You may be reimbursed for these expenses incurred on behalf of any individual in your family who is under the age of 13 and who can be claimed as a dependent on your Federal tax return; any other tax dependent who is mentally or physically unable to care for himself/herself; or your spouse, if your spouse is physically or mentally incapacitated. See Question & Answers 2 and 4 for more information about dependents for whom you can claim reimbursement from this account. A list of eligible dependent care expenses is available via the Flexible Spending Account link on the St. John Fisher College Insurances website (http://www.sjfc.edu/campus-services/hr/benefits/insurances/index.dot#flex). To qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed tax-free reimbursement. You may not claim any other tax benefit for the tax-free amounts received by you under this plan.

- Health Savings Account (HSA): if you have high deductible health plan coverage and have enrolled for an eligible HSA that reimburses you for eligible health care expenses, subject to the limitations set forth in the document provided by the HSA trustee/custodian with whom you establish the HSA, you can make contributions to the HSA on a pre-tax basis through this plan. You can only make contributions through this plan to certain HSA providers, which are named in the enrollment materials.

7. How much can I contribute for these other expenses?

Before you can first participate in the Program, and at the beginning of each Plan Year, you will be notified in your enrollment materials of the amount of employee contributions for Medical, Dental, Life Insurance and AD&D coverage, as well as the minimum and maximum amount you can contribute to an FSA for that Plan Year.

As of January 1, 2011, up to $5,000 may be elected per Plan Year for the General Health Care FSA or the Limited Purpose Health Care FSA. By law, beginning in 2013, the annual amount you can contribute to the General Health Care FSA or the Limited Purpose Health Care FSA will be reduced to $2,500.

The amount you can contribute to a Health Savings Account depends on whether you elected single or family coverage for the calendar year when you make the contribution. As of January 1, 2011, you can contribute $3,050 if you elect single coverage and $6,150 if you elect family coverage. You can make an additional catch-up contribution ($1,000 in 2011) if you are age 55 or older. The IRS adjusts the amount you can contribute annually. That amount is communicated in the enrollment materials.

The amount that you can contribute to a Dependent Care FSA depends on your marital and tax filing status. You can contribute up to the least of the following amounts:

- $5,000, if you are single, the head of the household for Federal tax purposes, or married and you and your spouse file a joint return;
- $2,500, if you are married but you and your spouse file separate tax returns (subject to a special rule for certain couples who do not share a residence during the last six months of the tax year);
- your earned income; or
- your spouse's earned income (if you are married at the end of the calendar year).

In general, earned income includes wages, salaries, tips, and other employee compensation that are includible in gross income for the taxable year, plus net earnings from self-employment. If your spouse has no earned income and is either a full-time student or incapable of self-care, then your spouse is treated as though he or she had earned income of $200 per month if you have one qualifying dependent or $400 per month for two or more qualifying dependents.

If your spouse has a dependent care assistance plan account through his or her employer, your combined contribution cannot be more than $5,000. If you and your spouse both work for the College, you may both contribute to the account, but may not contribute more than $5,000 combined.

Remember that in the case of divorced or separated parents, a child is treated as a dependent only of the parent who has custody for the greater portion of the calendar year. The non-custodial parent for tax purposes cannot establish a Dependent Care FSA.

The $5,000/$2,500 limit may be reduced for highly paid employees in any year if the plan should fail certain IRS-imposed antidiscrimination tests in that year.

8. When can I change the amount I contribute to the Program?

You can change your elections before the beginning of each new Plan Year. Once the Plan Year has started, Federal tax laws permit you to change your elections only when one of the following "changes in status" occurs:

- You have a special enrollment right under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which occurs when:
    - — You, your spouse or your dependents lose eligibility for employer group health plan or health insurance coverage

— You, your spouse or your dependents experience the termination of employer contributions toward non-COBRA group health plan or health insurance coverage

— You, your spouse or your dependents exhaust COBRA continuation coverage

— You acquired a new dependent by marriage, birth, adoption, or placement for adoption

- You, your spouse or dependent becomes eligible for continued health coverage under Federal law (COBRA) or similar state law under a group health plan of your Employer.

- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage.

- You, your spouse or dependent loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines).

- Your premium increases significantly. (However, if there is an ordinary increase or decrease in premiums, your contributions will automatically be adjusted to reflect the change.) Note, a significant increase in premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

- There is a significant curtailment in, or cessation of, your group coverage. (In the case of group health coverage, there must be reduced coverage for employees generally.) Note, that a significant curtailment in, or cessation of, your group coverage allows you to change the amount of the premiums you pay for that coverage through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other contributions to the Plan.

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

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

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

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

- A change in your place of worksite or residence, or the place of worksite or residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for HMO coverage at the new place of residence. Note, a change in residence allows you to change the amount of the premiums you pay through the Program for the group coverage for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Program or any other contributions to the Program.

- Your dependent's eligibility for health coverage changes due to the dependent's age, student status or marital status or similar circumstance.

- There is a change in your dependent care provider or a change in the cost of services provided by a dependent care provider who is not a relative.

- A person's status as a dependent for purposes of your dependent care election changes.

- Your spouse, former spouse or dependent makes a change under another plan which is either (i) consistent with one of the events described above, or (ii) for the normal election period under the other plan and that election period is different from the Plan Year of this Program.

- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan, through no fault of your own. Note loss of such coverage allows you to change the amount of premiums you pay through the Program for medical coverage, but does not allow you to change the amount of any other premiums you pay through the Program or any other contributions to the Program.

Election changes must be made within 30 days of an event described above, and must conform to and be consistent with that event. Not all qualifying events will

permit you to make changes to your elections for all types of benefits available under this Plan. For more information regarding election changes and the consistency requirements, contact the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, (585) 385–8048.

Your election change for payment of pre-tax premiums or for FSA or HSA contributions will not be effective until the date you complete your election change request (so long as it is submitted to the Human Resources Office prior to the applicable payroll cutoff). However, for medical coverage, dental coverage, supplemental life insurance coverage and accidental death & dismemberment coverage, your coverage in the underlying benefit program will be retroactive to the date of the qualifying event, but you will be required to pay for any retroactive period of coverage on an after-tax basis (unless your qualified change in status was birth, adoption, or placement for adoption, in which case retroactive premiums for medical coverage can be paid on a pre-tax basis).

In addition to the above HIPAA special enrollment periods and qualified change in status listed above, you also have a special enrollment opportunity if you or your eligible dependents either:

- lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment rights, you will have 60 days – instead of 30 days – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Employer group health plan. Note that this new 60 day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Also, even if you are allowed to change your FSA election due to a qualifying status change, you may not reduce the annual contribution elected to less than the amount of expenses already reimbursed to you for the Plan Year.

9. How do I receive my benefits from the Program?

Amounts are deducted directly from your pay and used to pay your premiums. To claim benefits, you need to follow the claims procedures for the specific Program.

Claims for payment or reimbursement from your General Health Care FSA, Limited Purpose Health Care FSA, or Dependent Care FSA must be made on forms provided by Human Resources or online at http://www.myebsaccount.com. You may request forms from the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, (585) 385–8048, or get them from the St. John Fisher College Insurances website at http://www.sjfc.edu/campus-services/hr/benefits/insurances/index.dot#flex.

Note:

- The amount of dependent care expenses paid or reimbursed cannot exceed the contributions you have made to the Dependent Care FSA, less the amount of such expenses already paid or reimbursed from the Program for the Plan Year.

- The amount of health care expenses paid or reimbursed cannot exceed the amount of your General Health Care FSA or Limited Purpose Health Care FSA contribution election for the Plan Year, less the amount of such expenses already paid or reimbursed from the Program for the Plan Year.

- Only expenses incurred on or after the date you begin participating in the Program and before the date you stop participating in the Program are covered under the Program. Generally, you stop participating in the Program when you are no longer an eligible employee of the Employer. (See Question & Answers 2 and 12 through 16.) In addition, any expenses incurred after you stop making Program contributions for those expenses are not covered.

- If you are employed through the end of the Plan Year, you have until the April 30th after the end of each Plan Year to submit a claim for payment or reimbursement for expenses that you incurred during the Plan Year. (Question & Answers 12 through 16 explain rules that apply when you terminate employment before the end of a Plan Year.)

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

10. What happens if I am employed by the Employer through the end of a Plan Year but my contributions for expenses (other than premiums) are greater than my actual expenses during the Plan Year?

If the amount you contribute for expenses exceeds the amount of those expenses which you actually incur during the Plan Year, you will forfeit the excess contributions to the General Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA. Therefore, you should be careful to contribute only the amount you think will be needed to cover your anticipated expenses for the Plan Year. Any amounts forfeited by participants may be used to defray expenses to administer the plan, to reduce contributions for participants in the following year, allocated to participants on a reasonable and uniform basis, or for any other purpose permitted by law. In the case of Dependent Care FSA forfeitures, the forfeited amounts may also be retained by your Employer.

However, you will not forfeit Health Savings Account contributions if the amount you contribute exceeds the expenses that you incur during the Plan Year. Health Savings Account contributions can be carried over from year to year.

11. How can I contribute to a Health Savings Account ("HSA")?

You can elect HSA contributions only if you are enrolled in a high deductible health plan, if you meet the other criteria for participation, and are actually enrolled in an HSA with a participating HSA trustee/custodian.

You cannot make an HSA contribution through the plan if you have disqualifying medical coverage that would prohibit you from contributing to an HSA. For example, if you have medical insurance that is not qualifying high deductible health plan coverage, or if you are enrolled in Medicare Part A, you cannot make HSA contributions. Also, if you participate in the General Health Care FSA, you cannot make HSA contributions at any time during the General Health Care FSA's coverage period, even if your FSA account balance reaches zero. Likewise, if you are covered by a general Health Reimbursement Account ("HRA") offered by your Employer, then you cannot make HSA contributions at any time during the General HRA's coverage period. The same restrictions apply if you are covered as a dependent under another employer's general health care FSA or general HRA, such as if your spouse participates in a general health care FSA or general HRA and your medical expenses are eligible for reimbursement from his or her account. If the General Health Care FSA has a claims filing grace period, then you also cannot contribute to an HSA through this Plan during the first three calendar months after the close of the General Health Care FSA's plan year unless your account balance in the General Health Care FSA at the end of the plan year was zero. If the employer sponsoring a General HRA allows you to waive or suspend participation, then you may be permitted to make HSA contributions under this Plan if you suspend participation prior to the start of a new HRA plan year or if your balance at the end of a plan year is zero and you waive participation for the following plan year. These restrictions do not apply to a Limited Purpose Health Care FSA or a similarly limited HRA.

Your Employer may also make a contribution to your HSA. The enrollment materials will specify the amount of the Employer's contribution, if any, and any conditions for it receipt.

The amount you can contribute to an HSA is limited by tax laws. Your maximum contribution depends in part on your high deductible health coverage option (i.e., single or family) for the calendar year in which the contribution is made. An additional catch-up contribution may be made by Participants who are age 55 or older. Maximums will be specified in the enrollment materials. The HSA maximum annual contribution will be reduced by any contribution made by your Employer and prorated for the number of months in which you are eligible to make HSA contributions.

HSA benefits under this Plan consist solely of the ability to make contributions to the HSA through payroll deductions on a pre-tax basis and for your Employer to make contributions to your HSA, if applicable. The HSA is not an Employer-sponsored employee benefit plan. The HSA trustee/custodian, not your Employer, establishes and maintains the HSA. The terms and conditions of coverage and benefits are described in the HSA documents published by the trustee/custodian, and are not a part of this Plan.

Although your Employer limits the HSA providers to whom it will forward HSA contributions, your Employer does not endorse of any particular HSA provider.

12. What happens if my employment terminates or I move to an ineligible status before the end of a Plan Year?

You may claim payment or reimbursement for expenses reimbursable under the Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA that were incurred before your termination, provided you submit your claim for payment or reimbursement no later than 90 days after your termination or change to an ineligible status. You may also have a right to COBRA continuation coverage for the Health Care FSA or Limited Purpose Health Care FSA. (See "COBRA Continuation Coverage" in Question & Answer 20.)

Even if you lose eligibility for this Program, you can continue to make contributions to and claim benefits from a Health Savings Account outside of this Program, in accordance with the HSA governing documents and procedures determined by the HSA trustee/custodian.

13. What happens if I take a paid sabbatical?

Your benefits under this Program will not change during a paid sabbatical. The college will continue to make deductions from your pay to fund your benefits as if you were in regular active status.

14. What happens if I become disabled during the Plan Year?

Your Medical Coverage continues while you are receiving Short-Term Disability or Workers' Compensation benefits for a job-related disability. You must pay your normal share of the premium and you will be billed accordingly.

Your Dental coverage also continues while you are receiving Short-Term Disability or Workers' Compensation benefits. You must pay your normal share of the premium and you will be billed accordingly.

If you begin receiving Long-Term Disability benefits, you will no longer be eligible for Employer Medical or Dental coverage, but you may be eligible to continue your benefits at your own expense with COBRA continuation coverage. (See "COBRA Continuation Coverage" in Question & Answer 20.)

You may continue FSA or HSA participation while on Short-Term Disability, Workers' Compensation, or Faculty Medical Leave. Participation continues on a pre-tax basis if you using paid absence or vacation time, or if you are on Faculty Medical Leave receiving salary. Otherwise, you must make arrangements to have pre-tax deductions taken in advance of your absence, and/or you may continue participating in a FSA or HSA by making after-tax contributions while on leave. If your leave spans two Plan Years, you may not pre-pay contributions due after the last day of the Plan Year in which

the leave begins. FSA participation and HSA contributions are terminated as of the effective date that you are approved for Long-Term Disability.

While on Short-Term Disability, Workers' Compensation, or Faculty Medical Leave, your Life Insurance benefits will continue until you are approved for Long Term disability benefits (up to 12 months). You will be billed for and must pay for any supplemental and/or dependent life insurance coverage. After you are no longer eligible for group Life Insurance coverage, you may have the right to convert to an individual policy at your own expense.

You may continue to participate in Accidental Death and Dismemberment (AD&D) insurance while on Short-Term Disability, Workers' Compensation, or Faculty Medical Leave. You will be billed for and must pay your premiums. Eligibility for AD&D coverage ends after twenty-six weeks, when you become eligible for Long-Term disability benefits.

15. What happens if I take a job-protected Family and Medical leave or military leave of absence during the Plan Year?

Your Medical and Dental Program coverage will continue during an approved Family Medical Leave (FMLA) or military leave if you are a regular full-time employee and are covered by the Medical and/or Dental Programs at the time your absence begins. Continuation rights end on the earliest of the following:

- The date you return to active employment, or
- The end of the job-protected leave period, or
- After 26 weeks, in the case of military leave.

You will be billed for your share of the premiums during your leave and must pay the premiums to continue receiving benefits. To the extent you continue receiving pay during the leave (e.g., vacation pay), pre-tax contributions for Medical, Dental, HSA, and FSA contributions will be taken from that income. You may also pay your anticipated premiums on a pre-tax basis by accelerating your payments and having them taken out of paychecks before you take leave. If your leave spans two Plan Years you may not pre-pay contributions due after the last day of the Plan Year in which the leave begins. Otherwise, you can continue to pay Medical, Dental, HSA, and FSA contributions with after-tax payments during the leave

In addition, your Life Insurance and AD&D coverage will continue while on FMLA or military leave, but you will be billed for and must pay to continue premiums for AD&D or supplemental and dependent life coverage.

A leave under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act is also a qualified change in status, so you may revoke or change your elections as explained in Question & Answer 8. However, you won't be eligible for reimbursement from your FSA for health care expenses or

dependent care expenses incurred during a period in which your contributions cease as a result of a leave. If you stop making contributions to your account, then you will have 90 days to submit eligible expenses incurred prior to the FSA cancellation date. If you choose not to continue coverage during leave, you may resume Program contributions when the FMLA Leave expires, provided you return to work in a benefit-eligible position and you enroll within 30 days of your return. You will have the choice whether to resume contributions at the same monthly amount as prior to your leave, or whether to increase that monthly amount to maintain the same annual contribution.

If you do not return to work after FMLA leave for reasons other than health conditions or some other reason beyond your control, the College will recover the cost from you of any payments it made to maintain your health insurance coverage.

If you continue your coverage during leave and exhaust your maximum coverage period, you will be sent a separate document that explains your rights under COBRA/USERRA continuation coverage. When you return to work at the Employer following a military leave, the Employer Health Care and Dental Programs will not be required to cover injuries or illness that are determined by the Secretary of Veterans' affairs to have been incurred in, or aggravated during, performance of services in the armed forces; those will be covered by the uniformed service. However, there will be no waiting periods or pre-existing condition limitations upon your return to work.

More information about FMLA or military leave is available in the Employee Handbook or from the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, (585) 385–8048.

16. What happens if I take unpaid leave that is not FMLA or military leave?

If you take unpaid leave that is not FMLA or military leave you will no longer be eligible for Employer sponsored benefits, but you may be eligible to continue your Health Benefits Plan, Dental Benefits Plan, General Health Care FSA, or Limited Purpose Health Care FSA benefits at your own expense with COBRA continuation coverage. (See "COBRA Continuation Coverage" in Question & Answer 20.) Your Life Insurance and AD&D benefits may continue for one month starting on the date your leave begins, but you may be required to pay premiums for continued coverage during this period. Contact Human Resources for more information.

17. Can the Employer amend or terminate the Program?

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

18. Who controls the operation of the Program?

A Committee appointed by the Employer controls and manages the operation of the Program. The St. John Fisher College Welfare Benefits Committee (the "Committee") has full discretionary authority to interpret the Plan and decide all questions relating to eligibility to participate in the Program or regarding pre-tax premium benefits, and may establish rules for the operation of the Program.

EBS Benefit Solutions, Inc. (EBS) is the claims administrator, and has full discretionary authority to interpret the Plan and to decide all questions relating to benefits offered under the Plan, including but not limited to the benefits payable under the Plan. EBS has the right to adopt reasonable policies, procedures, rules and interpretations of the Plan to promote orderly and efficient administration.

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

If you have general questions about any group coverage sponsored by the Employer, you should contact the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, (585) 385–8048. Claims for group coverage benefits should be filed in accordance with the procedures applicable to the specific Program.

If you disagree with a decision concerning your right to participate in the Program or regarding pre-tax premium benefits, you may file a claim in writing with the Committee at the address on page 16. If you wish to make a claim for a benefit, you may file a claim in writing with the applicable claims administrator.

If you wish, you may appoint someone to file the claim and act on your behalf, provided you give the Committee or claims administrator (as applicable) signed written notification of the appointment. The claim procedure is different depending on whether the claim is related to a health care expense or is any other type of claim.

Contact Human Resources if you have questions about this Program or if you need information on how to file a claim for a group coverage benefit. Detailed instructions for filing an FSA claim follow.

Filing FSA Claims with EBS Benefit Services, Inc.

If you have enrolled for Employer health coverage, then your out-of-pocket health care expenses will be automatically reimbursed from your FSA through Automatic Claims Transfer (ACT). You may opt out of ACT. If you are covering dependents on your medical coverage who do not qualify as Federal tax dependents (e.g., a same-sex spouse, a domestic partner, or the child of a same-sex spouse or domestic partner), then you must opt out of ACT because these individuals are not eligible to receive reimbursements from the FSA.

If the Employer health care plan is not the primary plan for you and/or your dependents, then you will need to file claims manually. You will also need to file your dental and Dependent Care out-of-pocket expenses manually.

Reimbursement forms for manual claims are available from Human Resources or can be printed from http://www.sjfc.edu/campus-services/hr/benefits/insurances/index.dot#flex. Claims can also be submitted online at www.myebsaccount.com. After submitting claims online, all receipts and supporting documentation must be faxed to EBS at 1-877-256-7228. Claims are paid on a weekly basis and can be reimbursed to you by check or direct deposit. A $30 minimum must be claimed before reimbursement is made. If you submit a claim for less than $30, the claim will not be processed until additional claims are filed totaling at least $30.

To submit claims, check FSA balances, view payment information including pending claims and reimbursements paid, log on to www.myebsaccount.com. Or, call customer service at 585-232-2632 or 1-800-327-7130.

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

If a claim is denied in whole or in part, you will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Program provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Program's review procedures and time limits; and (v) a statement that you have a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review. In the case of a health claim, the notice will also state the names of any medical or vocational experts whose advice was obtained by the Program in connection with the determination. If the Program relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Program relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Program to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If a claim is denied and you want a review, you must notify the Committee or claims administrator (as applicable) in writing within 180 days after you receive the written notice of denial of health claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee or claims administrator (as applicable) receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Program provisions on which the determination is based; (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) a statement that you have a right to sue under the Employee Retirement Income Security Act; and (iv) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." If the Program relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Program relied upon such criterion and a copy of the criterion is available free of charge upon request.

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

Because the General Health Care FSA and the Limited Purpose FSA are subject to ERISA, if all applicable appeals of your claim for those benefits have been denied, you have the right to bring a civil action under Section 502(a) of ERISA to challenge the denials in court. You may not bring a civil action under ERISA before you complete the administrative appeals process outlined above. If you bring a civil action, it must be filed no later than the earlier of (1) the applicable statute of limitations, or (2) the second anniversary of the Committee's or claims administrator's decision on appeal.

Appeals of adverse determinations regarding eligibility or pre-tax premium benefits should be sent to:

St. John Fisher College Welfare Benefits Plan Committee
3690 East Avenue
Rochester, New York 14618
(585) 385-8048

Appeals of denied claims for benefits should be submitted to the appropriate claims administrator for the specific Program. For FSA claim denials, appeals should be submitted to:

EBS Benefit Solutions, Inc.
P.O. Box 22999
Rochester, NY 14692
Fax: 1-877-256-7228

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

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

COBRA Continuation Coverage

You may have a right under "COBRA" to continue to participate in the Health Benefits Program, the Dental Benefits Program, the General Health Care FSA or the Limited Purpose FSA after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose your group health coverage.

Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it. This summary only explains your rights to continue coverage under the General Health Care FSA and the Limited Purpose FSA. For a description of COBRA rights to continue coverage under the Health Benefits Plan and the Dental Benefits Plan, see the summary plan description for the St. John Fisher College Welfare Benefits Plan.

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618. The notice must be in writing, and must contain your name and address, the name and address of any affected dependents, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each

qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. **For the General Health Care FSA and the Limited Purpose FSA, COBRA coverage lasts no longer than the last day of the Plan Year in which the qualifying event occurs.** (COBRA coverage lasts much longer for the Health Benefits Program and Dental Benefits Program; see the summary plan description for the St. John Fisher College Welfare Benefits Plan for more information).

Furthermore, COBRA continuation coverage for the General Health Care FSA and the Limited Purpose FSA is not available to a qualified beneficiary even for that Plan Year unless the qualified beneficiary could become entitled to payment or reimbursement for health care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Program for the remainder of that Plan Year.

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Program Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, (585) 385–8048.

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

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or the Uniformed Services Employment and

Reemployment Rights Act ("USERRA"). Information concerning your HIPAA and USERRA rights is available from the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, (585) 385–8048.

HIPAA Privacy Rights

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

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

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Program or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Program's privacy notice or more information about the Program's privacy practices, or you want to file a privacy violation complaint, please contact the Director of Human Resources, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, phone (585) 385-8048, fax (585) 385-8438.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for a parent to provide a child or children with health coverage. If the Plan receives a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan's QMCSO procedures are available, without charge, from the Human Resources Department, St. John Fisher College, 3690 East Avenue, Kearney Hall, Room 211, Rochester, New York 14618, (585) 385–8048.

Your Rights Under ERISA

Certain components of the Plan are governed by a Federal law known as the Employee Retirement Income Security Act of 1974 (ERISA), specifically the Health Benefits Program, the Dental Benefits Program, the General Health Care FSA, and the Limited Purpose FSA. If you participate in those components of the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Program participants shall be entitled to:

Receive Information About Your Program and Benefits

This includes the ability to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Program, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the Program 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 Program, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Program's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

- Inspect or copy applicable collective bargaining agreements, if any, upon written request to the Plan Administrator.

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 may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may

be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Program documents or the latest annual report from the Program and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Program'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 Program fiduciaries misuse the Program'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 Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.