SUMMARY PLAN DESCRIPTION

for the

ST. JOHN FISHER COLLEGE
WELFARE BENEFITS PLAN

This document, together with the separate benefit-specific summaries in the following tabs and the enrollment package you receive each year, describe the welfare benefits provided under the St. John Fisher College Welfare Benefits Plan (the "Plan) for eligible employees of St. John Fisher College (hereinafter the "College"). The specific benefits (each, a "Program") covered by the Plan are the following:

- Health Benefits
- Dental Benefits
- Flexible Benefits (Flexible Spending Accounts and Pre-Tax Premium Benefits)
- Long Term Disability Benefits
- Group Life Insurance and Accident Benefits
- Voluntary Personal Accident Insurance Benefits
- Employee Assistance Plan Benefits

More information about the providers of these Programs is found in Appendix A. More information about the specific benefits provided under a Program is found in the separate benefit-specific summary for that Program put together by the insurance company for that benefit, or with respect to the Pre-Tax Premium Benefits Program, in the St. John Fisher College Flexible Benefits Program and Pre-Tax Premium Benefits Program Summary Plan Description.

In general, the summary for each Program describes the specific benefits that are provided by the insurance company, including any terms and conditions associated with those benefits, the annual enrollment package describes eligibility, cost sharing and other matters that relate to the terms and conditions of participation in a particular year and this document describes supplemental information relevant to all Plan benefits – for example, information about the College, the classes of employees eligible to participate and certain legally-required statements about your benefits rights.

The aggregate information provided in the benefit specific summaries, the enrollment package, and this summary, are intended to constitute the summary plan description (SPD) for the covered benefits. The Plan document, a copy of which may be obtained by contacting the Human Resources Department, is the controlling legal document should any dispute arise over the terms and conditions of this Plan.

Name of Plan Sponsor

St. John Fisher College
3690 East Ave.
Rochester, NY 14618
Employer Tax Identification Number: 16-0746864

Plan Administrator and Agent for Service of Legal Process

Welfare Benefits Plan Committee
St. John Fisher College
3690 East Ave.
Rochester, NY 14618
Telephone Number: (585) 385-8048

The Plan Administrator determines, in its sole discretion, your eligibility to participate in this Plan and its component parts, and, for benefits managed internally, if any, your eligibility for benefits. For insured Programs, the insurer determines eligibility for benefits under its policy or contract in its sole discretion. For self-insured Programs, the third party claims administrator determines your eligibility for benefits under the terms of the Program in its sole discretion. The Plan Administrator has the discretion to administer and interpret all aspects of the Plan not set forth in an insurance policy.

The Plan Administrator has the sole responsibility to determine whether a medical child support order is "qualified" under the terms of ERISA (i.e., the Employee Retirement Income Security Act of 1974), though the Plan Administrator may delegate this responsibility to an insurer or third-party administrator. All such orders must be submitted to the Plan Administrator (preferably in draft form before being sent to the court for signature to minimize the chances of your having to return to court if the order is not qualified). The Plan Administrator will respond within 90 days to all affected parties on whether the order qualifies (or will qualify when signed by a court). You may obtain a copy of the procedures used for processing an order, free of charge, from the Plan Administrator.

Name and Plan Number of Benefits Covered by this Summary

St. John Fisher College Employee Welfare Benefits Plan: Plan No. 501

Type of Administration

The insured Programs are insurer-administered. The Pre-Tax Premium Benefits Program component of the Flexible Benefits Program and Pre-Tax Premium Benefits Program are administered by the Plan Administrator. The other components of the Flexible Benefits Program and Pre-Tax Premium Benefits Program are administered by a third party claims administrator in accordance with the terms of an administrative services contract.

Eligibility

Regular full-time faculty and staff members who are in an eligible employment status are eligible to participate in the Plan. A description of employment status eligibility rules is available at http://www.sjfc.edu/dotAsset/130803.pdf. A paper copy of this description is available upon written request to the Plan Administrator. Retirees are eligible for certain Plan

benefits as described in Exhibit D. Faculty members participating in the Bridge to Retirement Program are also eligible for Plan benefits, as described in the materials for that program.

An otherwise eligible employee is covered by a Program only if he or she falls within one or more categories of covered employees as described in the Program.

Except as otherwise described by the benefit-specific summary or enrollment package for a particular Program, the entry date for commencement of participation in a Program is the first day of the month next following the eligible employee's date of hire.

Participation in a Program is conditioned on completion of the relevant enrollment process and any enrollment materials, an employee's payment of the employee-required portion, if any, of the Program's cost and the employee's satisfying any other relevant terms and conditions imposed by the Plan Administrator, the insurance company, or the third party claims administrator.

Dependents may also be eligible to be covered by some of the Programs as described in the relevant enrollment materials and the brochures prepared by the insurance company. Eligible dependents generally include the following:

- The employee's spouse, if the marriage is recognized in New York State;
- The employee's child(ren) up to applicable age limits, if the child(ren) satisfies the Program's criteria for an eligible child(ren);
- The employee's domestic partner and the domestic partner's child(ren), for medical and dental insurance, if the domestic partnership satisfies the College's criteria for domestic partnerships at http://www.sjfc.edu/campus-services/hr/benefits/insurances/index.dot#partner.

Each Program and each insurance product maintains different eligibility criteria, and employees should carefully review the dependent eligibility criteria in the official brochure prepared by the insurance company or third party claims administrator before enrolling a dependent in benefits under a Program. A Dependent Eligibility Summary is available at http://www.sjfc.edu/dotAsset/130805.pdf. A paper copy of this summary is available upon written request to the Plan Administrator.

For some insured benefits, an eligible employee may also have an individual right to convert his or her group coverage to an individual policy as described in a Program.

Notwithstanding the above, the following persons are not eligible to participate in the Plan: (1) leased employees; (2) union employees, unless the relevant collective bargaining agreement provides for participation; (3) independent contractors (including persons treated by the College as independent contractors) even if a court or agency should determine such persons to be "employees"; and (4) 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.

Questions relating to Plan eligibility shall be decided by the Plan Administrator and shall be decided pursuant to the claims procedures set forth in Appendix B.

Costs of Plan

Employees pay the share of any Program's premiums and expenses as specified in the annual enrollment materials. The College pays the balance of any premiums and administrative expenses out of its general assets.

Plan Year

The calendar year.

Amendment and Termination

The College has adopted this Plan with the intent of it being maintained for an indefinite period of time. Notwithstanding this intention, the College reserves the right to amend or terminate the Plan at any time. The College can change a policy with an insurance company only with the consent of the insurance company. Insurance companies can generally change their policies and contracts from time to time and may eliminate or reduce future coverage of certain benefits or change their procedures.

Claims Procedure

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 for that Program. However, if the particular issue on which a claim is based does not relate to any Program, or if the claim procedures for the Program do not comply with applicable law, then the claim procedures in Appendices B and C apply.

An employee or dependent may have an authorized representative act on his behalf in pursuing an eligibility or benefits claim or appeal of the denial of eligibility or benefits. In order for a representative to be recognized as acting on behalf of such individual as the Claimant, the representative must submit documentation acceptable to the Welfare Benefits Plan Committee (Committee), insurance company, or third party claims administrator, as applicable. For eligibility claims and appeals presented to the Welfare Benefits Plan Committee:

- The employee or dependent must provide in writing to the Committee the name, address, and phone number of his authorized representative and a statement that the representative is authorized to act on his behalf.
- In the employee or dependent is deceased or incapacitated, an individual may demonstrate that he is the authorized representative by submitting certified Letters Testamentary, Letters of Administration, or valid documentation of Power of Attorney, as applicable.
- Notwithstanding the above, an employee may act as the authorized representative of his dependents without written authorization.
- If the authorized representative is requesting access to PHI in conjunction with the appeal process, then the HIPAA standards for release of PHI must also be met before PHI will be shared with the authorized representative.

In its discretion, the insurance company or third party claims administrator may establish different standards for an individual to demonstrate that he is the authorized representative for benefits claims presented to the insurance company or third party claims administrator.

Statute of Limitations

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 second anniversary of the Plan Administrator's decision on appeal.

HIPAA Privacy Rights

Group Health Plans (which include medical, dental and EAP Programs) have 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 (including genetic information), or the provision of or payment for health care.

The Group Health Plans are required to maintain the privacy of your PHI. They are also required to provide you with a notice of their legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Group Health Plans are also permitted by law to use and disclose your PHI in certain ways, which are described in their privacy notices.

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 Group Health Plan, or with the Secretary of the United States Department of Health and Human Services. If you want a copy of the Group Health Plan's privacy notice or more information about the Group Health Plan's privacy practices please, contact the Group Health Plan administrators listed in Appendix A.

HIPAA Certificate of Coverage

If you lose coverage under a Group Health Plan, you will automatically be given a certificate of coverage that specifies, among other items, the date you lost coverage and the amount of creditable coverage you had under the plan. You can use this certificate in connection with reducing or eliminating the impact of a pre-existing condition exclusion in a future health policy you obtain. If you lose the certificate or need a replacement for any reason, you may request one by notifying the Plan Administrator using the contact information on the first page of this summary. A replacement certificate will be sent to you as soon as administratively practicable.

Maternity and Newborn Infant Coverage Statement

Under Federal law, no insured group health program offering maternity or newborn infant coverage may 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from

the program or the insurer for prescribing a length of stay not in excess of the above periods. This requirement does not prevent an attending physician or other provider, in consultation with the mother, from discharging the mother or newborn child prior to the expiration of the applicable minimum period.

COBRA

Health benefits under this Plan are subject to COBRA continuation coverage. In the event of a qualifying event, you and your opposite-sex spouse and covered children, as applicable, will be given a notice of entitlement to elect continuation coverage for periods that can range up to 18, 29 or 36 months depending on the qualifying event. Although not required by federal law, the college extends similar rights to same-sex spouses and domestic partners. An election to take continuation coverage must be made within 60 days of this notice and individuals making this election must pay the full amount of the premiums plus a two percent administrative charge. The initial premium is due within 45 days of returning a notice electing coverage and must cover the entire premiums due from the date coverage otherwise would have ceased. In order for the College to send out a qualifying event notice and other materials to affected persons, a participant or affected beneficiary must notify the Plan Administrator within 60 days of divorce, legal separation or a dependent's no longer satisfying the age or other conditions of eligibility; failure to notify the College of a qualifying event within that timeframe will result in loss of the COBRA right. Similarly, a participant or beneficiary must notify the Plan Administrator of a second qualifying event that may occur after a beneficiary has become entitled to initial coverage of up to 18 or 29 months. All such notices shall be in writing, shall describe the relevant event and shall be accompanied by such proof of the occurrence of the event as the Plan Administrator may deem appropriate. More detailed information on COBRA will be found in the COBRA qualifying event notice.

If you are taking a military leave covered by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you have additional Group Health Plan continuation coverage rights. For the first 26 weeks of your leave, you and your dependents have the option to continue coverage during military leave on the same terms and conditions as if you had remained in active employment. After 26 weeks, you may continue participation in the health plan at your own expense, for the remainder of the period until your military leave has lasted for 24 months. The premium for this continuation period is the full amount of the insurance premium plus a 2 percent administrative charge.

State law may also provide continuation and/or conversion coverage. For example, if you exhaust your federal COBRA continuation coverage by receiving eighteen months of coverage, New York State Insurance Law may allow up to an additional eighteen months of continuation coverage for medical insurance provided by the medical Program insurer (dental and vision coverage is not eligible for New York State continuation coverage). This New York State continuation coverage is only available for medical Group Health Plans insured in New York and may not be available if the Group Health Plan becomes self-insured. New York State continuation coverage is available to all covered dependents, even if they are not qualified beneficiaries under federal law.

Special Enrollment Rights

If you are declining enrollment for yourself or your spouse or dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your spouse or dependents in a health insurance Program if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage), provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you and/or your dependents are covered under Medicaid or a state Child Health Insurance Program (CHIP) and lose eligibility for such coverage, you may be able to enroll yourself or your dependents who lost such coverage in a health insurance Program, provided that you request enrollment within 60 days after the loss of coverage. Likewise, if you and/or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself or your dependents who become eligible for premium assistance in a health insurance Program, provided that you request enrollment within 60 days after the date you are determined to be eligible for premium assistance. If your dependent child is receiving Medicaid or CHIP premium assistance toward the cost of plan benefits, you may also be able to disenroll the child from a health insurance Program and enroll the child in and receive child health assistance under the state child health plan, effective on the first day of any month for which the child is eligible for premium assistance, to the extent required by law.

Even if you enroll under special enrollee circumstances, you may be subject to a preexisting condition exclusion or limitation. To request special enrollment or obtain more information, contact the Office of Human Resources at (585) 385–8048. The Office of Human Resources is located in Kearney Hall, Room 211, 3690 East Avenue, Rochester, New York 14618.

Designation of Primary Care Providers and/or OB/GYN

If any medical plan option listed in Appendix A requires or permits the designation of a primary care provider as indicated in the applicable Program materials, then you have the right to designate any primary care provider who participates in the medical plan network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the medical plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information about selecting a primary care provider, or for a list of the participating primary care providers or of participating health care professionals who specialize in obstetrics or gynecology, contact the medical plan at the address or phone number provided in Appendix A.

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.

Antiassignment Provision

Except for voluntary assignments to health care providers as may be required by law or as may be provided in applicable policies, your right to receive benefits under any of the Programs covered by this summary may not be assigned, voluntarily or involuntarily, to any other person.

Grandfathering Notice

This Plan believes the Employee Assistance Program (EAP) is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the EAP Program may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Office of Human Resources at (585) 385–8048. The Office of Human Resources is located in Kearney Hall, Room 211, 3690 East Avenue, Rochester, New York 14618. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Nonguarantee of Employment

Nothing contained in this Plan shall be construed as a contract of employment between the College and any employee, or as a right of any employee to be continued in the employment of the College, or as a limitation of the right of the College to discharge any of its employees, with or without cause.

ERISA Rights Statement

This section supersedes the earlier ERISA statements found in the descriptions of certain benefit-specific summaries. Participants in the Programs covered by this summary have certain legal rights under Federal law. The Department of Labor requires that you be informed of these rights in the following form:

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

√ Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor.

- Obtain upon written request to the Plan Administrator copies of documents governing the administration of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Obtain a statement of your right to 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.

- Continue health care coverage for yourself, spouse or dependent 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 rights.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Health Benefits Program, 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.

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

√ *Prudent Action by Plan Fiduciaries*

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

√ *Enforce Your Rights*

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. 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, 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.

ST. JOHN FISHER COLLEGE
EMPLOYEE WELFARE BENEFITS PLAN

Appendix A – Component Programs of Plan

A. Health Benefits Program

Enhanced EPO J
Basic Healthy Blue
Consumer Directed HDHP
Medicare Blue Choice Low Option
Medicare Blue Choice High Option
Blue Cross Blue Shield Preferred Blue Million
Medicare Supplement C
Medicare Supplement C Rx

All offered through Excellus
165 Court Street
Rochester, NY 14647
Telephone: Call the telephone number printed on your Member ID Card, or use the listing below to locate the number for your plan:

Blue Choice or Blue Choice Senior	Member prefixes beginning with V dial 1-800-499-1275 all others call (585) 454-4810 or 1-800-462-0108
BlueChoice Option	1-800-338-4995
BlueCross BlueShield, Blue Advantage, Blue Care, Excellus BlueEPO, Excellus BlueEPO Balance, Blue Million, Excellus BluePPO, BluePPO Savings Account, ClassicBlue, Comprehensive, Comprehensive Ultima, Comprehensive Plus, Flexible Spending Account, Healthy NY, Medicare Supplemental or MSABlue	Member prefixes beginning with V dial 1-800-499-1275 all others call (585)325-3630 or 1-800-847-1200
HealthyBlue or SimplyBlue	1-800-499-1275
Medicare Blue Choice	1-800-671-6081 ext. 1003
TTY Line for the Deaf or Hearing Impaired	(585) 454-2845 or use the New York Relay Service at 1-800-662-1220

B. Dental Benefits Program

Modified Smile Saver I Without Ortho
Modified Smile Saver IV

All offered through Excellus
165 Court Street
Rochester, NY 14647
Telephone: 1-800-724-1675

C. Flexible Benefits Program

Flexible Spending Accounts
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

Pre-Tax Premium Benefits
Welfare Benefits Plan Committee
St. John Fisher College
3690 East Ave.
Rochester, NY 14618
Telephone: (585) 385-8048

D. Long Term Disability Benefits Program

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
Telephone: 1-800-523-2233

E. Life Insurance and Accident Benefits Program:

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
Telephone: 1-800-523-2233

F. Voluntary Personal Accident Benefits Program

The Hartford
Group Benefits Division, Customer Service
P.O. Box 2999
Hartford, CT 06104-2999
Telephone: 1-800-523-2233

G. Employee Assistance Plan

EAP of Rochester (through October 31, 2011)
Diocese of Rochester
1150 Buffalo Road
Rochester, NY 14624
Telephone: (585) 546-3617
www.eaprochester.org/

Strong EAP (effective November 1, 2011)
550 White Spruce Blvd.
Rochester, NY 14623
Telephone: 585-475-0432
www.urmc.rochester.edu/EAP

ST. JOHN FISHER COLLEGE
EMPLOYEE WELFARE BENEFITS PLAN

Appendix B – Eligibility Claim Procedure

Any employee (participant) or dependent (beneficiary), 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."

The following procedures shall apply if the Claimant is inquiring about eligibility to participate in a Program. These rules do not apply if the Claimant is claiming the right to receive benefits under a Program rather than just inquiring about eligibility. If you are filing a claim for benefits, please refer to the claims procedures that apply to the particular Program under which you are claiming benefits. If the claim involves both the right to receive benefits under a Program and eligibility to participate in the Program, then the Committee shall decide the claim for eligibility within the time specified in, and under a process based upon, the claims procedures in the applicable certificates of insurance

Any claim for eligibility shall be submitted to the Plan Administrator in writing. The Plan Administrator will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Plan Administrator 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 Plan Administrator 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 Plan Administrator expects to render a decision.

If the Claimant's claim is denied in whole or in part, the Plan Administrator will provide the Claimant, within the time period described above, with a written or electronic 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.

If a Claimant disagrees with the decision reached by the Plan Administrator, the Claimant may submit a written appeal requesting a review of the decision. The Claimant's written appeal must be submitted within 60 days of receiving the initial adverse decision. The Claimant's written appeal should clearly state the reason or reasons why the Claimant disagrees with the Plan Administrator'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, the Claimant, upon request and free of charge, may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Plan Administrator will generally decide a Claimant's appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Plan Administrator will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

Once the Plan Administrator has made a decision, the Claimant shall receive written or electronic notification of the decision within five (5) days. In the case of an adverse decision, the notice will explain the reason or reasons for the decision, include specific references to Plan provisions upon which the decision is based, and indicate that the Claimant is entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim.

ST. JOHN FISHER COLLEGE
EMPLOYEE WELFARE BENEFITS PLAN

Appendix C – Benefits Claim Procedure

Any employee (participant) or dependent (beneficiary), 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 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:

≈ HEALTH PLAN CLAIMS PROCEDURES

This procedure applies only to claims submitted for medical 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. Claimants will be provided with 30 days advance written notice of any rescission.

Claimants who need assistance with a claim, appeal of a denied claim, or the external review process, 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 medical Programs 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 Plan Administrator may delay implementation of the particular delayed provision until the enforcement deadline.

In the case of non-grandfathered medical 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 Appendix A that provides benefits for health care or treatment.
5. ***Plan Administrator*** means the person or entity responsible for the relevant claims determination under the Plan.

B. Determination of Benefits

The amount of time that the Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 received by the Plan.

2. Pre-Service Claims. The Plan Administrator 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 Plan Administrator 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 Plan Administrator 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.

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 Plan Administrator 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 Plan Administrator 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 medical 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 medical 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 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 medical 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 medical 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 medical 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 Plan Administrator 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 medical 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 Plan Administrator of the Plan. The Plan Administrator 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 Plan Administrator 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 medical 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 Plan Administrator 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 Plan Administrator will respond to the claim within a certain period of time. The amount of time that the Plan Administrator 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 medical 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 medical 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 medical plans subject to the expanded claims procedure requirements under PPACA. Specifically, they apply to such plans that are self-insured. Fully-insured group medical 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator will assign an independent review organization (IRO) accredited by a nationally-recognized accrediting organization to conduct the external review. The Plan

Administrator will contract with at least two IROs by January 1, 2012, and with at least three IROs by July 1, 2012, for assignments under the Plan and rotate claim assignments among them 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 Plan Administrator 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 Plan Administrator decides to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment, the Plan Administrator 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 Plan Administrator.

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 Plan Administrator 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 Plan Administrator 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 College 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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. 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; and
7. 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 Plan Administrator 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 Plan Administrator of the Plan. The Plan Administrator will not have been involved in the initial benefit determination nor will the Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 Plan Administrator 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 the Claimant until the date on which the Claimant responds to the request for additional information.

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 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;
5. 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;
6. 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.
7. 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.

≈ OTHER CLAIMS FOR BENEFITS

A Claimant may assert a claim for benefits not covered by the claims procedures for health or disability plans set forth above, such as a claim relating solely to whether a participant or beneficiary is eligible to participate in a particular Program. Any such claim shall be submitted to the Plan Administrator in writing. The Plan Administrator will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Plan Administrator 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 Plan Administrator 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 Plan Administrator expects to render a decision.

If the claim is denied in whole or in part, the Plan Administrator 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 Plan Administrator, 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 Plan Administrator'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 Plan Administrator 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

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 are dissatisfied with the decision on appeal of a denied claim, the Claimant 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 the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Plan Administrator's decision on appeal.

In the case of non-grandfathered medical plans subject to the expanded claims procedure requirements under PPACA, then notwithstanding the previous paragraph, if the Program fails to adhere to all of the requirements of the procedures set forth above for medical Program claims or rescissions of medical Program 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 Plan Administrator'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.

ST. JOHN FISHER COLLEGE
EMPLOYEE WELFARE BENEFITS PLAN

Appendix D – Retiree Benefits

Eligibility

Former employees may be eligible to continue participation in certain Programs following separation from employment from the College, if, at the time they separated, they satisfied the following definition of retiree:

- The former employee must have at least 10 years of full-time employment with St. John Fisher College, and
- The former employee's years of service plus age must equal at least 65.

All retirees are eligible to participate in the plans. A retiree may leave the plans at any time and rejoin again at a later date.

Benefits

Retirees are eligible for the following Plan benefits:

- Life Insurance Benefits: All retirees are provided with a College paid life insurance policy in the amount of $5,000;
- Health Benefits: Retirees may enroll in certain health insurance benefit program options. The College subsidy, if any, is described in the enrollment materials;
- Dental Benefits: Retirees may enroll in dental insurance benefits. The College subsidy, if any, is described in the enrollment materials.

Eligible Dependents

Dependents may also be eligible to be covered by some of the Programs as described in the relevant enrollment materials and the brochures prepared by the insurance company. Eligible dependents generally include the following:

- The employee's spouse, if the marriage is recognized in New York State; and
- The employee's child(ren) up to applicable age limits, if the child(ren) satisfies the Program's criteria for an eligible child(ren).

A retiree's domestic partner and/or domestic partner's child(ren) are not eligible for coverage as a retiree's dependent(s).

Each Program and each insurance product maintains different eligibility criteria, and employees should carefully review the dependent eligibility criteria in the official brochure prepared by the insurance company before enrolling a dependent in benefits under a Program. A Dependent Eligibility Summary is available at http://www.sjfc.edu/dotAsset/130805.pdf. A paper copy of this summary is available upon written request to the Plan Administrator.

In the event a retiree dies, the retiree's covered spouse may continue to participate in the plans, without the College's subsidy. In the event an active employee dies while employed, and is retirement eligible at the time of death, their surviving spouse may elect retiree status health and/or dental benefits available at the time, without the College contribution.

Additional Information

Additional information is available in the Employee Handbook policy entitled "Employee Benefits: Retirement – Saving for the Future and Benefits for Retirees" and on the Intranet site's "Retirement" page at http://www.sjfc.edu/campus-services/hr/benefits/retirement/. Paper copies of this information is available upon written request to the Plan Administrator.