



Daemen College
Employee Health and Welfare Plan
And
SUMMARY PLAN DESCRIPTION

Amended and Restated

Effective:

July 1, 2016

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974, as amended, and summarizes the welfare benefits offered under the Daemen College Employee Health and Welfare Plan.

Table of Contents

1.	Introduction	3
2.	General Information About the Plan	5
3.	Eligibility and Participation Requirements	8
	Eligibility	8
	Participation	8
	Change in Employment Classification	8
	Termination of Employment and Subsequent Rehire	8
	Participant/Spouse Employment	9
	Leased or Temporary Employment	9
	Section 125 Eligibility	9
	Special Enrollment Periods	9
	Change in Election Events	9
	Election Mistakes	12
	Benefits for Adopted Children and Guardianship Agreements	13
	Termination of Participation	13
	Uniformed Services Employment and Re-employment Rights Act	14
	Termination of Coverage for Cause, Included Fraud or Intentional Misrepresentation	14
4.	HIPAA Rights for Health Care Benefits	16
5.	COBRA	20
6.	Qualified Medical Child Support Orders	25
7.	How the Plan is Administered	26
	Right to Receive and Release Necessary Information	26
	Discretion of the Plan Administrator	26
	Duties of the Plan Administrator	26
	Plan Administrator Compensation	27
	Power and Authority of Insurance Company	27
	Power and Authority of Insurance Company or Third Party Administrators	27
	Questions	27
8.	Family and Medical Leave and Health Leave	28
9.	Amendment or Termination of the Plan	30
10.	No Contract of Employment	30
11.	Claim Procedures	30
	Fully-Insured Benefits	30
	Self-Insured Benefits	36
	Subrogation / Right of Reimbursement	36
	Coordination of Benefits and Right of Recovery	37
12.	Statement of ERISA Rights	38
13.	Summary of Benefits and Contributions	40
14.	Legal Compliance/Conformity	41
	Insurance Contracts	41
	Special Rights on Childbirth	41
	Special Rights for Women	41
	Genetic Information Nondiscrimination Act (“GINA”)	41
	Mental Health Parity and Addiction Equity Act (“MHPAEA”)	42
	Non-Assignment of Benefits	42
	Continuation and Conversion Rights	42
	Plan’s Failure to Follow Procedures	42
	Effect on Workers’ Compensation	43
	Law of Governing Venue	43
	Statute of Limitations for Plan Claims	43
	Other Circumstances that May Affect Benefits	43
15.	Definitions	44
16.	Exhibit A – Flexible Spending Account Plan (“FSA”)	48
17.	Resolution of the Board of Trustees	56

1. Introduction

Daemen College Employee Health and Welfare Plan (the “**Plan**”) is an employee welfare benefit plan maintained by Daemen College (the “**College**” or the “**Plan Sponsor**”) for the benefit of its Eligible Employees, Eligible Retiree (medical (including prescription drugs) and dental coverage only), Spouses, Domestic Partners and their Dependents.

Grandfathered Status under Health Care Reform Law

Daemen College believes that the medical benefit option under the plan is considered a "non-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. However, your health plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and dependent coverage to age 26, and no cost-sharing on preventive care services. Questions regarding which protections apply to a non-grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, US Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Note: Health Care Reform applies only to the medical and prescription drug benefits that are being offered under the Plan.

Daemen College Employee Health and Welfare Plan is an employee welfare benefit plan within the meaning of § 3(1) of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). This document and its Attachments constitute the summary plan description for each of the component plans as required by ERISA § 102. Participants should read this entire Plan document, including all exhibits and/or attachments to ensure that all requirements and conditions of the Plan are fully understood. Not all benefits in the Plan are considered ERISA benefits, specifically the Employee Assistance Program is a non-ERISA benefit.

The Plan is intended to qualify as a “cafeteria plan” under Internal Revenue Code § 125, and regulations issued shall be interpreted to accomplish that objective.

The purpose of the Plan is to provide Employees with the opportunity to choose among those benefits available to them under the Plan. All eligible employees contribute towards the premium cost of medical (including prescription drugs) and dental coverage on a pre-tax basis through salary reduction. Employees who elect to participate in the voluntary vision insurance or the flexible spending account program (medical and dependent care spending accounts) pay the full premium cost or contribute on a pre-tax basis through salary reduction. Employees who elect to participate in the voluntary term life insurance benefit for Employees, Spouses and Dependents are required to pay the full cost of coverage with post-tax payroll deductions.

Pre or post-tax premium requirements can be found in Attachment # 9.

Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description, benefit agreement, or another governing document prepared by the insurance company or third party administrator. A copy of each booklet, summary or other governing document is addressed in this document as Attachment # 1 to # 8. Copies of all documents for the Plan, including those provided by third party administrators have been previously made available to you. All documentation related to the Plan is on file in the Daemen College Human Resources Department and can be provided to you with your written request.

Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, the Plan Sponsor, or the insurance company with his or her current address. If required by the insurance company, each employee who is a Participant shall be responsible for providing the insurance company with the address of a covered spouse and each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The insurance company, the Plan Administrator, and the Plan Sponsor shall have no obligation or duty to locate a Participant.

2. General Information About the Plan

Plan Name: Daemen College
Employee Health and Welfare Plan

Type of Plan: Health and Welfare Benefits Plan

Plan Administrator Telephone Number: 716-839-8218

ERISA Plan Year: January 1st to December 31st

Policy Year(s):

Medical (including prescription drugs),
Business Travel Accident, Dental, Voluntary
Vision, Flexible Spending Account Program:

June 1st to May 31st

Voluntary Term Life Insurance, Short Term
Disability (NY DBL), Long Term Disability:

January 1st to December 31st

Plan Number: 501

Plan Sponsor: Daemen College
4380 Main Street
Amherst, NY 14226

Plan Administrator: Director of Human Resources
Daemen College
4380 Main Street
Amherst, NY 14226

Agent for Service of Legal Process: Director of Human Resources
Daemen College
4380 Main Street
Amherst, NY 14226

**Plan Sponsor's Employer
Identification Number:** 16-0759798

Funding Medium and Type of Plan Administration:

The following benefits under the Plan are fully insured through insurance contracts:

Medical (including prescription drugs): <ul style="list-style-type: none">• POS 206	Blue Cross Blue Shield of Western New York
Voluntary Vision Insurance:	Vision Service Plan (VSP) / Davis Vision
Voluntary Term Life Insurance for Employees, Spouses and Dependents:	The Guardian
Short Term Disability (NY DBL):	Wesco Insurance Company
Long Term Disability:	The Guardian
Business Travel Accident Insurance:	Gerber Life Insurance Company

Insurance premiums for Employees and their eligible family members are paid in part by the College out of its general assets and in part by Employees' pre or post-tax salary reductions. Required Employee pre or post-tax contributions for the Plan can be found in Attachment # 9.

The insurance companies, not Daemen College, are responsible for paying claims with respect to these programs. Daemen College shares responsibility with the insurance companies for administering these program benefits.

Employees self-fund their pre-tax salary reduction contributions for the flexible spending account program into the general assets of the employer and claim payments are made from the general assets of the Employer. The dental program is self-insured and the Employer pays claim payments from their general assets and employees pay pre-tax salary reduction premium contributions into the general assets of the employer.

Coverage:

Administrative Service Provided by:

Dental: Salary Continuation Plan: Flexible Spending Account Program (including medical and dependent care spending accounts):	The Guardian Daemen College M&T Insurance Agency, Inc.
---	--

The following employee benefit program is paid by the employer with fees paid through the general assets of the Employer:

Benefit Program:

Administrative Service Provided by:

Employee Assistance Program:	WorkLifeMatters (The Guardian)
------------------------------	--------------------------------

Purpose of the Plan Document

Daemen College is providing this document to address certain information that may not be addressed in the attached group insurance contracts or third party administrator booklets. This document, together with the group insurance contract issued by the insurance company, is the Plan document required by ERISA. This Plan document is not intended to give any substantive rights to benefits that are not already provided by the attached group insurance contracts.

The following is a list of Attachments to this document that have been previously made available to you. You may receive an additional copy with your written request to the Human Resources Department.

Plan Benefits and Premium Contribution Requirements:

Attachment #	Benefit	Carrier Name / TPA Group Number	Funding Status
1	Medical (including Prescription Drugs)	Blue Cross Blue Shield of Western New York Group Number: 00412598 www.bcbswny.com	Fully Insured
2	Dental	The Guardian Group Number: 00324707 www.guardiananytime.com	Self-Insured
3	Voluntary Vision	The Guardian Vision Service Plan (VSP) or Davis Vision Networks Group Number: 00324707 www.guardiananytime.com	Fully Insured

4	Voluntary Term Life Insurance for Employees, Spouses and Dependents	The Guardian Group Number: 00324707 www.guardiananytime.com	Fully Insured
5	Short Term Disability (NY DBL)	Wesco Insurance Company www.wescoinsurance.com	Fully Insured
6	Salary Continuation Plan	Daemen College <i>See the Human Resources Department for more information regarding benefits in this plan</i>	Self-Funded
7	Long Term Disability	The Guardian Group Number: 00324707 www.guardiananytime.com	Fully Insured
8	Business Travel Accident Insurance	Gerber Life Insurance Company Policy Number: BTA-120482 www.gerberlifeinsurancecompany.com	Fully Insured
Exhibit A	Flexible Spending Account Program (including medical and dependent care spending accounts)	M&T Insurance Agency, Inc. www.mtb.com	Self-Funded
9	Employee Premium Contribution Requirements	Daemen College Summary of Employee Benefits and Open Enrollment Materials	N/A

3. Eligibility and Participation Requirements

Eligibility for benefits includes coverage for Eligible Full-Time Employees, Eligible Retirees (medical (including prescription drugs) and dental coverage only), Spouses, Domestic Partners and Dependents.

Component Benefit	Eligibility
Medical (including prescription drugs), Dental, Voluntary Vision, Flexible Spending Account Program (including medical and dependent care spending accounts), Voluntary Term Life Insurance, Short and Long Term Disability, Salary Continuation Plan, Business Travel Accident, and the Employee Assistance Program	Full-Time or Limited Full-Time Employees scheduled to work 25 hours or more per week.

You are not eligible to participate if you are employed by the Employer on a part-time, per diem, or contingent basis; if you are providing services to the Employer pursuant to an agreement with a third party leasing organization; if you are an independent contractor who is not on an Employer payroll or if you are enrolled as a student at the College.

Employees must be enrolled in benefits prior to enrolling their eligible family members. To determine if you or your eligible family members are eligible to participate in a component benefit program, please read the eligibility information contained in the Attachments for the applicable component benefit programs or you may contact the Human Resources Department if you have any questions regarding your eligibility.

Component Benefit	When Participation Begins
Medical (including prescription drugs), Voluntary Vision, Dental, Flexible Spending Account Plan (including medical and dependent care spending accounts), Business Travel Accident, and the Employee Assistance Program	1 st of the month following the month of employment.
Short Term Disability Insurance (NY DBL)	Completion of six (6) months of full-time employment.
Voluntary Term Life Insurance, Long Term Disability and Salary Continuation Plan	1 st of the month following 90 days of continuous employment.

Employees must enroll in the health insurance program within 30 days of their initial eligibility date. If you have experienced a mid-year change in family status or special enrollment under HIPAA as outlined below, you may enroll in the plan outside of the open enrollment cycle.

Change in Employment Classification

An Employee changing from an ineligible to an eligible employment classification can elect coverage on the date the change in employment classification is effective, provided the Employee has completed the applicable waiting period while they were ineligible to participate. Benefits will begin on the 1st day of the month following the date of change from an ineligible to eligible status.

If you are an Eligible Employee, you may begin participating in the Plan on your election to participate in a component benefit program in accordance with the terms and conditions established for that program.

Termination of Employment and Subsequent Rehire

If you terminate your employment and are subsequently rehired, you will be eligible for benefits as if you are new Employee. See the Human Resources Department for more information regarding reinstatement periods and your eligibility for benefits.

Participant/Spouse Employment

If you, your Spouse, or your Domestic Partner are eligible employees of Daemen College you may be covered under the Plan as an Employee or a Dependent of your Spouse or Domestic Partner.

Leased or Temporary Employment

Leased employees or persons classified by Daemen College as temporary employees of Daemen College (as determined by the employer) are not eligible for benefits under this Plan. A person who is not characterized by Daemen College as an employee of Daemen College but who is later characterized by a regulatory agency or court as being an employee will not be eligible for the period during which he or she is not characterized as an employee by Daemen College

Special Enrollment Periods

Special Enrollment Rights – Health Insurance Portability and Accountability Act. If you, your Spouse or a Dependent is entitled to special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) under a group health plan, you may change your election to correspond with the special enrollment right. For example, if you declined enrollment in your Employer's Health Insurance Plan for yourself or your eligible Dependents because of medical coverage under another plan, and eligibility for such coverage is subsequently lost due to certain reasons (that is, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible Dependents who lost such coverage, provided that you request enrollment within **30 days** after the applicable event. Furthermore, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and a newly-acquired Dependent, provided that you request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Rights – Children's Health Insurance Program Reauthorization Act. If you and your Dependents are eligible but not enrolled for coverage under your employer's group health plan you may enroll in two circumstances: 1) you or your Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; and 2) you or your Dependent becomes eligible for a Subsidy under Medicaid or CHIP (if offered by your state). You or your Dependent(s) must request coverage within **60 days** after you or your Dependent is terminated from, or determined to be eligible for such assistance.

Change in Election Events

If a Change in Election Event (including a Change in Status) occurs, you must inform the Human Resources Department and complete a new Election Form/Salary Reduction Agreement within 30 days of the occurrence.

Generally, you cannot change your election to participate in the medical (including prescription drugs), voluntary vision, dental, flexible spending account plan (including medical and dependent care spending Accounts) benefits or vary the salary reduction amounts you have selected during the Plan Year (known as the irrevocability rule). Your election will terminate if you are no longer working for the Employer.

Of course, you can change your elections for benefits and salary reductions during the open enrollment period for programs in which you are participating. See the Plan Administrator for more information on open enrollment periods.

Prior to the beginning of each Plan Year, the Plan Administrator will provide information regarding enrollment or changes to your enrollment election. If you do not enroll or make changes to your enrollment, your elections will remain the same for the upcoming Plan Year, including an election of no coverage. The Employer

reserves the right during any open enrollment period to ask you to re-enroll in any benefit program offered in the Plan.

To participate in the medical and/or dependent care flexible spending accounts you must make an affirmative election during the Open Enrollment period. If you do not affirmatively enroll in the health care and/or dependent care flexible spending accounts, your participation in the flexible spending account program will cease as of the end of the current Plan Year.

There are several important exceptions to the irrevocability rule, known as *Change in Election Events*. "Change in Election Events" include the following events, as more fully described below: FMLA leave, Change in Status, certain judgments, decrees and orders; Medicare and Medicaid: Change in Cost, and Change in Coverage. (*Change in Status, Cost and Coverage* are defined below). However, the Change in Election Events do not apply to all benefits in the Plan, exclusions apply. Examples are described below for each such Event.

1. **FMLA Leave.** You may change an election under the Plan upon commencement of or return from FMLA leave.
2. Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under subsequent IRS regulations:
 - A change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation or annulment). "*Spouse*" means the person who is legally married to you and is treated as a Spouse under the Internal Revenue Code (*Code*);
 - A change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent). "*Dependent*" means your tax Dependent under the Code;
 - Any of the following events that change the employment status of you, your Spouse, or your Dependent and that affects benefit eligibility including (this Plan or other employee benefit plan of you, your Spouse, or your Dependents). Such events include any of the following changes in employment status, termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in work site, switching from salaried to hourly paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of Employment; or any other similar change which makes the individual become (or cease to be) eligible for benefits; and
 - An event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a benefit (such as attaining a specified age or similar circumstance).
3. **Change in Status-Other Requirements.** If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:
 - *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For health benefits (here, the medical insurance under the Health Insurance Plan), a special rule governs which type of election changes are consistent with the Change of Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

Example: Employee Mike is married to Sharon, and they have one child. The employer offers a calendar-year cafeteria plan that allows employees to elect no health coverage, employee-only coverage, employee -plus-one-dependent coverage, or family coverage. Before the plan year, Mike elects family coverage for himself, his wife Sharon, and their child. Mike and Sharon subsequently divorce during the plan year. Sharon loses eligibility for coverage under the Plan, while the child is still eligible for coverage under the plan. Mike now wishes to revoke his previous election and elect no health coverage. The health coverage for Sharon is consistent with this Change in Status. However, an election to cancel coverage for Mike and/or the child is not consistent with this Change in Status. In contrast, an election to change to employee-plus-one-dependent coverage would be consistent with this Change in Status.

- *Gain of Coverage Eligibility under another Employer's Plan.* For a Change in Status in which you, your Spouse or your Dependent gains eligibility for coverage under another employer's cafeteria plan (qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- 4. **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment or custody change requires your Dependent child (including a foster child who is your Dependent) to be covered under the Plan, you may change your election to provide coverage for the Dependent child. If the order requires that another individual (such as your former Spouse) cover the Dependent child, then you may change your election to revoke coverage for the child.
- 5. **Medicare or Medicaid.** If you, your Spouse, or a Dependent becomes entitled to Medicare or Medicaid, you may cancel that person's health coverage under the Health Insurance Plan. Similarly, if you, your Spouse, or a Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin or increase that person's health coverage.
- 6. **Change in Cost.** If the Administrator notifies you that the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another Plan option that provides similar coverage or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if there is no option available under the Plan that provides similar coverage; (d) coverage under another employer plan, such as a Spouse's or Dependent's employer, is treated as similar coverage. For insignificant increases or decreases in the cost of benefits, however, the Administrator will automatically adjust your election contributions to reflect the minor change in cost.
- 7. **Change in Coverage.** You may also change your election for the Plan if one of the following events occurs:
 - *Significant Curtailment of Coverage.* If the Administrator notifies you that your coverage under the Plan is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible), then you may revoke your election and elect coverage under another Plan option that provides similar coverage. If the Administrator notifies you that your coverage under the Plan is significantly curtailed with a loss of benefit coverage, then you may either revoke your election and elect coverage under another Plan option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage but only if there is no option available under the plan that provides similar coverage.
 - *Addition or Significant Improvement of Plan Option.* If the Plan adds a new option or significantly improves an existing option, the Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the component Plan.
 - *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse or Dependent, if any of you loses coverage under any group health

coverage sponsored by a government or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).

- *Change in Election under another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) this Plan permits you to make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan. For example, if an election is made by your Spouse during his/her employer's open enrollment to drop coverage, you may add coverage to replace the dropped coverage.

8. **Dependent Care Spending Account.** This event applies to Dependent Care Spending Accounts, but not to Medical Spending Accounts in the Flexible Spending Account Plan. You are permitted to change your election if a change in cost occurs during the Plan Year. If the caregiver is a relative, no change is permitted. As well, a significant coverage change or curtailment may apply to your Dependent Care Spending Account, but not to Medical Spending Accounts, when there is a change in provider, or eligibility for state-funded school resulting in decreased need for child care expenses. If there is a change in coverage of Spouses or Dependents under another Employer's Plan, you may be allowed to change your election in your Dependent Care Spending Account, but not the Medical Spending Account, under the Plan provided that the change is on account of and consistent with the change in coverage that is made under the other employer's plan and is also consistent with the rules under Section 125 of the Internal Revenue Code.

A change must be "on account of and correspond with" a Change in Status Event. To meet this requirement, the change that you wish to make must be on account of and correspond with a Change in Status Event that affects eligibility for coverage under the Plan. This rule is satisfied as to the Dependent Care Spending Account in the Flexible Spending Account Plan if the Change in Status Event affects expenses under that Account, such as when the child become 13 years old and is no longer a qualifying individual. The determination of whether a requested change is "on account of and consistent with" a Change in Status Event will be made by the Plan Administrator (in its sole discretion) in accordance with interpretations of the Internal Revenue Service.

If the employer adds a new benefit option or if an existing benefit option is significantly improved during a Plan Year or coverage period (as determined by the Plan Sponsor), you may change your elections to replace a benefit option that provides similar benefits with the new or improved benefit option, or, if you did not previously elect a similar benefit option, you may elect to begin participating in the new or improved benefit option.

Note that changes such as Automatic Small Cost Changes, Significant Cost Increases (with or without loss of coverage), Significant Coverage Curtailment, Addition or Elimination of Benefit Package Option or Change in Coverage under Other Employer's Plan does not permit changes to your Flexible Spending Account Plan medical spending account. Also, note participants cannot reduce Flexible Spending Account Plan medical spending account elections to the amount where cumulative contributions are less than amounts already reimbursable for the plan year.

Additionally, the Administrator may modify your election(s) in the medical (including prescription drugs), dental, voluntary vision and flexible spending account benefits of the Plan downward during the Plan Year if you are a key employee or highly compensated individual (as defined by the Internal Revenue Code), if necessary, to prevent the Plan from becoming discriminatory within the meaning of the federal income tax law.

Election Mistakes

If the Plan Administrator determines, based on clear and convincing evidence, that an election was a mistake, the Plan Administrator may correct the mistake. The Plan is intended to qualify for tax favored treatment under

Code sections 125, 129, and 79. In some circumstances, a benefit otherwise payable to a Highly Compensated Employee or Key Employee or other prohibited group identified in the Code may not be payable without violating the applicable Code Section. The Plan Administrator may treat the election associated with the benefit as a mistake and correct it.

Benefits for Adopted Children and Guardianship Agreements

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Employee Participants who currently cover eligible dependents under a Guardianship Agreement will be required, upon enrollment and subsequent requests, to show proof of continued guardianship in order to continue coverage in the Plan for Dependent child(ren).

Termination of Participation

Medical (including prescription drugs), Voluntary Vision, and Dental	The last day of the month in which employment ends
Voluntary Term Life Insurance, Short and Long Term Disability, Salary Continuation Plan, Business Travel Accident, and the Employee Assistance Plan.	The date employment ends
Flexible Spending Account Plan (including Medical and Dependent Care Spending accounts)	Deposits stop with the last paycheck received after termination. Reimbursement is made for eligible expenses incurred up to date termination. Participants have 90 days following their date of termination to submit claims incurred up to their date of termination.

Please refer to the plan summaries or booklets for the applicable component benefit in the event of your termination of employment. To obtain information regarding your rights to conversion of your life and medical (including prescription drugs) insurance coverage to an individual policy, please contact the appropriate insurance carrier. Also see Section 5 – COBRA for continuation of your medical (including prescription drugs), voluntary vision, dental, and flexible spending account (medical account only) plan benefits.

Coverage may also terminate if:

- ✓ Your hours drop below any required hourly threshold;
- ✓ With respect to any coverage requiring Participant contributions and with respect to which Participant contributions are discontinued, the last day of the period for which contributions by the Participant are paid;
- ✓ You submit false claims; or
- ✓ If Daemen College discontinues the plan for any reason.

Coverage will end at:

- ✓ The end of the year following the day on which an eligible dependent ceases to be an eligible dependent in the medical (including prescription drugs), voluntary vision and dental benefits;
- ✓ Except in the case of certain leaves of absence, the day on which the participant ceases to qualify as an active eligible employee of Daemen College unless otherwise specified (see the Termination of Participation provisions above); or
- ✓ Except to the extent required by law, the first day of the month following the date on which the participant reports for active duty as a member of the armed forces of any country, in the case of the

Plan's medical (including prescription drugs), voluntary vision and dental coverage the day on which the participant reports for such active duty, with respect to the Plan's life insurance, and short and long term disability insurance.

Uniformed Services Employment and Re-employment Rights Act

Regardless of any provision described above, if you take a leave of absence from employment with Daemen College because of military service, you may elect to continue coverage under the Plan to the extent required by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for you and your covered Spouse or Dependents or you may extend benefits through COBRA.

You have the following rights under USERRA:

1. If your military leave period is for 30 days or less, you have the right to continue health coverage for yourself and Dependents that were covered under the group health plan for up to 30 days, at a cost of not more than the cost for a similarly situated active employee.
2. If the military leave period is for 31 days or more, you have the right to elect USERRA continuation coverage for yourself and your Dependents that were covered under the health plan. The maximum period is 24 months (note that New York State COBRA law requires 36 months of continuing coverage, the 24 months runs concurrently with this provision).

You will be required to pay up to the 102% of the applicable premium whether you elect continuation coverage under USERRA or COBRA.

If you extend your coverage through USERRA, such coverage will end on the earlier of: (1) the last day of the 36-month period beginning on the date your absence begins; or (2) the day after the date on which you fail to apply for or return to a position of employment with Daemen College. See the COBRA section of this document for more information on continuation of coverage through COBRA.

If you take military leave, but your coverage under the Plan is terminated – for instance, because you do not elect the extended coverage, when you return to work, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies. Please contact the Plan Administrator if you have questions about coverage during periods of military service.

Termination of Coverage for Cause, Including Fraud or Intentional Misrepresentation

The Employer reserves the right to terminate coverage for you, your Spouse, your Domestic Partner, or your Dependent(s) prospectively without notice for cause or if you, your Spouse, your Domestic Partner, or your Dependent(s) are otherwise determined to be ineligible for coverage under the Plan. In addition, if you, your Spouse, or your Dependent(s) commits fraud or intentional misrepresentation in an application for coverage under the Plan, in a claim or appeal for benefits, or in response to any request for information by the Plan Administrator, a claims administrator, an appeals administrator, or the Employer, the Plan Administrator may terminate your, your Spouse's, your Domestic Partner, or your Dependent's coverage retroactively to the date of the fraud or misrepresentation upon 30 day notice.

When you enroll a family member in the Plan, you represent the following:

- The individual is eligible under the terms of the plan; and
- You will provide evidence of eligibility on request.

Further, you understand that:

- The Plan is relying on your representation of eligibility in accepting the enrollment of your family members;
- Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
- Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual becomes ineligible for Plan coverage, as determined by the Plan Administrator and subject to the Plan's provisions on rescission of coverage.

If the medical (including prescription drugs), voluntary vision and dental program undertakes an eligibility audit and finds ineligible Dependents enrolled in the Plan, the Plan may cancel coverage for such Dependents prospectively without violating the prohibition on rescission rules of the Patient Protection and Affordable Care Act (Health Care Reform). A termination of coverage with prospective effect is not considered a rescission and may be permitted without proof of fraud or misrepresentation.

In order to cancel coverage retroactively, however, the Plan must make a showing of fraud or intentional misrepresentation of a material fact and provide advance written notice of the rescission.

4. HIPAA Rights for Health Care Benefits

This provision shall only apply to benefits that are subject to the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) and its implementing regulations, issued under the Privacy Regulations at 45 C.F.R. Parts 160 and 164.

This section shall be interpreted in a manner that permits the Plan to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state laws regarding protection of Protected Health Information (PHI).

The health component benefits of the Plan will use and disclose protected health information (PHI), as defined in 45 CFR 164.501, to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the health component benefits will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations as defined in the health component benefit HIPAA Privacy Notice (as defined in 45 CFR 164.520) distributed to Participants.

Health *information* means any information, whether oral or recorded in any form or medium, that:

- a) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
- b) Relates to the past, present, future physical or mental health or condition of any individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual; and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future payment for the provision of health care to an individual; and
 - a. Identifies the individual; or
 - b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information means individually identifiable health information (defined above):

1. Except as provided in paragraph (2) of this definition; that is:
 - a. Transmitted by electronic media;
 - b. Maintained in electronic media; or
 - c. Transmitted or maintained in any other form or medium.
2. Protected Health Information excludes individually identifiable health information in:
 - a. Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;
 - b. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
 - c. Employment records held by a covered entity in its role as employer.

The HIPAA Privacy Rules covers protected health information in any medium while the HIPAA Security Rule covers electronic protected health information.

The health component benefits of the Plan will disclose PHI to Daemen College only upon receipt of a certification from Daemen College that this Summary Plan Description has been amended to incorporate the

provisions below and that the Employer agrees to certain conditions regarding the use and disclosure of PHI and the adequate separation between the health component benefits and Daemen College

Daemen College' Obligations with Respect to PHI

With respect to PHI, Daemen College agrees to certain conditions. Daemen College agrees to:

- not use or disclose PHI other than as permitted or required by this Summary Plan Description or as required by law;
- ensure that any agents (including a subcontractor) to whom Daemen College provides PHI received from the Plan agree to the same restrictions and conditions that apply to Daemen College with respect to such PHI;
- not to use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of Daemen College unless authorized by an individual;
- report to the Plan any PHI use or disclosures of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purposes of determining the Plan's compliance with HIPAA;
- if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- Daemen College will follow the privacy and security obligations required under the Health Information Technology for Economic and Clinical Health Act (HITECH), including notification of a breach involving unsecured PHI within the required 60-day timeframe, securing PHI, and development of procedures for breach identification.

Access to PHI within Employer

Adequate separation will be maintained between the Plan and Daemen College. If the persons described herein or any other employees do not comply with the Summary Plan Description, Daemen College shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. Daemen College shall cooperate with the Plan to correct and mitigate any such noncompliance.

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

- A. To the extent necessary to assist Plan participants and their family members with getting benefit claims resolved;
- B. That is the result of pre-employment physicals requested or required by the Plan Sponsor before hiring prospective employees;
- C. To the extent necessary to fulfill any responsibility they may have to review and determine claims and appeals of denied claims under this Plan;
- D. To the extent necessary to monitor and enforce the subrogation provisions of the Plan, and work with the Plan Sponsor's subrogation entity to help the Plan obtain reimbursement when appropriate;

- E. For activities related to ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care; and
- F. To the extent necessary to correspond with other group health plans on coordination of benefits issues.

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

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

Privacy Official

The Privacy Official shall be responsible for compliance with Daemen College and the health component benefits obligations under this section and HIPAA. Specific rules regarding the Privacy Official follow:

1. Appointment, Resignation and Removal of Privacy Official. Daemen College shall appoint one or more individuals to act as Privacy Official on matters regarding the health component benefits. The Director of Human Resources is the Privacy Official. The individual appointed as Privacy Official may resign by giving 30 day notice in writing to Daemen College. Daemen College shall have the power to remove that individual for any or no reason.
2. Policies and Procedures. The Privacy Official shall from time to time formulate and issue to Participants and Daemen College such policies and procedures as he or she deems necessary for substantive provision of the health component benefits. Additionally, such policies and procedures must be accepted by the Plan Administrator.
3. Privacy Notice. The Privacy Official shall be responsible for arranging with Daemen College, the Plan Administrator and any third-party administrator for the issuance of, and any changes to the Privacy Notice under the health component benefits.
4. Complaint Contact Person. The Privacy Official shall be the contact person to receive any complaints of possible violations of the provisions of this section and HIPAA. The Privacy Official shall document any complaints received, and their disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the health component benefits HIPAA Privacy Notice.

If you believe your privacy rights have been violated, you may file a complaint with the Director of Human Resources of Daemen College or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized or retaliated against for filing a complaint.

HIPAA Security Standards

This section explains Daemen College's obligations with respect to the security of Electronic Protected Health Information under the security standards of HIPAA.

Where Electronic Protected Health Information (e-PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, Daemen College will reasonably safeguard the e-PHI as follows:

- Daemen College will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that Daemen College creates, receives, maintains, or transmits on behalf of the Plan,
- Daemen College will ensure that the adequate separation that is required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures,
- Daemen College will ensure that any agent, including a subcontractor, to whom it provides e-PHI agrees to implement reasonable and appropriate security measures to protect such e-PHI, and The Plan Sponsor will report to the Plan any Security Incidents of which it becomes aware as described below:
 - ✓ Daemen College will report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's e-PHI, and
 - ✓ Daemen College will report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

5. COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. ***Since your benefit programs are fully insured through insurance contracts, your Employer is subject to COBRA requirements under New York State law.***

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

New York state law requires insurers to offer employees and their dependents to continue coverage for those who are not covered by an employer or government plan (such as Medicare) for a period of up to 36 months.

New York state law provides an option to continue coverage for unmarried children who have “aged out” of their parent’s group health policy. Such children are not required to be financially dependent on their parents to elect this benefit. Continuation coverage may continue through age 29 as long as they are not entitled to Medicare or covered under another group health insurance program.

Always check with your COBRA Administrator listed at the end of this section regarding your rights under Federal or State COBRA laws.

There may be other coverage options for you and your family. You will be able to buy coverage through the Health Insurance Marketplace during the open enrollment period or if you have a special enrollment opportunity. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

If you or your eligible family members qualify for such continuation coverage, the medical (including prescription drugs), dental, voluntary vision or flexible spending account plan (Medical Spending Account only) will be treated as individual plans for purposes of COBRA.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of the medical (including prescription drugs), dental, voluntary vision, or flexible spending account plan (Medical Spending Account only) coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, Spouse, or Dependent, you will become a qualified beneficiary if an Employee loses coverage. An eligible Employee, covered Spouse or covered Dependent are entitled to an additional 18 months of coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or

- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an employee, you will become a qualified beneficiary if you lose your coverage. You are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happen:

- Your Spouse dies;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage. They are entitled to an additional 36 months of coverage under the Plan because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The parent-employee can no longer claim you as a “dependent child” under the Plan.

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify Daemen College in writing within 60 days after the later of when the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The Employee or family member can provide notice on behalf of themselves, as well as other family members affected by the qualifying event. Written notice of the qualifying event should be sent to Daemen College and should include the following information:

- Date (month/day/year)
- Social Security Number / ID Number
- Spouse / Dependents Telephone Number
- Date of Birth (month/day/year)
- Employer's Name
- Employee's Social Security Number / ID Number
- Loss of Coverage (month/day/year)
- Spouse / Dependent's Name
- Spouse / Dependent's Address
- Gender
- Relationship to Employee
- Employee's Name
- Reason for Loss of Coverage

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becomes entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Paying for Continuation Coverage

You do not have to show that you are insurable to choose COBRA continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. Your employer reserves the right to charge an additional 2% administration fee in addition to the regular premium.

For disability extensions up to 30 months if an individual is determined to be disabled (for Social Security disability purposes) Daemen College reserves the right to charge an additional 50% of the regular premium. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 30 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under your insurance carrier.

Most coverage under COBRA is paid for with the value of your premiums (plus a 2% administration fee) associated with each insured benefit (i.e. medical (including prescription drugs), voluntary vision and dental). If you have not incurred claims sufficient to spend-down your account balance as of your date of termination, you may continue your participation in the Flexible Spending Account Plan Medical Spending Account for the remainder of the current Plan Year. Payment for continuation of your Flexible Spending Account Plan Medical Spending Account benefit is based on the contribution you made to your account while employed. Your premium is the same amount of those contributions withheld from your paycheck during employment. ***COBRA will be offered only to those who have “underspent” their Medical Spending Account.***

Grace period for monthly payments

Although monthly payments are due on the first day of each month of COBRA coverage, COBRA participants will be given a grace period of 30 days to make each monthly payment. COBRA coverage will be provided for each month as long as payment is made before the end of the grace period for that payment, but coverage is subject to being suspended as explained below.

If payment is made after the due date but before the end of the 30-day grace period for that month, health coverage may be suspended as of the first day of the month when payment was due. Coverage will be retroactively reinstated (going back to the first day of the month) when the payment for that month is received. Any claim(s) submitted for reimbursement while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

Termination of Continuation Coverage

The law also provides that your continuation coverage may be terminated for any of the following four reasons:

1. Daemen College no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to Medicare;
4. You have 29 months of continuation coverage due to your disability and there has been a final determination that you are no longer disabled.

The Trade Preferences Extension Act of 2015 and COBRA

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals typically include those who have been displaced due to foreign competition). The Trade Preferences Extension Act restored the provisions of the Trade Act of 2002 which expired on January 1, 2014. Under these tax provisions, eligible individuals can either take a tax credit or get advance payment of a portion of premiums paid for qualified health insurance including continuation coverage. The new legislation also added rules for coordinating the health care tax credit with the premium tax credit that is available under health care reform to eligible individuals receiving individual health insurance through an Exchange. A new rule excludes coverage through an Exchange from the list of qualified health insurance for which the health care tax credit may be claimed beginning in 2016. There is also a new requirement to make an election in order for the health care tax credit to apply, and the premium tax credit is not available for the months to which the election applies.

If You Have Questions

Questions concerning your participation in the Daemen College Employee Health and Welfare Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or

District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information for return of COBRA Election Forms and Premium Payments:

COBRA Administrator:

***Director of Human Resources
Daemen College
4380 Main Street
Amherst, NY 14226***

716-839-8325

Written notice is considered to have been made on the date the notice is postmarked or, if notice is delivered by carrier or in person, the date it is signed as being received by that office.

All notices must include: the name and address of the employee covered under the Plan, the name(s) and address(es) of the Qualified Beneficiary(ies), the Qualifying Event and the date the event happened.

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

6. Qualified Medical Child Support Order

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA Section 609(a)). The Plan will provide benefits to Dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of participants or beneficiaries, in accordance with ERISA Section 609(c).

In order for this Plan to recognize a Qualified Medical Child Support Order it must satisfy the following criteria.

It must be a judgment, decree or other court order relating to health benefits coverage for a Dependent child of a covered Employee, and the order must specify:

- a. the name and address of the Employee or their designee;
- b. the order must indicate who will pay for the Alternate Payee's coverage (required contributions towards premium, deductibles, coinsurance, copayments or other benefit payments);
- c. statement that acknowledges the Plan's right to terminate coverage under the Order for which payment is not made on a timely basis as required;
- d. the name and mailing address of each dependent child covered by the order;
- e. a reasonable description of the type of coverage offered by the Plan;
- f. a beginning period for which the order applies;
- g. an end date for which the Alternate Payee would no longer be eligible for coverage;
- h. social security number of each Dependent child covered by the order; and
- i. the name and address of each Alternate Payee, which means the Spouse, former Spouse, legal guardian of the Dependent child or the child of an Employee.

Upon receipt of a medical child support order, the Plan Administrator shall promptly notify the Employee and Alternate Payee. The Plan Administrator shall determine whether an order received meets the criteria and promptly notify the Employee and each Alternate Payee. In the event of a dispute regarding any medical child support order furnished to the Plan Administrator, the Employee or Alternate Payee shall promptly notify the Plan Administrator in writing.

Coverage shall commence upon either the date specified in the order or the date the Employee becomes eligible for coverage, if later.

Any order that requires the Plan to provide any type of benefit or increased benefits not otherwise provided by this Plan, other than under COBRA, will not be recognized as a Qualified Medical Child Support Order.

Please see the Human Resources Department for questions regarding Qualified Medical Child Support Orders.

7. How the Plan is Administered

The administration of the Plan is under the supervision of the Plan Administrator, Daemen College and the duly authorized person(s) who acts on behalf of the Plan Administrator. The named fiduciaries with respect to the management and control of the Plan's administration and operation shall be the Plan Administrator.

Any duly authorized officer of the Plan Administrator may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan. The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a claim fiduciary to receive, review, and to process claims for benefits.

Right to Receive and Release Necessary Information

Each of (i) Daemen College or (ii) contract administrator (with respect to participants or beneficiaries receiving benefits under the Plan which it administers or provides services with respect to) may, without the consent of or notice to any person, release or obtain any information which such Plan Sponsor or contract administrator reasonably deems necessary in order to perform its duties under the Plan. Any person claiming benefits under the Plan shall furnish such information as may be reasonably required by Daemen College or contract administrator. Daemen College or any contract administrator will act in accordance with the rules established under the Health Insurance Portability and Accountability Act's Privacy and Security Rules.

Discretion of the Plan Administrator

In carrying out its duties under the Plan, the Plan Administrator has discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it. The Plan Administrator's determinations shall be given deference and shall be final and binding on all interested parties.

Duties of the Plan Administrator

- 1) To administer the Plan in accordance with its terms for the exclusive benefit of persons entitled to participate in the Plan;
- 2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions;
- 3) Prescribe applicable procedure, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan;
- 4) To decide disputes that may arise relative to a Plan participant's rights;
- 5) To prescribe procedures for filing a claim for benefits and to review claim denials;
- 6) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;
- 7) To reject elections or to limit contributions or benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Internal Revenue Code;
- 8) To provide Employees with reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;
- 9) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609;
- 10) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Plan Administrator determines shall be paid if the Plan Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Plan Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;
- 11) To appoint a Claims Supervisor to pay self-insured claims, or to appoint agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan; and

12) The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

Plan Administrator Compensation

The Plan Administrator serves without compensation however, all expenses for plan administration, including compensation for hired services, will be paid by Daemen College.

Daemen College will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Company

Certain benefits under the Plan are fully insured and provided by contract with an insurance company. Daemen College has insurance contracts to provide for the following benefits:

Blue Cross Blue Shield of Western New York	Medical (including prescription drugs)
The Guardian	Voluntary Vision, Voluntary Term Life Insurance, Long Term Disability
Wesco Insurance Company	Short Term Disability (NY DBL)
Gerber Life Insurance Company	Business Travel Accident

The insurance companies are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Power and Authority of Insurance Company or Third Party Administrators

The Plan also has benefits that are self-insured or self-funded with administrative services provided by a third party administrator or insurance company. The Plan Administrator has delegated certain responsibilities to the third party administrator and insurance company and they are responsible for (1) determining eligibility for and the amount of any benefits payable under their respective component benefit plans, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective component benefit plans.

Daemen College has contracted with the following third party administrator and insurance company to provide administrative services for the following self-funded benefits:

M&T Insurance Agency, Inc.	Flexible Spending Account Plan (including Medical and Dependent Care Spending Accounts)
Dental	The Guardian

Daemen College self-administers the following benefit program:

Salary Continuation Plan	Daemen College
--------------------------	----------------

Questions

If you have questions regarding eligibility for, or the amount of, any benefit payable under the fully or self-funded component benefit plans, please contact the appropriate insurance company, third party administrator, or the Plan Administrator.

8. Family and Medical Leave and Health Leave

Benefit and Service Continuation during Family and Medical Leave

- ❖ During the period of your leave under this Plan, Daemen College Employee Health and Welfare Plan will continue your medical benefits, as required by law. This means Daemen College will continue your benefits on the same basis as if you were continuing your employment.
- ❖ Employees on unpaid leave are required to pay required premiums for medical (including prescription drugs), dental, voluntary vision, voluntary term life insurance or flexible spending account plan benefits during their leave. Premiums can be paid during your leave with post-tax dollars. The method of payment will be chosen at the discretion of the Plan Administrator.

If you elect to cease participation in any benefit in which you participate, expenses incurred while participation has lapsed will not be eligible for reimbursement. If you elect to continue participation in the dependent care spending account, expenses incurred during the leave would not be eligible for reimbursement because you are not working, but contributions could be made during the leave and applied to expenses incurred after you return from leave.

If you elect to cease participation during the leave period, coverage will resume upon your return to work under your prior elections, unless changed by you in accordance with the Change in Election Event rules described above. However, you have two choices regarding the flexible spending medical spending account:

- You can elect to have your contributions resume at the level in effect prior to the leave, in which case the annual medical account contribution you elected would be reduced to reflect the period of no contributions.
- You can elect to increase your contributions for the remainder of the year following the leave so that your annual contribution to the flexible spending medical account will equal the annual contribution in effect prior to the leave.

For example, suppose you had elected a \$1,200 flexible spending medical account (monthly contributions of \$100) and were absent on leave for the months of April, May and June. When you return to work in July, you could continue to make contributions of \$100 per month, in which case the maximum annual reimbursement from the flexible spending medical account would be \$900 (\$1,200 minus \$300 in missed contributions). Alternatively, you could increase your monthly contribution to \$150 for the remainder of the year and have a maximum annual reimbursement from the flexible spending medical account of \$1,200 (three months of \$100 contributions, three months of \$0 contributions and six months of \$150 contributions).

- ❖ Leaves of absence under this policy shall *not* constitute a break in the employee's length of continuous service nor will you lose any employment benefits you have accrued prior to taking leave.
- ❖ If you terminate your employment during your leave, the date of your qualifying event will be the day of your termination of employment.

Please contact the Human Resources Department regarding procedures and guidelines for the Family Medical Leave Act.

Health Leave

If you are eligible for health leave (see the Employee Handbook), you will, for a limited period, continue to be treated as an active employee for purposes of eligibility under this Plan. The period of extended eligibility begins at the start of your health leave and continues according to the following schedule:

When Health Leave Begins:

Period of Extended Eligibility will be:

Before completion of one (1) year of service:

Six months;

After completion of one (1) year of service but before completion of five (5) years of service:

Twelve months;

After completion of five (5) years of service but before completion of ten (10) years of service:

Eighteen months;

After completion of ten (10) years of service:

Twenty-four months.

If your active coverage remains in effect during your leave, at the end of your leave you will be entitled to COBRA coverage. See the COBRA section of this document for more information regarding your rights under COBRA law.

9. Amendment or Termination of the Plan

The Plan Administrator shall have the unlimited right to amend, terminate, or merge the Plan at any time without prior written notice to any Participant. Any such amendment, termination, or merger shall be documented in writing by an authorized representative of the Employer and shall become effective as of the date specified in the appropriate documentation. Any such amendment, termination or merger shall be binding upon all Employees and Dependents (including those Participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed without their written consent.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator. No one has the authority to make any oral modification to the Plan. Any change must be endorsed by the Plan Administrator or the duly authorized representative of the Plan Administrator and attached to this Plan Document. An amendment to this Plan may be retroactively effective, but shall not adversely affect the rights of a Participant under this Plan for benefits provided after the effective date of the amendment but before the amendment is adopted.

In the event of termination of the Plan or any benefit program in the Plan, claims or expenses incurred prior to the termination shall be paid in accordance with the terms of the relevant benefit program.

Additionally, the Employer reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

Any provision of the Plan which, on its effective date, is in conflict with the requirement of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

10. No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Daemen College to the effect that you will be employed for any specific period of time.

11. Claim Procedures

This Summary Plan Description is intended to provide summary information regarding claims procedures. Always review the attached insurance carrier booklets, summary plan descriptions or governing documents for more information about how file a claim and for details regarding the insurance company's claim procedures.

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company

denies your claim, in whole or part, you will receive a written notification explaining the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). You have voluntary rights to an external appeal if your internal appeal is denied.

CLAIMS AND APPEALS TIMETABLE

	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
Medical Dental Vision Care Health Care Flexible Spending Account	Urgent Care Claims	As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your claim by the Claims Administrator. Note that this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.	As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review by the Claims Administrator.
	Pre-Service Claims	Within a reasonable period of time appropriate to the medical circumstances but not later than 15 days after receipt of your claim by the Claims Administrator, unless an extension of up to an additional 15 days is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for review by the Claims Administrator.
	Post-Service Claims	Within a reasonable period of time, but not later than 30 days after receipt of your claim by the Claims Administrator, unless an extension of up to an additional 15 days is necessary due to matters beyond the control of the Claims Administrator.	A reasonable period of time, but not later than 60 days after receipt of the request for review by the Claims Administrator.
	Concurrent Care Claims	An extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above, but a claim for urgent care continuation submitted 24 hours before the end of the of the approved course of treatment must be processed within 24 hours instead of 72 hours .	An appeal for an extension of a course of treatment will follow the pre-service, post-service or urgent care procedures above
Long Term Disability		Within a reasonable period of time, but not later than 45 days after receipt of your claim by the Claims Administrator, unless an extension of up to an additional 30 days is necessary due to matters beyond the control of the Claims Plan Administrator.	A reasonable period of time, but not later than 45 days after receipt of your request for review by the Claims Administrator. May be extended for an additional 45 days .*

	Type of Claim	Timing for Claim Decision	Timing and Notification of Appeal Decision(s)
All Eligibility Determinations and Other Benefits	Includes Life and Dependent Care Flexible Spending Account	Within a reasonable period of time, but not later than 90 days after receipt of your claim by the Claims Administrator.	A reasonable period of time, but not later than 60 days after receipt of the request for review by the Claims Administrator. May be extended for an additional 60 days .*

* Upon written notice explaining the special circumstances that create a need for an extension.

Notice of Decision of Claim

Denied Claims under the Health Plan

If your claim for benefits under the Plan is denied, you will receive a written notice of the decision to deny the claim within 30 days after Blue Cross Blue Shield of Western New York or The Guardian (the designated claims processor) receives the claim, unless special circumstances require an extension of up to 15 additional days to process the claim. If such an extension of time for processing the claim is required, as determined in the designated claims processor's sole discretion, you will receive written notice of the extension before the end of the initial 30-day period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the designated claims processor expects to render a benefit determination. If your claim for benefits under the Plan is denied, the written notice of denial shall include:

- The specific reason or reasons for the denial;
- Reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit the claim for review.

Denied Claims Made Under the Long Term Disability Plan

If your claim for benefits under the LTD Plan is denied, you will receive a written notice of the decision to deny the claim within 45 days after the receipt of the claim by The Guardian or any successor thereto ("Disability Claims Processor"), unless the Disability Claims Processor determines that matters beyond the control of the Plan necessitate an extension of up to 30 days to process the claim. If the Disability Claims Processor determines that a decision cannot be rendered during the first 30-day extension period due to matters beyond the control of the Plan, the period for making a determination regarding your claim may be extended for an additional 30 days. If an extension of time for processing the claim is required (as described above), you will be provided with an explanation of the circumstances requiring the extension of time, including the following information:

- The date by which the Disability Claims Processor expects to render a decision on the claim;
- An explanation of the standards on which entitlement to a benefit is based;
- A description of the unresolved issues that prevent a decision on the claim; and
- A description of additional information needed to resolve such issues.

If the extension notice requires you to provide additional information to process your claim, you must provide the information to the Disability Claims Processor within 45 days after the date the notice is sent to you. If an extension notice requests specific information, the extension period will not begin to run until you respond to the Disability Claims Processor's request for information. If you do not respond to the Disability Claims

Processor's request for additional information within 45 days, your claim will be decided without such information.

If your claim for benefits under the LTD Plan is denied, the written notice of denial shall include:

- The specific reason or reasons for the denial;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material and information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, protocol, or other criterion was relied upon in making the adverse determination and will be provided to the claimant free of charge upon request; and
- If the adverse benefit determination is based on a medical necessity or experimental treatment or other similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to the claimant's medical circumstances will be provided to the claimant free of charge upon request.

Review Procedures for Denied Claims

Review of Claims under the Health Plan

The following claims review procedures apply without regard to any conflicting procedures described in the attached booklet.

Appeal. If your claim for benefits is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim or no notification as to an extension of the determination period within 90 days after submission of the claim to the designated claims processor, the claim for benefits will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing a written request for review with the Claims Administrator.

You must file a written request for review of a denied claim within 60 days after you receive written notice of the denial of the claim, or within 60 days after the date such claim is deemed to be denied. In connection with an appeal, you shall be permitted to review pertinent documents with respect to your claim, as determined by the Claims Administrator. Additionally, you may submit to the Claims Administrator written issues and comments relating to your claim in connection with the Claims Administrator's review of your claim.

Review: The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within 60 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the Claims Administrator will render a decision as soon as possible, but not later than 120 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 60-day period. The extension notice shall indicate the special circumstances requiring an extension of time.

The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim.

Disposition on Review: You will receive written notification of the Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

- The specific reason or reasons for the denial of the claim; and
- Specific references to pertinent plan provisions on which the benefit determination is based.

If the decision on review is not furnished within the period specified above, the claim shall be deemed denied on review at the expiration of that period.

If you have questions about claims procedures, contact:

Customer Services toll-free number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

Rights to an External Appeal – Medical (including prescription drug) Benefits

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if insurance company has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an external appeal agent, an independent entity certified by the State to conduct such appeals.

You will lose your right to an external appeal if you do not file an application for an external appeal within a period of time stated in the attached insurance contract.

The external appeal program is a voluntary program. Please refer to the appropriate attachment to this document for more information on requesting an external appeal.

Review of Claims Made under the Long Term Disability Plan

The following claims review procedures apply to the review of claims denied under the LTD Plan without regard to any conflicting claims appeal or review procedures described in the attached booklet.

Appeal: If your claim for benefits under the LTD Plan is denied, you may file a written request for review in accordance with the procedures described in this paragraph. Additionally, if you receive no notification as to the disposition of your claim under the LTD Plan or no notification as to an extension of the determination period within 45 days after submission of the claim to the Disability Claims Processor, the claim will be deemed to have been denied. If your claim has been denied or is deemed to have been denied, you may appeal the denial of the claim by filing with the Claims Administrator a written request for review, provided that your request for review of a claim must be submitted within 180 days after (a) your receipt of the written notice of the denial or (b) the date of the deemed denial of the claim.

Review: The Claims Administrator will review claims submitted for its review in writing and within the periods described in the previous paragraph. The Claims Administrator will render a decision regarding the claim within 45 days after the date the Claims Administrator receives your request for review, unless the Claims Administrator, in its sole discretion, determines that special circumstances require an extension of time for reviewing the claim, in which case the Claims Administrator will render a decision

as soon as possible, but not later than 90 days after the Claims Administrator's receipt of your request for review. If such an extension of time for review is required, the Claims Administrator shall furnish written notice of the extension of time to the claimant before the end of the initial 45-day period; such notice shall indicate the special circumstances requiring an extension of time and the date by which the Claims Administrator expects to render a determination on review. The Claims Administrator may, in its sole discretion, request additional information or a meeting to clarify any matters related to the review of the claim. If you request that the Claims Administrator review your claim, you may submit written comments, documents, records and other information relating to the claim. Additionally, you shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim, provided that the Claims Administrator shall determine, in its sole discretion, whether documents, records and information are relevant to your claim, subject to applicable regulations.

In reviewing your claim, the Claims Administrator shall take into account all comments, documents, records, and other information you submit that relates to your claim, without regard to whether such information was submitted or considered in the initial benefit determination. Additionally, the Claims Administrator's review of your claim shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination regarding your claim nor a subordinate of such individual. In deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate named fiduciary of the Plan shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, provided that such health care professional shall not be the individual who was consulted in connection with the initial adverse benefit determination regarding the claim or a subordinate of such individual.

Disposition on Review: You will receive written notification of the Claims Administrator's decision as to the disposition of a claim submitted for review and the notice will be written in a manner calculated to be understood by you. If your claim is denied on review, the notice shall include:

- The specific reason or reasons for the denial of the claim;
- Reference to the specific Plan provisions on which the benefit determination is based; and
- A statement that you are 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 for benefits, provided that the Claims Administrator shall, in its sole discretion, determine whether documents, records and information are relevant to your claim under applicable regulations;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided to you free of charge upon request;
- A statement of your right to bring an action under ERISA;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination that applies the terms of the Plan to your medical circumstances will be provided free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

You may, upon request and free of charge, obtain the identity of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination regarding your claim, without regard to whether such expert's advice was relied upon in making a benefit determination on review.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide on your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for denial. See the certificate of insurance for more information about how to file a claim and for details regarding the claims procedures of the applicable insurance company.

Claim Procedures for Self-Insured Plans – Dental, Salary Continuation, and Flexible Spending Account Program

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the College's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-insured arrangement.

The Plan Administrator will delegate the responsibility to a Third Party Administrator to decide your claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide you appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal in accordance with ERISA appeals in the claims procedures section of this document, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

Please refer to the Attachments to this document and Exhibit A for the Flexible Spending Account Program to determine specific claim procedures as provided by the Claims Administrators for self-insured benefit programs.

Subrogation/Right of Reimbursement

As a condition to receiving medical, disability or any other benefits under the Plan, covered person(s), including all Dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a covered person received any recovery, by way of judgment, settlement or otherwise, from another person or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefit paid by it (i.e. the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the covered person). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability, or other expenses. Also, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the covered person's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the covered person. The Plan may enforce its reimbursement or subrogation rights by requiring the covered person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the covered person's claim without prior express written authorization by the Plan. The Plan will not be subject to any "make whole" or other subrogation rule.

Coordination of Benefits and Right of Recovery

Coordination of Benefits

Except as otherwise described in an applicable Evidence of Coverage or Benefits Booklet, in the event that a Participant is entitled to benefits from another plan or policy or medical benefits under workers compensation, benefits under this Plan may be reduced to an amount, which together with all other amounts paid under any other plan or policy, will not exceed the benefits that would in fact be eligible for reimbursement under this Plan.

Medicare benefits will be secondary to health plan coverage with respect to covered individuals who receive Plan coverage by virtue of current employment status during a mandatory Medicare secondary period. In all other circumstances, Medicare benefits will be primary and the Plan will coordinate with Medicare to the extent permitted under applicable law.

Right of Recovery

Whenever benefits have been paid with respect to covered expenses in a total amount at any time in excess of the amount of payment necessary, the Plan Administrator shall have the right to recover such payments to the extent of such excess from among any one or more of the following, as the Plan Administrator shall determine: (i) any persons (including, without limitation, an Employee, a Covered Dependent, a trust, or an estate) to, for or with respect to whom such payments were made, (ii) any insurance companies, or (iii) any other organizations. The Plan Administrator shall have the right to pay any amount it shall determine to be warranted to satisfy the intent of this Section to any organization making payments under other plans which should have been made under this Plan.

12. Statement of ERISA Rights

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

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as other work-sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the 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 or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them in 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that the plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit 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 publication's hotline of the Employee Benefits Security Administration.

13. Summary of Benefits and Contributions

The Plan provides you, your Spouse, Eligible Retirees (medical (including prescription drugs) and dental coverage only), your Domestic Partner, and eligible Dependents with benefits in the Plan. A summary of each benefit provided under the Plan is set forth in the attached summary plan descriptions, carrier booklets or other governing document behind the applicable Attachments.

The cost of certain benefits provided through the component benefit programs will be funded in part by Daemen College contributions and in part by pre or post-tax employee contributions. Daemen College will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time. The current cost of participating in programs where you are required to pay the premium cost can be found in Attachment # 9.

Daemen College will make its contributions in an amount that (in Daemen College's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. Daemen College will pay its contribution and your contributions to the insurance carrier for fully insured benefits. Your contributions toward the cost of a particular benefit will be used in its entirety prior to using Daemen College contributions to pay for the cost of such benefits.

Contributions for Coverage

Daemen College pays the full premium cost or claims for benefits in the following plans:

- Short Term Disability (NY DBL)
- Salary Continuation Plan
- Long Term Disability
- Business Travel Accident

You are responsible for a portion of the premium cost of coverage you elect under the following plans:

- Medical (including prescription drugs) (pre-tax dollars)
- Dental Insurance (pre-tax dollars)

You are responsible for the full cost of participating in the following plans:

- Voluntary Vision (pre-tax dollars)
- Voluntary Term Life Insurance (post-tax dollars)
- Flexible Spending Account Plan (including medical and dependent care spending accounts) (pre-tax dollars)

A summary of the current structure of Participant pre or post-tax contribution requirements can be found in Attachment # 9.

With respect to benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as CHIPRA, COBRA, FMLA, HIPAA, HITECH, GINA, NMHPA, MHPAEA, PPACA and WHCRA.

14. Legal Compliance/Conformity

Insurance Contracts

The Director of Human Resources of Daemen College may sign insurance contracts for this Plan on behalf of Daemen College, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

Special Rights on Childbirth

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

Special Rights for Women

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Protheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Genetic Information Nondiscrimination Act ("GINA")

GINA prohibits employer-sponsored group health plans and health insurers providing group insurance from:

- Increasing premium or contribution amounts based on genetic information;
- Requesting or requiring an individual or family member to undergo a genetic test; and
- Requesting, requiring or purchasing genetic information prior to or in connection with enrollment, or at any time for underwriting purposes.

Genetic information means:

- The individual's genetic tests;
- The genetic tests of family members;
- The manifestation of a disease or disorder in family members; or
- Any request for, or receipt of, genetic services or participation in clinical research that includes genetic services, by the individual or family member.

Genetic information does not include information about the sex or age of any individual. It does include, with respect to a pregnant woman, an individual who is utilizing an assisted reproductive technology, or a family member, genetic information of any fetus carried by the pregnant woman or of any embryo legally held by the individual or family member.

Mental Health Parity and Addiction Equity Act (“MHPAEA”)

MHPAEA prohibits financial requirements and treatment limits for mental health and substance use disorder benefits that are more restrictive than the predominant financial requirement or treatment limit that applies to all or substantially all medical and surgical benefits.

Treatment limits include limits on the scope and duration of treatment.

The MHPAEA regulations set out a framework for assessing compliance with respect to financial requirements such as deductibles and coinsurance and quantitative treatment limits (e.g. day and visit limitations).

When the plan provides a mental health or substance use disorder benefit in any of the following six classifications, mental health and substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.

The Plan is prohibited from providing a more restrictive financial requirement or treatment limit than the predominant level that applies to all or substantially all medical/surgical benefits on any mental health or substance use disorder benefit within each of the above classifications.

Non-Assignment of Benefits

Except as may be required pursuant to a “Qualified Medical Child Support Order” which provides for Plan coverage for an alternate recipient, no participant or beneficiary may transfer, assign or pledge any Plan benefit.

Continuation and Conversion Rights

If you receive health care benefits under the Plan, you may have the right to continue to receive these benefits even if your normal coverage under the Plan ends and if you have exhausted your rights under COBRA. In addition, if any of your health care benefits and life insurance benefits is provided through insurance, you may have the right to convert your coverage for those benefits from the group policy to an individual policy. If you would like more information regarding your benefit continuation or conversion rights, please contact the insurance company.

Plan’s Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

No clerical error made by the Plan Sponsor, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If

the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under the Plan and its amount.

Effect on Workers' Compensation

The Plan is not intended to be and is not in lieu of any Workers' Compensation Act insurance and does not affect any requirement for Workers' Compensation Act insurance coverage.

Law of Governing Venue

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement. Any actions related to this Plan shall be brought in the federal or state courts located in the State of New York.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under component benefits of the Plan more than six years after the final review/appeal decision by the Plan Administrator or Claims Administrator has been rendered (or deemed rendered).

Other Circumstances that May Affect Benefits

Denial or Loss of Benefits

An Eligible Employee's benefits (and the benefits of his or her eligible spouses, and dependents) will cease when the Employee's participation in the Plan terminates (that is, when coverage ends). Benefits also cease upon termination of the Plan. In both instances, expenses incurred before coverage ended generally remain payable.

Other Circumstances

Other circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. For example, benefits may be denied based on lack of medical necessity. The group insurance contracts provide additional information.

15. Definitions

Claim Fiduciary means having the authority and responsibility to adjudicate claims in accordance with the provisions of the Plan. In the event a member appeal for review of a denied claim, the Claim Fiduciary makes the final determination as to whether the claim is covered. Daemen College cannot overrule this determination.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

College means Daemen College, its successors in interest, the sponsor of this Plan.

Dependent – Medical Insurance means any child (including adopted child(ren), child(ren) under court-appointed guardianship, or step-child(ren) living with the Employee) who has not reached the age of 26 as provided by the Patient Protection and Affordable Care Act of 2010. Coverage in the Plan will terminate at the end of the year in which the dependent reaches their 26th birthday.

Dependent – Dental and Voluntary Vision Benefits means any individual who is (a) the Spouse of the Plan participant; (b) an unmarried child of a Plan participant if the child is under age 19 and is primarily dependent on the participant for support; (c) an unmarried child of a Plan participant if the child is age 19 or over, by the end of the calendar year in which the dependent attains age 23 (limiting age) for dental coverage, a full-time student in regular attendance at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on (verification of full-time status is required), and primarily dependent on the participant for support; (d) any child of a Plan participant if the child is mentally or physically incapable of self-support and is dependent upon the participant for support, regardless of the child's age, provided such mental or physical condition commenced prior to the attainment by the child of age 19, or by the end of the calendar year in which the dependent attains age 23 (limiting age) for dental coverage if the child was age 19 or over and enrolled as a full-time student at the date of such commencement (verification of full-time status is required); (e) any child of a participant who does not qualify as a dependent under subsections (b), (c), or (d) above, solely because the child is not primarily dependent upon the participant for support so long as over half of the support of the child is received by the child from the participant pursuant to a multiple support agreement; (f) any other individual who is a dependent of the Plan participant described in Section 152(a) of the Internal Revenue Code and whose welfare is the legal responsibility of the Plan participant pursuant to legal guardianship, written divorce settlement, written separation agreement or a court order.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter and maintains full-time student status the entire semester. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

Dependent – All Benefits – means a child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability and considered to be totally disabled, and who was covered under the Plan prior to reaching the limiting age or due to other loss of dependent's eligibility and who lives with the employee, will remain eligible for coverage under the Plan beyond the date coverage would otherwise end.

To cover a child under this provision, the Plan Administrator must receive proof of incapacity within 31 days after coverage would otherwise terminate. The Plan Administrator may require at reasonable intervals during the two (2) years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency.

Your eligible Dependents can be enrolled in medical (including prescription drugs), vision and dental coverage under the Plan only if the Eligible Employee is enrolled.

The following individuals are not eligible for medical (including prescriptions drugs), vision or dental coverage, regardless of whether they are tax dependents of the employee:

- A spouse or a child living outside the United States; or
- A parent of you or your Spouse.

Dependent Care Spending Account (“DCAP”) means an account in the Flexible Spending Account Plan that is authorized by Section 129 of the Internal Revenue Code and reimburses eligible dependent care expenses. The Dependent Care Spending Account operates under Section 125 Cafeteria Plan rules of the Internal Revenue Code and allows payments for certain benefits on a pre-tax basis.

Domestic Partner means two individuals at least 18 years of age, of the same or opposite sex, in a committed relationship and intending to remain so indefinitely. Domestic Partners may not be related by blood or married to another person. In order to enroll your Domestic Partner you must complete and sign an Affidavit of Domestic Partnership and provide Proof of Cohabitation with an original copy of any three types of proofs from the listing shown on the Affidavit of Domestic Partnership. See the Human Resources Department for more information regarding benefit eligibility for your Domestic Partner.

Eligible Employee means any full-time individual employed by the Employer or Affiliated Employer as a common law employee. An individual shall be considered to be employed by the Employer or Affiliated Employer as a common-law employee only if the Employer or Affiliated Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer or Affiliated Employer, and such individual is determined by the Employer or Affiliated Employer to be a common-law employee for purposes of the Employer's or Affiliated Employer's payroll records. It is expressly provided that any individual who is treated as an independent contractor, seasonal, or temporary by the Employer or Affiliated Employer and any other common-law employee not described above is not an Employee and is not eligible to participate in this Plan. Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law employee" of the Employer or Affiliated Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as a common-law employee by the Employer or Affiliated Employer.

Eligible Retiree means an Employee who fully retires after age 55 with fifteen years of employment at Daemen College. Eligible Retirees may continue to participate in the medical (including prescription drugs) and dental programs after their retirement at their own expense. Retirees over 65 are required to enroll in the Medicare Advantage Plan offered by the College.

Employee means an employee of the Employer.

Employer means Daemen College, any of its Affiliates, and any other persons, firms, or organizations that have expressly adopted this Plan with the consent of Daemen College.

Enrollment Period means such period of time prior to the beginning of the Plan Year as may be specified by the Plan Administrator and communicated to Eligible Employees during which Eligible Employees and Participants may elect, or reject, to participate in the Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

GINA means the Genetic Information Nondiscrimination Act of 2008.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

Insurance Policy means the Policy providing such insurance coverage to Employees as may be agreed upon between the Employer and Insurer.

Life Event or Change in Election Event Under Section 125 means, and is limited to: (a) a change in an Employee's marital status; (b) the addition of an Employee's dependent; (c) loss of a dependent of an Employee; (d) commencement or termination of employment by an Employee's Spouse and gain or loss of health coverage by an Employee's Spouse under employee welfare benefit plans sponsored by the Spouse's employer; (e) termination of employment by an Employee; (f) status change from an eligible status to an ineligible status by an Employee or Spouse and the subsequent gain or loss of health coverage by the Employee or Spouse; or, (g) a significant change in the health coverage of an Employee or Spouse due to such coverage attributable to the Spouse.

Medical Flexible Spending Account means a type of self-insured ERISA welfare benefit plan that reimburses eligible medical expenses that are not reimbursed through other sources. Section 125 Cafeteria Plans are authorized by Section 125 of the Internal Revenue Code and allows payments for certain benefits on a pre-tax basis.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

NMHPA means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

Participant is a person covered under this Plan or the legal representative or guardian of a minor or incompetent person covered under this Plan.

Plan means the Daemen College Employee Health and Welfare Plan.

Plan Year is the twelve-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year, which is a short Plan Year.

Pre-Tax Salary Reduction means a separate written authorization of the Employee to have his or her after-tax salary reduced in exchange for the Employer making equivalent pre-tax contributions on the Employee's behalf directly to the Insurer to pay for the level of insurance coverage elected by the Employee and his Dependents in the Plan. The maximum Employer pre-tax contributions which can be made hereunder in consideration of a Salary Reduction cannot exceed the cost of the level of coverage elected by the Participant under the Plan reduced by any Employer Premium Contribution.

Qualified COBRA Beneficiary means an individual, on the day before a Qualifying Event, is a Spouse or dependent child of an Employee and who is covered under the medical (including prescription drugs), vision, dental, or flexible spending medical account. In the case of a Qualifying Event, Qualified Beneficiary means an individual who on the day before the Qualifying Event is an Employee.

Qualifying COBRA Event means any of the following events: (a) death of an Employee; (b) the voluntary or involuntary termination (other than by reason of gross misconduct) of an Employee; (c) a change in an Employee's status to an ineligible status; (d) divorce or legal separation of an Employee from his or her Spouse; (e) an Employee's commencement of entitlement to coverage under Medicare or a similar governmental benefit plan; (f) a dependent child ceasing to be a dependent child under the terms of the Employer's Plan.

Spouse means the Spouse is an Employee's husband or wife married under a legally valid marriage including common law marriage in States where it is recognized. The term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal

residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

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

WHCRA means the Women's Health and Cancer Rights Act of 1998, as amended.

Exhibit A

Section 125 / Cafeteria Plan Benefits – Flexible Spending Account Plan: Medical and Dependent Care Spending Accounts

Before Tax Savings

When you elect to make contributions to the Medical or Dependent Care Flexible Spending Account or elect to pay premiums under the Medical (including prescription drugs), Dental or Voluntary Vision Plans with before-tax payroll reductions, you save the federal income tax and the Social Security tax that would ordinarily be deducted from your paycheck as a result of that compensation.

Your actual tax savings will depend on how much you earn, your federal income rate, and how much you spend on before-tax benefits. Suppose that you earn \$25,000 and are married; that your rate on your joint tax return is 28%; and that you decide to pay \$1,000 for dependent care coverage. You would calculate your savings (based on 2016 federal income tax and Social Security tax rates) as follows:

7.65%	Social Security tax rate
+ 28.00%	Federal income tax rate
35.65%	Total tax savings rate

35.65% x \$1,000 = \$356.50 total savings.

If your compensation is greater than the Social Security taxable wage base in any year (\$118,500 in 2016), you will have lower Social Security tax savings. This is because the old age portion of the Social Security tax (6.2% out of 7.65%) is not applied to compensation in excess of the taxable wage base for a year. The Medicare portion of Social Security tax (1.45% out of 7.65%) continues to apply to compensation in excess of the taxable wage base for the year. Therefore, your tax “savings” are reduced with respect to compensation in excess of the taxable wage base. However, you will still save federal income tax and possibly state and local income tax (see below). Most states do not impose an income tax on employee before-tax contributions to plans such as the Cafeteria Plan.

Please consult your tax advisor on whether these amounts are taxable by municipal taxing authorities.

Examples of Tax Advantages When Participating in the Plan

Participating in the Plan can actually increase your take home pay. Consider the following example:

You are married and have one child. The Employer pays for 80% of your medical insurance premiums, but only 40% for your family. You pay \$2,400 in premiums (\$400 for your share of the Employee-only premium, plus \$2,000 for family coverage under the Employer’s medical insurance plan). You earn \$50,000 and your Spouse (a student) earns no income. You file a joint tax return.

	If you participate in the Cafeteria Plan		If you do not participate in the Cafeteria Plan
1. Gross Income	\$50,000		\$50,000
2. Salary Reductions for Premiums	\$2,400 (pretax)		\$0
3. Adjusted Gross Income	\$47,600		\$50,000
4. Standard Deduction	(\$9,700)		(\$9,700)
5. Exemptions	(\$9,300)		(\$9,300)
6. Taxable Income	\$28,600		\$31,000

7. Federal Income Tax (Line 6 x applicable tax schedule)	(\$3,590)		(\$3,904)
8. FICA Tax (7.65% x Line 3 Amount)	(\$3,641)		(\$3,825)
9. After-tax Contributions	(\$0)		(\$2,400)
10. Pay After Taxes and Contributions	\$40,365		\$39,821
11. Take Home Pay Difference	\$544		

Wages which are reported to the Social Security Administration (SSA) will not include your payroll reductions under the Section 125 Cafeteria Plan. Wages reported to the SSA are eventually used to determine the average compensation on which your Social Security benefit is based. Consequently, you may have a slightly reduced Social Security retirement or disability benefit. This will happen if your taxable wages after before-tax contributions are less than the Social Security taxable wage base (\$118,500 indexed for 2016). However, the current tax advantages should more than offset any reduction in your Social Security benefit.

Flexible Spending Accounts

If you contribute to the Flexible Spending Account Plan (including medical or dependent care accounts) Daemen College will establish an account in your name under the applicable plan(s). Your contributions for medical expense reimbursement will be allocated to your medical flexible spending account, and your contributions for dependent care assistance will be allocated to your dependent care flexible spending account. You may contribute before-tax dollars to either or both accounts.

Any eligible medical, dental, hearing and/or vision expenses that you incur may be reimbursed from your medical flexible spending account. Any eligible dependent care expenses may be reimbursed out of your dependent care flexible spending account. Amounts cannot be transferred from one flexible spending account to the other.

When you elect to contribute an amount to medical or dependent care accounts, Daemen College will deduct the amount you have elected to contribute and allocate that amount in the account you have chosen. When you incur an eligible medical or dependent care expenses, you are reimbursed from the appropriate account.

Contributions

Generally, you may contribute a minimum of \$400 per pay and up to a maximum of \$2,550 each year. You may contribute up to a maximum of \$5,000 (or up to \$2,500 if you are married and file separate tax returns) to the Dependent Care Spending Account each year. However, see the tax related sections below regarding the amount of tax-free reimbursement you can receive from the dependent care account each year.

The amounts you contribute to the Flexible Spending Account Plan are contributed on a before-tax basis and will not be subject to federal or, in most cases, state income tax. This means that your taxable compensation will be reduced, but your gross income will not be.

Special Rule for Dependent Care Spending Account Contributions

The amount of contribution into the Dependent Care Spending Account cannot be greater than the Participant's income or the Participants Spouse's income, whichever is lower. For example, if the Participant earns \$25,000 a year and a Spouse earns \$4,500, the maximum contribution for dependent care expenses cannot exceed \$4,500.

Eligible medical expenses that exceed my account balance

You may be reimbursed from your medical account up to the total amount you have elected to contribute for the Plan Year, even if the balance in your Account is less than the elected amount at the time you request the reimbursement.

Eligible dependent care expenses that exceed my account balance

Unlike your medical account, you will only be reimbursed up to the balance in your dependent care account at the time of your request for reimbursement. Any eligible expenses exceeding your balance will automatically be reimbursed as new contributions are added to your account.

Balance at the end of the year

You are permitted to carry-over up to \$500 in any Plan Year to be used for expense incurred in the following plan year. Any unused balances at the end of the Plan Year that exceed the allowable \$500 carry-over will be forfeited. The money in your account that exceeds the allowable \$500 carry-over at the end of the year cannot be cashed out by you or converted to any other benefit. The carry-over does not accumulate with each plan year.

The carry-over rule does not apply to your dependent care spending account. You must use all of the money in your dependent care spending account for claims incurred during a Plan Year or the unused balance is forfeited.

Reimbursable medical account expenses

Generally, only expenses which are considered by the Internal Revenue Service to be tax-deductible medical expenses are considered eligible for reimbursement under the medical account, with the exception of premiums paid for other health plan coverage (including Medicare or plans maintained by Daemen College or the employer of your Spouse or Dependent) and certain long-term care expenses. In addition, non-prescription (over-the-counter) medicines and drugs that are used for medical care are eligible, even though these expenses are not tax-deductible for federal tax purposes. Eligible expenses include those expenses for the diagnosis, treatment and prevention of disease, prescription drugs and insulin. Of course, medical expenses reimbursed through your medical account cannot be claimed as an additional deduction for income tax purposes. Expenses must be incurred on behalf of you, your Spouse and any Dependent with respect to whom you are entitled to claim a deduction on your federal income tax return (without regard to the earned income limit that applies for income tax purposes). A prescription is required for reimbursement of over-the-counter (OTC) medical care items.

Refer to IRS Publication 502, "Medical and Dental Expenses," (available on the IRS' website at www.irs.gov) for more information regarding eligible and ineligible medical expenses, subject to the caveats in the preceding paragraph.

If you receive a reimbursement from your Medical Spending Account and reimbursement for the same expense through your medical (including prescription drugs), dental, voluntary vision or another health plan, you must refund the reimbursement you received from your Medical Spending Account to the Plan.

Eligible expenses reimbursable from dependent care spending accounts

Generally, reimbursable expenses include day-care costs for children and dependent adults; provided such expenses are necessary in order for you and your Spouse to work or attend school full-time. (A special rule applies if your Spouse is physically incapacitated.).

If the dependent is a child, the following rules also apply:

The child must be younger than 13, lives with you for more than one-half of the calendar year and does not provide more than one-half of his or her own support for the year;

Care may be provided either inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes or one of your children under age 19;

If the care is provided by a facility that cares for more than six children, the facility must be licensed.

If the dependent is an adult or an older dependent child, the following rules also apply:

The dependent must be physically or mentally incapable of caring for him or herself;

He or she must either be your spouse or be dependent upon you for at least 50% of his financial support;

He or she must live with you for more than one-half of the calendar year;

He or she must not have gross income in excess of a specified amount; this does not apply to a spouse.

He or she must not be someone else's "qualifying child" for federal income tax purposes;

Care may be provided either inside or outside your home; however, expenses outside of your home (e.g., at a nursing home) are eligible only if the dependent regularly spends at least eight hours each day in your household.

To make sure your situation and the type of care being provided meets IRS requirements refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses."

Dependent care provider in your home

If you use a dependent care provider inside your home you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees." These forms and publications are available on the IRS' website (www.irs.gov), and also should be available at your local post office or public library.

Reimbursements under the medical and dependent care account and taxation

Amounts paid to you under the Flexible Spending Account Plan are intended to be tax-free to you and no taxes will be withheld from any reimbursement. However, special rules applicable to the dependent care account may cause some reimbursement to be taxable to you. Federal law provides that the amount of dependent care reimbursement excluded from your gross income cannot exceed the lesser of:

- \$5,000 (\$2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse's annual income.

If your Spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your Spouse's actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either \$250 (if you claim expenses for one dependent) or \$500 (if you claim expenses for two or more dependents). The amount you use to determine

your Spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either \$250 or \$500. By making an election under the Plan to contribute to a dependent care account, you are representing to the Employer that your contributions to the Flexible Spending Account Plan dependent care account are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the \$2,500 limit described above will not apply if you are (1) legally separated or (2) your Spouse did not reside with you for the last six (6) months of the calendar year, you maintained a household that was your dependent's primary residence for more than six (6) months during the year and you paid more than half of the expenses of that household.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's social security number. Your care provider should be made aware of this reporting requirement.

Other income tax considerations affecting participation in the dependent care account

You should be aware that there is a dependent care tax credit and an earned income credit.

The Federal Dependent Care Tax Credit

Dependent care expenses for which you are reimbursed from your dependent care account will not qualify for the federal tax credit available with respect to dependent care expenses. Under the Internal Revenue Code, you are entitled to a dollar for dollar credit against your income tax liability in an amount equal to a specified percentage of your qualifying dependent care expenses. For purposes of the credit, there are limitations on the dollar amount of qualifying dependent care expenses that can be taken into account. These limitations are reduced dollar for dollar by dependent care expenses reimbursed under the Dependent Care FSA. In addition, these expenses cannot be taken into account to the extent they exceed the lesser of your or your spouse's earned income.

Therefore, you must determine whether it is more advantageous for you not to establish a dependent care account in order to avail yourself of the federal tax credit. In making this determination, it is important to consider that the amount of compensation you elect to reduce under the Plan is not subject to federal income tax, but also is not subject to Social Security withholding tax (FICA) (7.65% up to \$118,500 in 2016).

As a general rule, depending upon your particular situation, paying for qualifying dependent care expenses through compensation reduction under the dependent care account will produce greater tax savings the higher your income level. ***If you are not certain as to what extent, if any, it is to your advantage to participate in the Plan, you should consult your personal tax advisor.***

The Federal Earned Income Credit

Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for-dollar the federal tax you have to pay, but is calculated somewhat differently from the child care credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. An additional credit is available to individuals with a child who is under one year old. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the dependent care account for dependent care expenses, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. Moreover, the use of the dependent care account may result in a reduction in your taxable income thus qualifying you for the earned income credit where you would not otherwise have qualified.

Losing coverage under the Flexible Spending Account Plan

If you elect to participate in the medical account, you have a right to choose continuation coverage if you lose your coverage due to a qualifying COBRA event. In general, you may only continue coverage in the amount in effect on the day before you lost coverage; you may not alter the coverage. If you lose coverage under the Plan, see the COBRA Section in this document for your rights to continue coverage in the Flexible Spending Account Plan. Special continuation rules do not apply to any dependent care account election in the Flexible Spending Account Plan.

Special rules for highly compensated and key employees

Under the Internal Revenue Code, certain employees are considered “highly compensated employees” and “key employees”. To prevent discrimination in favor of these employees, the Plan Administrator may limit or reduce their contributions in a uniform and nondiscriminatory manner. If you are a highly compensated and/or a key employee, the Plan Administrator will notify you if it becomes necessary to modify the amount of your contributions.

Incorrect amounts in connection with the Plan

It will be assumed that all payments to you are excludable for federal and state income tax purposes and no taxes will be withheld. It is your obligation to determine whether each payment is actually excludable from your gross income for such purposes.

If you receive any payment or reimbursements under the Flexible Spending Account Plan that are not warranted, justified or correct, you will indemnify and reimburse the Employer for any liability which it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

Benefit Claims for the Flexible Spending Account Plan

You can submit a claim for an eligible medical expense at any time during the Plan Year by using your personalized debit card or with a paper claim form. Claims should be submitted to:

M&T Insurance Agency, Inc.

For paper claims, you may also obtain a Reimbursement Request Form for Medical Reimbursement from the Plan Administrator. When submitting your claim form, you must also submit a copy of the original itemized bill or receipt for an expense not covered under your medical (including prescription drugs), vision or dental coverage, or the explanation of benefits from the insurance company.

In accordance with the Uniform Reimbursement Requirement for Flexible Spending Accounts under the provisions of the Internal Revenue Code, you may obtain reimbursement up to the amount you have elected (plus any available Employer contributions) to deposit into your Medical Spending Account.

You can submit a claim for an eligible dependent care expense at any time during the Plan Year.

The money deposited in your account for the Plan Year will be used to reimburse you for eligible expenses incurred during that year only. An expense is incurred when the care is provided, and not when the bill is sent or payment is made. There is no extension of the claims incurrence period for the Dependent Care Spending Account.

Reimbursements for dependent day care expenses are allowed up to the amount actually in your Dependent Care Spending Account at the time you submit your request. If your claim for benefits exceeds the amount currently available in your Dependent Care Spending Account, you will receive additional reimbursements as

more money is deposited into your account through salary reductions and through any contributions your Employer may make.

Change in Employment Status or Death of a Participant

In the event of a death of a participant, deposits stop. Your surviving dependents may submit for reimbursement, eligible expenses incurred prior to the participant's death. Claims for eligible expenses incurred prior to the participant's death must be submitted within 60 days following the close of the Plan Year.

If your employment status changes from an eligible to ineligible status, deposits stop at the date of the change in status. Requests for reimbursement of expenses incurred prior to the change in employment status must be submitted within 60 days following the close of the Plan Year.

Denial of benefit in the Flexible Spending Account Plan

The following information is provided regarding claims and review procedures for benefit plans that are covered by the Employee Retirement Income Security Act ("ERISA"). It is based upon regulations issued by the U.S. Department of Labor. The Medical Spending Account under this Plan is a benefit that is covered by ERISA.

If your claim for medical account benefits is denied by the Plan Administrator or Third Party Administrator, you will be notified of this, in writing, within thirty-one (31) days after receipt of your claim. If the Plan Administrator or Third Party Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Plan Administrator or Third Party Administrator will notify you within the initial thirty-one (31) day period that the Plan Administrator or Third Party Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because you failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that you will need to provide to the Plan Administrator or Third Party Administrator. You will have no less than forty-five (45) days from the date you receive the notice to provide the requested information.

If your claim for dependent care account benefits is denied by the Plan Administrator or Third Party Administrator, you will be notified of this, in writing, within ninety (90) days (or one hundred eighty (180) days under special circumstances) after receipt of your claim.

The written notice of denial will include the following information:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for the claimant to perfect his or her claim and an explanation as to why such information is necessary;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at the claimant's request; and
- a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that the claimant is eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal).

If an initial claim for benefits is denied by the Plan Administrator or Third Party Administrator, you or your duly authorized representative may appeal the denial by filing a written request with the Plan Administrator or Third Party Administrator within sixty (60) days (in the case of a dependent care account claim) or one hundred

eighty (180) days (in the case of a medical account claim) after receipt of the notice denying the initial claim for benefits. Upon your decision to appeal a denied claim for benefits, you or your duly authorized representative will be able to submit written comments, documents, records, and other information relating to his or her claim for benefits (regardless of whether such information was considered in the initial claim for benefits) to the Plan Administrator or Third Party Administrator for review and consideration. You or your duly authorized representative will be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the appeal.

Upon receipt of your appeal of a denied claim for benefits, the Plan Administrator or Third Party Administrator will respond to the claim within sixty (60) days (or one hundred twenty (120) days in the case of a dependent care account claim), after receipt of the appeal.

If the Plan Administrator or Third Party Administrator denies the claim (in whole or in part), the Plan Administrator or Third Party Administrator will provide you or your duly authorized representative with written notice of the denial. This notice will include the following:

- the specific reason or reasons for the denial;
- reference to the specific Plan provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to the claim and/or appeal for benefits;
- in the case of a medical account claim, a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you or your duly authorized representative free of charge at his or her request; and
- a statement that the claimant is entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue his or her claim for benefits.

You must follow all the steps described above before you may consider legal action against the Plan or the Plan Administrator. Naturally, both you and the Plan Administrator will want to avoid legal action. However, if you feel that legal action is necessary, any summons or other legal documents should be served to the agent for service of legal process found in this Plan document.

Termination of Employment

If you terminate your employment with Daemen College, all claims for benefits from the Flexible Spending Account Plan incurred during your employment are reimbursable to you within 60 days of your date of termination. You must submit the appropriate claim form to the Claims Administrator for the Flexible Spending Account Plan. You may also have a right to COBRA continuation coverage for your medical spending account.

**Daemen College
Resolution of the Board of Trustees
Amendment and Restatement of Health Insurance Plan**

Daemen College maintains certain employee welfare benefit plans providing the following benefits:

- Medical (including prescription drugs)
- Voluntary Vision
- Dental
- Voluntary Term Life Insurance
- Short Term Disability (NY DBL)
- Salary Continuation Plan
- Long Term Disability
- Employee Assistance Plan
- Business Travel Accident
- Flexible Spending Account Program (including medical and dependent care spending accounts)

Daemen College reserves the right to amend benefits listed above and in effect as the date of this Resolution. Daemen College wishes to amend and restate these programs accordingly.

It is resolved that Daemen College Employee Health and Welfare Plan (Plan) is hereby amended to read as set forth in the document entitled "Daemen College Employee Health and Welfare Plan and Summary Plan Description" in substantially the form attached to this Consent.

The Trustees of Daemen College or any one of them is authorized to execute the Plan and any and all other documents, and to take such other action, which is necessary or convenient to effectuate this resolution.

Signature:

Trustee

Dates (effective date)

Attestation (witness)