Le Moyne College
Health and Welfare Retirement Benefit Plan
Summary Plan Description

For Retirees Who Terminated Employment
On Or After July 1, 2012

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Post July 1, 2012 Retirees
Summary Plan Description

I. **Effective Date.** The Le Moyne College Health and Welfare Retirement Benefit Plan ("Plan") was most recently restated, effective January 1, 2012. This Summary Plan Description ("SPD") describes the Plan benefits provided to eligible retirees who terminated employment on or after July 1, 2012.

II. **Plan Year.** The Plan Year for the Plan shall be January 1 through December 31.

III. **Purpose.** The purpose of the Plan is to provide health and welfare benefits to eligible retirees and their eligible spouses. This SPD is intended to provide you with an easily understandable description of the main provisions of the Le Moyne College Health and Welfare Retirement Benefit Plan. To serve this purpose, the SPD cannot explain all of the details of the Plan. If there are any inconsistencies between this SPD and the Plan Document, the Plan Document will control. There are also certain other documents regarding the Plan that have been approved by the Le Moyne College Office of Human Resources ("Office of Human Resources") that provide additional information about the health and welfare benefits offered under the Plan (collectively, "Plan Materials"). The Plan Materials are intended to be read with, and considered part of, this SPD.

The Health Reimbursement Arrangement ("HRA") offered under the Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Section 105 and 106, and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Employer contributions made on behalf of Participants will be excludable from gross income for federal income tax purposes, and benefits paid hereunder will be excludable from a Participant's gross income.

This SPD describes benefits offered under the Plan to eligible retirees who terminated employment on or after July 1, 2012. Separate SPDs describe benefits offered to: (i) eligible retirees who terminated employment prior to July 1, 2010, and (ii) eligible retirees who terminated employment on or after July 1, 2010 and prior to July 1, 2012.

LEMOYNE COLLEGE RESERVES THE RIGHT TO AMEND OR TERMINATE THIS PLAN AT ANY TIME.

IV. **Definitions.** As used in this Plan, the following terms have the following meanings:

A. Eligible Retired Employee means the following:

1. **Health Insurance.** For purposes of the health insurance benefits offered under the Plan, the term "Eligible Retired Employee" means any former employee whose age plus years of service with the Employer totals at least 75. Notwithstanding the foregoing, a former Employee who has attained age 55 with at least ten years of service with the Employer on his or her retirement date shall

be eligible for the "Access Only" health insurance benefit described in Section VI(A).

2. **Dental Insurance**: For purposes of the dental benefits offered under the Plan, the term "Eligible Retired Employee" means any former Employee who was enrolled in the group dental plan offered by the Employer at the time he or she terminated employment.

B. Eligible Expense means a health insurance premium expense incurred by a Participant for himself or herself which qualifies as an expense incurred for medical care within the meaning of Section 213(d) of the Internal Revenue Code.

C. Eligible Spouse means the Spouse of an Eligible Retired Employee. An Eligible Retired Employee's Spouse is not eligible to participate in the HRA benefit under the Plan.

D. Employer means Le Moyne College.

E. HRA means a health reimbursement arrangement as defined in IRS Notice 2002-45 and, more specifically, in this Plan.

F. HRA Account means the HRA Account described in Section VIII (B) below.

G. HRA Eligible Individual means an Eligible Retired Employee who is at least age 65 with 75 points (age plus years of service).

H. Medicare Plan means a Medicare supplement insurance plan sponsored by the Employer.

I. Participant means any Eligible Retired Employee who elects to become a Participant in the Plan and has not for any reason become ineligible to participate further in the Plan, and his or her Eligible Spouse.

J. Plan Materials means the booklets, pamphlets and other documents provided by the Employer, applicable insurer or third-party administrator that describe the terms and conditions of the retiree benefits offered under the Plan. Plan Materials are described in Appendix A.

K. Spouse means the lawful spouse of an Eligible Employee.

V. Eligibility and Participation.

A. Eligibility to Participate in Health Insurance. You are eligible to participate in the Plan if you are an Eligible Retired Employee and you satisfy the enrollment requirements described in this Section.

If you are an Eligible Retired Employee, you must elect Plan coverage no later than 30 days prior to your retirement. In addition, as an active employee prior to

your retirement date, you must also have been enrolled as a participant in one of the Employer-sponsored health insurance plans during the calendar year of your retirement date.

If you have an Eligible Spouse, you must elect Plan coverage for your Spouse no later than 30 days prior to your retirement date. Your Eligible Spouse must have been enrolled as a dependent participant in one of the Employer-sponsored health insurance plans during the calendar year of your retirement date.

An Eligible Retired Employee who is at least age 55 with 75 points or more may retire and defer the right to the subsidized coverage described in Section VI until the Eligible Retired Employee attains age 59-1/2. In order to defer your subsidized coverage, you must maintain continuous health coverage by purchasing one of the Employer's health insurance plans at 100% until you reach age 59-1/2.

The failure to elect Plan coverage in accordance with the requirements of this Section could result in ineligibility for Plan benefits. It is important to note that you will only have one opportunity to enroll in the Plan. A second enrollment opportunity will not be extended to you if you fail to enroll in the Plan when you first become eligible to participate. Further, if you initially enroll in any of the benefits offered under the Plan and subsequently disenroll, you will not be offered the opportunity to subsequently re-enroll in such benefit.

B. **Commencement of Participation in Retiree Health Insurance.** If you are an Eligible Retiree, you will commence participation upon completing the enrollment materials provided by the Employer and following your last day of employment.

C. **Termination of Participation.** You will cease to be a Participant in the Plan upon the earlier of:

(i) the date you disenroll;

(ii) the termination of the Plan;

(iii) the date required pursuant to the terms of any applicable Plan Materials;

(iv) the date of your death;

(v) the date you fail to make any required contributions to the Plan;

(vi) the date on which you cease to be an HRA Eligible Individual; or

(vii) the date on which your HRA account has a zero balance.

Your Spouse will cease to be a Participant upon the occurrence of one of the events described above or, if earlier, upon the loss of Eligible Spouse status under

the Plan.

Reimbursements from an HRA Account after termination of participation will be made pursuant to Section VIII(D) below.

D. Election Changes. Each year, you will have the opportunity to change the health insurance benefit option that you are enrolled in during the annual enrollment period made available by the Employer. After your initial enrollment period at retirement, you are not able to add a Spouse to your coverage.

E. Survivor Benefits. If you die while enrolled in the retiree health benefits described in this SPD, your Eligible Spouse will continue to be eligible to receive coverage under the Plan by paying 100% of the applicable premium. The survivorship benefit does not apply to the HRA.

VI. Health Insurance Benefits Offered To Retirees Prior To Attaining Age 65

A. Health Insurance Benefits. The health insurance benefits available under the Plan are the same benefits offered to active employees. Benefits and related provision are determined according to the applicable Plan Materials (which are incorporated by reference and made a part of the Plan) and by the other terms of the Plan. The Plan Materials for the health insurance benefits are described in Appendix A.

1. Cost of Health Insurance Coverage

The cost of health insurance coverage will be communicated to Plan Participants prior to the beginning of each Plan Year, and can also be obtained from the Office of Human Resources. Eligible Retired Employees who have attained age 59-1/2 will receive an Employer contribution towards the cost of coverage, in accordance with the following schedule:

a. 85 Points or More: Eligible Retired Employees with 85 points (age plus years of service) or more will receive an Employer contribution of sixty five percent (65%) of the applicable premium.

b. 75-84 Points: Eligible Retired Employees with at least 75 points, but less than 85 points, will receive an Employer contribution of fifty percent (50%) of the applicable premium.

There is no subsidized coverage for your Spouse.

2. Access Only Coverage

Eligible Retired Employees who have attained age 55 with at least 10 years of service may elect continued access to coverage under the Plan (until reaching age 65), if the retiree contributes 100% of the premium (i.e., no Employer subsidy will apply to the coverage). You will have only one opportunity to

enroll in access only coverage under the Plan.

You may continue health insurance coverage for your Spouse by paying 100% of the premium of the applicable health insurance plan offered by Le Moyne College. Your Spouse must be enrolled in the health insurance plan as a participant during the calendar year you are retiring to be eligible for this access to health insurance.

There is no "access only" health insurance coverage for dependents (child) other than your Spouse upon your retirement.

VII. Health Insurance Benefits Offered To Retirees Age 65 and Older

A. Health Insurance Benefits Offered. When you become a Participant in accordance with Section V above, an HRA Account will be established for you in order to receive benefits in the form of reimbursements for premium expenses. Separate HRA Accounts are established for each Eligible Retired Employee and the beginning balance amount of the account is dependent on your accumulated points (age plus years of service) on your retirement date. The following are the initial HRA account balances along with the corresponding spending limits for premium reimbursements based on the following point system:

Points	HRA	Spend Limit (Annual Reimbursement Amount)
85 + points:	$50,000	$2,000 annual limit
75 – 84 points:	$35,000	$1,500 annual limit

The initial HRA amount for a new retiree will be determined by HRA balances above, set as of July 1, 2008 and adjusted at 3% each year. During retirement, the remaining unused balance will receive an interest credit of 3% per year.

An Eligible Retired Employee who has attained age 55 with at least 10 years of service with the College may elect to participate in the Medicare Plan offered by the Employer if the Eligible Retired Employee contributes 100% of the applicable premium (i.e., no College subsidy will apply to the Employee). Benefits and related provisions regarding the Medicare Plan are determined according to the applicable Plan Materials (see Appendix A).

An Eligible Retired Employee may also cover his or her Spouse under the Medicare Plan (to the extent available), by paying 100% of the health insurance premium for a Spouse. The Spouse's enrollment must be completed at the earlier of your enrollment or when your Spouse turns age 65.

An Eligible Retired Employee will only have one opportunity to enroll in access only coverage under the Plan.

B. Contributions (Spending Limit). The maximum annual health insurance premium amount that you can submit for reimbursement from your HRA account is fixed at a set amount during your retirement as follows:

i. a retiree with 85 + points = $2,000 annually
ii. a retiree with 75 + points = $1,500 annually

Your remaining HRA balance will earn an interest credit of 3% every year on June 30th.

There are no Participant contributions under the HRA, except as required under the COBRA provisions of Section VIII (E).

C. Funding. All of the amounts payable under this HRA shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which HRA benefits are paid.

VIII. Health Reimbursement Arrangement Benefits Age 65 and Older.

A. Benefits. You are entitled to payment/reimbursement of premiums you pay for your Eligible Expenses (health insurance premiums) from your Account provided: (1) there are sufficient funds in the Account to pay the Eligible Expense; (2) the Eligible Expense was incurred on or after the date you become a Participant and before participation ceases; (3) the Eligible Expense has not been reimbursed, and is not reimbursable, from any other source; and (4) you properly complete any applicable claim forms and provide any information required by the Claims Administrator.

An Eligible Expense is incurred at the time when you are billed, charged, or pay for the health insurance premium.

Payments or reimbursements made from your HRA account will reduce your HRA Account balance. The maximum amount available for payment or reimbursement equals the amount then credited to your HRA Account.

Reimbursements to highly compensated individuals may be limited or treated as taxable compensation to comply with Internal Revenue Code requirements, as may be determined by the Plan Administrator in its sole discretion.

B. Establishment of HRA Account. The Plan Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. Separate HRA Accounts will be maintained for an Eligible Retired Employee and his or her Eligible Spouse. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and reimbursement amounts.

C. Reimbursement Procedure.

(i) **General.** The Claims Administrator will establish a procedure for the reimbursement of Eligible Expenses which will be communicated to Participants.

(ii) **Claims Substantiation.** A claim for reimbursement must include the information requested by the Claims Administrator for substantiation of the claim.

(iii) **Claims Denied.**

(a) Upon denial of a claim for reimbursement, the notification will be in writing and must be written in a manner calculated to be understood by the claimant. It must include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific Plan provisions on which the determination is based; (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and (4) 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 an action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA") following an adverse benefit determination on review.

(b) Following receipt of an adverse determination, the claimant will have 180 days to file a request for review in writing. On review, the review will not afford deference to the initial adverse determination, and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse determination that is the subject of the appeal, nor the subordinate of such individual.

(1) The reasonable period for a determination on review shall not be later than 60 days after the date that the Plan receives the claimant's request for review of the adverse determination. No unilateral extension by the Plan is permitted.

(2) The written notification shall include all of the information that would be required under Section VIII(C) (iii) (a) when there is an adverse determination on review.

(c) The right of a claimant to bring a civil action in federal court under Section 502(a) of ERISA is contingent upon the claimant exhausting the administrative remedies set forth in this Section VIII(C) (iii).

D. Reimbursements After Participation Ends. If you cease participation in the HRA due to your death or loss of eligibility under the Plan, any amount credited to your HRA Account (after payment of claims for Eligible Expenses incurred before participation ceased) is forfeited. Claims for Eligible Expenses incurred prior to the date of death or ineligibility must be submitted within six (6) months of the date of loss of coverage under the HRA.

E. COBRA. An Eligible Spouse has the right to elect COBRA continuation coverage for himself or herself, if the Eligible Spouse loses coverage under the Plan due to divorce or legal separation from an Eligible Retired Employee.

An Eligible Dependent Child has the right to elect COBRA continuation coverage for himself or herself, if coverage otherwise would end due to any of the following events: (1) divorce or legal separation of you and your spouse; (2) loss of dependent child status under the terms of the Plan.

An Eligible Spouse or Eligible Dependent Child who has the right to elect COBRA continuation coverage is referred to as a "Qualified Beneficiary."

In addition, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event with respect to the HRA. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage for an HRA Eligible Individual, the HRA Eligible Individual is a COBRA qualified beneficiary with respect to the bankruptcy.

Notice and Election Provisions. You (or a family member of a legal representative) must inform the Plan Administrator, in writing, in the event of a divorce, legal separation, or loss of dependent child status. The written notice must describe the qualifying event triggering the COBRA coverage (e.g. identify whether the qualifying event was due to divorce, legal separation, or loss of dependent status) and the date on which the event occurred. The Spouse, Dependent (or a legal representative) must notify the Plan Administrator in writing within 60 days of the date of a divorce or loss of dependent status or the date on which coverage would end because of the event. If the Plan Administrator is not notified within 60 days, the right to COBRA health continuation coverage will be lost.

When the Administrator is notified on a timely basis that a qualifying event has occurred, the Qualified Beneficiary will be notified of the right to choose COBRA health continuation coverage. The Qualified Beneficiary or a legal representative will have 60 days from the later of the date of notification about COBRA or the date of loss of coverage to inform the Plan Administrator that the Spouse wants to continue health coverage. If the Qualified Beneficiary does not choose COBRA health continuation coverage, health coverage under this Plan will end.

Cost of Continuation Coverage. A Qualified Beneficiary who chooses to continue health coverage will have to pay 102 percent of the full cost to the Plan for the health coverage. The first premium payment must be made in advance, along with any premium payments owed from the date health coverage ended,

within 45 days from the date the qualified beneficiary chooses to continue health coverage.

Length of Continuation Coverage. An Eligible Spouse or Dependent may continue health coverage for 36 months in the event of loss of coverage due to divorce. An Eligible Dependent also may continue health coverage for 36 months in the event of loss of coverage due to loss of dependent child status under the Plan.

Termination of COBRA Continuation Coverage. A Spouse's or Dependent's COBRA continuation health coverage may be terminated for any of the following reasons: (a) the Employer ceases to provide health coverage to any employees; (b) the premium for the Spouse's or Dependent's health continuation coverage is not paid on a timely basis; or (c) the maximum period of continuation ends.

F. Compliance With ERISA, COBRA, HIPAA, etc. Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

G. Coordination of Benefits. Benefits under this HRA are intended to pay benefits solely for Eligible Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise Eligible Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan.

IX. Dental Insurance Benefits Offered.

An Eligible Retired Employee may continue to access the dental benefits provided by the Employer following retirement, if the Eligible Retired Employee was enrolled in the dental benefit program offered by the Employer at the time of retirement. Your Eligible Spouse and eligible dependents covered at the time of retirement are also eligible to continue coverage following your retirement in accordance with the guidelines set forth in the Plan Materials. The Employer does not subsidize any costs associated with retiree dental benefits. You will be responsible for the entire applicable premium, which will be communicated to you on an annual basis. The total premium must be paid at the beginning of the Plan Year.

X. CLAIMS FOR BENEFITS

Each claims administrator must follow claims procedures that satisfy the requirements specified in United States Department of Labor regulations and summarized in this Section. For purposes of these procedures, the person who is responsible for making a claims decision is referred to as the "claims administrator."

(A) Urgent Care: An "urgent care claim" is a claim for medical treatment or care that, if not provided quickly, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the case, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment

requested.

A decision on an urgent care claim will be made within 72 hours after the request is received. If the request is incomplete, the claimant will be notified within 24 hours of the submission (and will be told of the specific information necessary to complete the claim). The claimant then has 48 hours after the notice is received (unless the claims administrator allows a longer period) to provide the additional information. A decision will be made by the later of (i) 48 hours after the additional information is provided, or (ii) the expiration of the deadline to provide additional information.

An appeal of an adverse decision (denial) regarding an urgent care claim will be decided within 72 hours after the appeal request is filed.

(B) **Pre-Service Claims:** A "pre-service claim" is any claim for a benefit where the terms of the Plan require approval prior to obtaining medical care.

An initial decision on a pre-service claim must be made in a reasonable time, but no later than 15 days after the submission of the claim. This time period can be extended for an additional 15 days if the claims administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected. If the request is incomplete, the claimant will be notified within 5 days of the submission (and will be told of the specific information necessary to complete the claim).

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

An appeal of an adverse decision (denial) regarding a pre-service claim will be decided within 30 days after the appeal request is filed.

(C) **Post-Service Claims:** A "post-service claim" is any claim that is not a "pre-service claim" (in other words, no prior approval is required before obtaining health care).

The claimant will be notified of any adverse benefit determination of a post-service claim within a reasonable time, but not later than 30 days after receipt of the claim. The period for a decision may be extended for an additional 15 days if the claims administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

An appeal of an adverse decision (denial) regarding a post-service claim will be decided within 60 days after the appeal request is filed.

(D) **Concurrent Care:** A "concurrent care claim" involves a decision by the Plan or an issuer to reduce or stop a course of treatment that has already begun.

Any reduction or termination of an ongoing course of treatment to be provided over a period of time or a specified number of treatments shall be treated as an "adverse benefit determination" (unless due to an amendment or termination of the Plan). The claimant will be notified of the decision to reduce or terminate the course of treatment in sufficient time to allow an appeal (and a determination on the appeal) to take place before the benefit is reduced or terminated.

The timing for adverse benefit determinations and determinations on appeal of an adverse determination will depend upon whether the claim is an urgent care claim, a pre-service claim or a post-service claim.

(E) **Requirements for Notification of an Adverse Benefit Determination:** The claims administrator will provide the claimant with a written or electronic notification of any adverse benefit decision. The notification will state, in a manner calculated to be understood by the claimant:

- the specific reason(s) for the adverse determination;
- 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 complete the claim and an explanation as to why such material or information is needed;
- a description of the Plan's review procedures and time limits (including a statement of the claimant's rights to bring a civil suit under Section 502(a) of ERISA following an adverse benefit determination on review); and
- if the claim is an urgent care claim, a description of the expedited review process.

(F) **Appeal of an Adverse Determination:** A claimant may request a review of an adverse benefit determination within 180 days following receipt of the adverse benefit determination. A review will be conducted by a fiduciary who is neither the individual who made the initial determination nor a subordinate of that person. If the adverse benefit determination was based, in whole or in part, on a medical judgment (including whether a particular treatment, drug, etc., is experimental, investigational or not medically necessary or appropriate) the reviewer will consult with an appropriate health care professional. Any expert whose advice was obtained in connection with the adverse benefit determination will be

identified to the claimant.

In addition to the notification requirements set forth in paragraph (E) above, the written notification will also include the following:

- if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the contents of the determination will either: (i) include the specific rule, guideline, protocol or other similar criterion; or (ii) include a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant on request; and

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the contents of the determination will include either: (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; or (ii) a statement that such an explanation will be provided free of charge upon request.

XI. **General Information.** This Section contains certain general information, which you may need to know about the Plan.

A. **Employer Information.** The Employer's name, address, and identification number are:

Le Moyne College
1419 Salt Springs Road
Syracuse, NY 13214-1301
EIN: 15-0545841

B. **Plan Administrator Information.** The name, address, and business telephone number of the Plan Administrator are:

Le Moyne College
1419 Salt Springs Road
Syracuse, NY 13214-1301

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan. The Employer is the "named fiduciary" for the Plan within the meaning of Section 402(a) of ERISA.

The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Employer and any references to the Employer shall instead apply to the delegate. However,

if the Employer assigns any of the Employer's responsibility to an employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

C. **Service of Legal Process.** The Plan Administrator is the Plan's agent for service of legal process. Process can be served at the address specified in Section X (B) above.

D. **Type of Administration.** The Plan is administered by the Claims Administrator. The Claims Administrator for the HRA is:

EBS – RMSCO
P.O. Box 22 999
Rochester, NY 22999
(800) 327-7130 phone
(877) 256-7228 fax

E. **Funding and Type of Administration.** The health insurance benefits under the Plan are provided and administered pursuant to contracts the Employer has with insurance providers. The HRA benefit is self-insured by the Employer and administered by a third-party administrator. Participants are required to contribute towards the cost of health insurance benefits, other than the HRA.

F. **Discretion of Plan Administrator.** Notwithstanding any other provision in the Plan and SPD, and to the full extent permitted by ERISA and the Code, the Plan Administrator (and its designees and representatives) has the discretionary authority to construe any uncertain or disputed term or provision in the Plan and this SPD. The Plan Administrator's exercise of this discretionary authority shall be binding and shall be given deference on any judicial (or other) review, to the fullest extent permitted by law. Notwithstanding the foregoing, to the extent an insurer exercises sole discretionary authority or discretionary responsibility over the benefit claims procedure, it shall be the only fiduciary for purposes of the Plan with authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets and certificates.

G. **Right to Amend and Terminate Plan.** The Employer expressly reserves the unqualified right to amend or terminate the Plan at any time and for any reason, including, but not limited to the right to change any benefit provisions and required premium contributions, deductibles and co-payments. Notwithstanding any other provision in the Plan or this SPD to the contrary, no participant, spouse, dependent or other beneficiary shall have any right to benefits under the Plan or SPD which in any way interferes with the Employer's right to terminate the Plan or amend the Plan. There are no contractual rights to benefits under the Plan. THE EMPLOYER MAKES NO PROMISE TO CONTINUE PLAN BENEFITS IN THE FUTURE AND RIGHTS TO FUTURE BENEFITS DO NOT VEST. In particular, termination of employment or retirement does not in any manner confer upon any participant or other beneficiary any irrevocable right to continued benefits under the Plan.

H. **Information To Be Furnished**. You are required to provide the Plan Administrator and its designee(s) with such information and evidence, and to sign such documents, as may reasonably be requested from time to time for the purpose of Plan administration. If not so provided or signed, the Plan Administrator or its designee(s) may deny benefits until the requested information, evidence, and/or a document is/are furnished. If any false or misleading information concerning the Plan or any Plan benefit is provided to the Plan Administrator or its designee(s) by the Participant or a Qualifying Dependent (collectively, "Covered Person") or any person or entity acting on behalf of a Covered Person, the Plan Administrator (or, if applicable, a designee of the Plan Administrator) will have the discretionary authority, to the full extent permitted by law, to terminate the coverage of the Covered Person prospectively and to recoup, offset or otherwise recover any overpayment or other benefit that the Covered Person received as a result of such false or misleading information. In the case of fraud or an intentional misrepresentation of material fact made by a Covered Person, the Plan Administrator or its designee reserves the right to terminate a Covered Person's coverage retroactively, to the extent permitted by law, and to recoup, offset or otherwise recover any overpayment or other benefit that the Covered Person received as a result of such fraudulent act or intentional misrepresentation.

I. **Newborns' and Mothers' Health Protection Act.** Under this federal law, sometimes referred to as the "NMHPA," certain requirements are imposed on group health plans that provide maternity or newborn infant coverage. This includes the fact that the group health plans and health insurance issuers (such as insurance companies and HMOs) may not restrict benefits for any Employer stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, the NMHPA does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

J. **ERISA Rights.** As a Participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits - This includes the ability to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series if required to be filed) filed by the Plan with the U.S. Department

of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series if required to be filed) and updated SPD. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report (if such report is required to be filed by the Plan). If applicable, the Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage - You may have a right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of group health benefit coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on 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 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 the 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 a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits 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 medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court

may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions - If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington , D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A

PLAN MATERIALS

The following Plan Materials (and any subsequent Employer-approved modification(s) and/or restatements of these documents) are incorporated by reference and made a part of the Le Moyne College Health and Welfare Retirement Benefit Plan:

Health Insurance Plan Materials

- A booklet entitled "Excellus BluePPO" issued by Excellus.
- A booklet entitled "HealthyBlue – Plan Type: Copay and Deductible Option" issued by Excellus.
- Any group contract or other written contract or certificate between Excellus and the Employer, regarding health benefits under the Plan, exclusions, eligibility, effective dates, and/or related Plan provisions concerning health insurance benefits.
- A booklet entitled " Le Moyne College Aetna Medicare Plan – Medicare 15 PPO Plan" issued by Aetna.
- Any group contract or other written contract or certificate between Aetna and the Employer, regarding health benefits under the Plan, exclusions, eligibility, effective dates, and/or related Plan provisions concerning health insurance benefits.
- Any other document(s) or web site pages specified by the Office of Human Resources.

Dental Insurance Plan Materials

- A booklet entitled "Description of Benefits Group Dental Program For Employees of Le Moyne College" issued by Delta Dental.
- Any group contract or other written contract or certificate between Delta Dental and the Employer, regarding health benefits under the Plan, exclusions, eligibility, effective dates, and/or related Plan provisions concerning dental benefits.
- Any other document(s) or web site pages specified by the Office of Human Resources.