

ROCHESTER INSTITUTE OF TECHNOLOGY

Retiree-Only Health Reimbursement Arrangement

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RIT reserves the right to modify or terminate all or any portion of the benefits package at any time with or without notice. Such changes automatically will apply to you and your relationship with RIT.

Introduction

Effective January 1, 2019, Rochester Institute of Technology (RIT) established the Retiree-Only Health Reimbursement Arrangement Plan (the “Plan”) in order to provide financial support to Medicare-eligible retirees, LTD recipients, and their eligible family members who participate in the Via Benefits Medicare Exchange for their medical coverage.

Important Note About Passwords

Password security is critical due to the confidential, private, and financial data that is available online. The employee/participant/covered family member is responsible for maintaining security of their passwords and adhering to RIT information security policies and standards.

Eligibility to Participate in the Plan

You are eligible to participate in the Plan if you are covered by Medicare and meet the requirements for one of the categories described in this section: retiree, LTD recipient, or dependent, and you obtain your medical insurance coverage supplementing Medicare through RIT’s arrangement with the Via Benefits Medicare Exchange.

Eligibility for Retirement

Age, years of service, and date of hire (or adjusted date of hire, if applicable) determines an employee’s eligibility for retirement from RIT. The eligibility rules have changed over time and are currently as follows:

Employees Hired Before January 1, 2019, who

- Were age 45 or older on January 1, 2019 **OR**
- Under age 45 with 10 years of regular full-time service or 15 years of qualifying regular part-time service on January 1, 2019

If adjusted date of hire is prior to July 1, 1990:

- ◆ **Age:** At least 50
- ◆ **Service:** At least 5 years of regular full-time or 10 years of qualifying regular part-time service
- ◆ **Age plus Service:** At least 70 points

If adjusted date of hire is on or after July 1, 1990 but before January 1, 1995:

- ◆ **Age:** At least 50
- ◆ **Service:** At least 10 years of regular full-time or 15 years of qualifying regular part-time service
- ◆ **Age plus Service:** At least 70 points

If adjusted date of hire is on or after January 1, 1995:

- ◆ **Age:** At least 55
- ◆ **Service:** At least 10 years of regular full-time or 15 years of qualifying regular part-time service
- ◆ **Age plus Service:** At least 70 points

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A year of qualifying regular part-time service is a year in which the employee is scheduled to work at least 750 hours. All years of extended part-time service (an employee work classification that existed prior to July 1, 2017) counts as an eligible year of service.

For those who have both regular full-time and qualifying regular part-time service, the following rules apply for counting the Service component:

- ◆ *If the employee meets the Age and Age+Service components and if the employee has at least 5 years of regular full-time service and the regular full-time years of service plus one-half of qualifying regular part-time years of service is at least 10 years, the employee would be eligible to retire with full-time cost sharing.*
- ◆ *If the employee meets the Age and Age+Service components and if the employee has less than 5 years of regular full-time service and the regular full-time years of service plus the qualifying regular part-time years of service is at least 15 years, the employee would be eligible to retire with part-time cost sharing.*

Service must be regular full-time and/or qualifying regular part-time service.

Employees Hired Before January 1, 2019, who

- **Were under age 45 on January 1, 2019 AND**
- **Had less than 10 years of regular full-time service or less than 15 years of qualifying regular part-time service on January 1, 2019**

Employees Hired On and After January 1, 2019

- ◆ **Age:** At least 62
- ◆ **Service:** At least 15 years of regular full-time or 20 years of qualifying regular part-time service
- ◆ **Age plus Service:** Not applicable

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A year of qualifying regular part-time service is a year in which the employee is scheduled to work at least 750 hours. All years of extended part-time service (an employee work classification that existed prior to July 1, 2017) counts as an eligible year of service.

For those who have both regular full-time and qualifying regular part-time service, the following rules apply for counting the Service component:

- ◆ *If the employee meets the eligibility age and if the employee has at least 10 years of regular full-time service and the regular full-time years of service plus one-half of qualifying regular part-time years of service is at least 15 years, the employee would be eligible to retire with full-time cost sharing.*
- ◆ *If the employee meets the eligibility age and if the employee has less than 10 years of regular full-time service and the regular full-time years of service plus the qualifying regular part-time years of service is at least 20 years, the employee would be eligible to retire with part-time cost sharing.*

Service must be regular full-time and/or qualifying regular part-time service.

The following exception applies to all categories of employees listed in the two sections above:

If, however, the following occurs, eligibility for retiree benefits is modified as described below:

- an individual is an employee (faculty or staff) of RIT; and
- the individual is retirement-eligible; and
- the individual is terminated for cause; and
- the reason for the termination is determined to be the willful misconduct of the employee and excludes actions which are beyond the reasonable control of the individual,

Then:

If the Assistant Vice President-Human Resources (AVP-HR) determines that the person is not a retiree for benefits purposes, then the individual will not be eligible to receive retiree benefits and privileges, effective as soon as administratively practicable on or after the date the determination has been made and communicated to the affected individual.

This is the case whether the willful misconduct occurs before or after the date that the individual retires from RIT – an employee may not elect to retire in advance of the conclusion of an audit or investigation’s final report, with findings submitted to management, in order to avoid discharge and to preserve retiree benefits eligibility.

A committee appointed by the AVP-HR will review the circumstances of the case and provide counsel to the AVP-HR. The AVP-HR will be solely responsible for determining whether the person will be considered a retiree for benefits purposes.

The individual’s eligibility to receive retirement income from the RIT Retirement Savings Plan is not impacted by this determination.

Eligibility as an RIT Long-Term Disability Recipient

Regular full-time employees who are approved for long-term disability by RIT's insurance company are eligible to participate under this plan if Medicare-eligible and enroll in Medicare and medical coverage through Via Benefits as outlined below.

If your LTD effective date is prior to January 1, 2019, participation will continue while approved for LTD. When RIT's LTD insurance company determines that you are no longer eligible for LTD, participation under this plan will end if you were not eligible for retirement from RIT on your LTD effective date.

When your LTD ends and you were eligible for RIT retirement on your LTD effective date, you would be eligible to continue participation under this plan as a retiree.

If your LTD effective date is in 2019 or after, participation will continue for up to two years from the LTD effective date. Participation under this plan will end before two years has elapsed when RIT's LTD insurance company determines that you are no longer eligible for LTD and you were not eligible for retirement from RIT on your LTD effective date.

When you reach the two year benefits continuation maximum and you were eligible for RIT retirement on your LTD effective date, you would be eligible to continue participation as a retiree.

If your LTD ends before the two year benefit continuation maximum and you were eligible for RIT retirement on your LTD effective date, you would be eligible to continue participation as a retiree.

Eligibility as a Dependent

A Medicare-eligible family member of an eligible RIT retiree or LTD recipient who is enrolled in Medicare and medical coverage through Via Benefits is eligible to participate in this plan as outline below. If the RIT retiree or LTD recipient is not yet covered by Medicare, their Medicare-eligible dependent may participate in the Plan, as long as they are enrolled in Medicare and medical coverage through Via Benefits.

- Spouse of an RIT retiree who is married to the retiree on the last day of active employment prior to the retiree's retirement date, or was married after the retirement date if the retirement date was prior to January 1, 2005 and was married before January 1, 2005.
- Spouse of a deceased former employee or LTD recipient who became eligible for coverage with an RIT financial subsidy toward medical coverage prior to January 1, 2019.
- Domestic partner of an RIT retiree for whom an Affidavit of Domestic Partnership is on file with RIT on the day prior to the retiree's retirement from RIT or was the domestic partner after the retirement date if the retirement date was prior to January 1, 2005 and was the domestic partner before January 1, 2005.
- Domestic partner of a deceased former employee or LTD recipient who became eligible for coverage with an RIT financial subsidy toward medical coverage.
- Retiree's unmarried tax-dependent child who is physically or mentally disabled and is under the age of 26.
- Retiree's unmarried tax-dependent child who is physically or mentally disabled, was covered by RIT's employee medical plan, and was determined to be eligible for continued coverage by the administrator of the RIT employee medical plan upon the child's reaching the maximum age for coverage under that plan, prior to January 1, 2019.
- Spouse of an LTD recipient who is married to the LTD recipient on the day prior to the date the former employee became an LTD recipient.
- Domestic partner of an LTD recipient for whom an Affidavit of Domestic Partnership is on file with RIT on the day prior to the date the former employee became an LTD recipient.
- LTD Recipient's unmarried tax-dependent child who is physically or mentally disabled and is under the age of 26.

- LTD recipient's unmarried tax-dependent child who is physically or mentally disabled, was covered by RIT's employee medical plan, and was determined to be eligible for continued coverage by the administrator of the RIT employee medical plan upon the child's reaching the maximum age for coverage under that plan, prior to January 1, 2019.

For simplicity, references to retiree in this document shall also include an LTD recipient, and references to dependents, spouse or domestic partner, shall include those eligible family members of retirees and LTD recipients, including a surviving spouse/partner.

Adding a New Dependent After Retirement

RIT believes it is important to provide access to health care coverage. Therefore, any Medicare-eligible dependent who becomes an eligible dependent of a retiree after retirement (except as noted above) will be eligible for coverage through the Medicare Exchange, Via Benefits, but there will be no HRA contribution from RIT. In addition, the new family member will not have access to the retiree's HRA.

How the Plan Works

A Health Reimbursement Arrangement (HRA) is an account, provided by RIT if you enroll in medical coverage through Via Benefits, which you can use to be reimbursed for eligible healthcare expenses. Reimbursements are not taxable to the retiree for expenses for the retiree and spouse, and disabled children, but are taxable for expenses for a domestic partner. The HRA is administered by Via Benefits on RIT's behalf. Here is how it works:

- When you enroll for supplemental Medicare medical coverage through Via Benefits, RIT will establish a joint HRA for you and your eligible spouse/partner, if applicable. At the beginning of each calendar year, RIT will credit your account with the applicable HRA amount(s). HRA amounts will be announced in advance annually by RIT. For the current year HRA amounts, see the General Plan Information section of this document.
 - If you are retired and become Medicare-eligible during the year or if you retire during the year and you are Medicare-eligible, the HRA amount will be prorated based on when you enroll in medical coverage through Via Benefits.
- The HRA for an eligible disabled child will be a separate account.
- You can use the funds to be reimbursed for eligible premiums and/or your share of qualifying out-of-pocket healthcare expenses during the year. After you enroll in medical coverage through Via Benefits, they will send you a *Funding Guide to Reimbursement* that explains the reimbursement process.
- The HRA can be used for eligible expenses for those enrolled in medical coverage through Via Benefits who are also eligible for an HRA credit.
- Any dollars remaining in your HRA at the end of the calendar year will roll over automatically for you and/or your eligible spouse/partner to use in future years, as long as you both continue medical coverage through Via Benefits.
- The current year's HRA cannot be used for a prior year's expense.
- Claims for reimbursement must be submitted by June 30 for claims incurred during the prior calendar year in order to be reimbursed.

HRA Eligible and Ineligible Expenses

HRA expenses that are *eligible* for reimbursement are as follows:

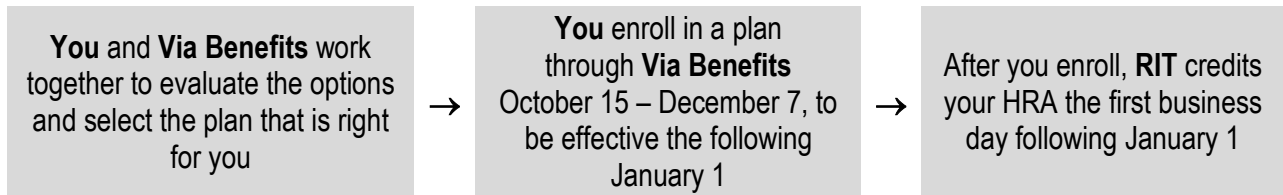
- Medical, prescription drug, dental, and vision premiums (*pre-tax deductions from a paycheck are **not** eligible for reimbursement*)
- Medicare Part B premiums

- Higher premiums you may pay above the standard premiums for Medicare Part B or Medicare Part D due to your higher income; this is called an Income-Related Monthly Adjustment Amount (IRMAA) by Medicare
- Qualifying out-of-pocket medical, dental, and vision expenses such as deductibles, copays and your share of coinsurance, excluding prescription drugs.

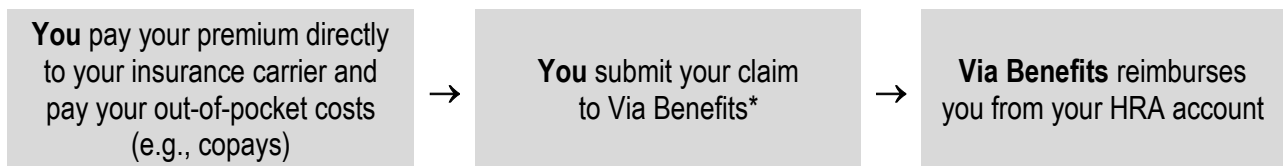
Health care expenses that are **not eligible** for reimbursement are as follows:

- Prescription drug out of pocket costs (e.g., deductible, copays)
- Long-term care premiums and out-of-pocket expenses.

The HRA Set Up Process



Getting Reimbursed from your HRA



** Some insurance companies send proof of your premium payment to Via Benefits so you can be automatically reimbursed for your premium without submitting a manual claim to Via Benefits for reimbursement. Ask your Benefit Advisor about Via Benefits’ “Automatic Reimbursement.” If automatic reimbursement is not available with your insurance company, ask the Benefit Advisor about the Recurring Premium Reimbursement process, which only requires you to complete one form at the beginning of each year.*

Claims are required to be filed no later than June 30 of the year following the year the expense was incurred. Claims received after this deadline will not be reimbursed.

How do I receive reimbursement under the Plan?

If you did not elect automatic or recurring reimbursement for your premium payments, you must complete a reimbursement form and submit online, mail or fax it to Via Benefits along with a copy of your insurance premium bill. To be reimbursed for qualifying out-of-pocket expenses, you need to submit an “explanation of benefits” or “EOB,” or, if no EOB is provided, a written statement from the service provider. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment, (d) the amount incurred and (e) name of provider. You can obtain a reimbursement form from Via Benefits. Your claim is deemed filed when it is received by Via Benefits.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by Via Benefits.

Via Benefits shall determine the method or mode of reimbursement payments, including whether by direct deposit, written check or otherwise.

Any HRA payments that are unclaimed (e.g., uncashed benefit checks or unclaimed electronic transfers) shall automatically forfeit twelve months after the check was mailed or the payment was otherwise attempted.

Claim Denials and Appeals

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after Via Benefits receives your claim. If Via Benefits determines that an extension of this time period is necessary due to matters beyond the control of the Plan, Via Benefits will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of Via Benefits, you may file a written appeal. You should file your appeal with the Plan Administrator at the address provided in the General Plan Information section no later than 180 days after receipt of the denial notice. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim.

You will be notified in writing of the decision on appeal no later than 60 days after the Plan Administrator receives your request for appeal. The notice will contain the same type of information provided in the first notice of denial provided by Via Benefits.

Note that you cannot file suit in federal court until you have exhausted these appeals procedures. Any claim or action that is filed in a court or other tribunal against or with respect to the Plan and/or the Plan Administrator must be brought within the following timeframes:

- For any claim or action relating to HRA benefits, the claim or action must be brought within 18 months of the date of the denied appeal.
- For all other claims (including eligibility claims), the claim or action must be brought within two years of the date when you know or should know of the actions or events that gave rise to your claim.

Upon Your Death if You are Retired or a LTD Recipient Who is Eligible to Retire

If the retiree or retirement-eligible LTD recipient dies with no surviving spouse/partner/child, the deceased retiree's estate or representatives may submit claims for eligible medical expenses incurred by the retiree before his or her death. Claims must be submitted within one year following his or her death. After one year, any remaining account balance would be forfeited.

If the retiree or retirement-eligible LTD recipient dies and is survived by an eligible spouse or partner who is a Participant, the joint HRA Account shall continue and the surviving Participant can continue to submit eligible medical expenses for reimbursement. If there is an eligible surviving child, the child can continue to submit eligible medical expenses for reimbursement. The surviving spouse or partner will continue to receive his or her own annual HRA credits, unless he or she subsequently remarries/re-partners. The surviving child will continue to receive his or her own HRA credits, unless he or she reaches the age limit of the plan or is deemed no longer disabled. The deceased retiree's estate or representatives may submit claims for eligible medical expenses incurred by the retiree before his or her death. Claims must be submitted within one year following his or her death. If the surviving spouse elects and pays for COBRA continuation coverage, as described in the COBRA

section of this summary, then both the retiree's and spouse's annual HRA credits would continue to be provided during the COBRA continuation period.

If the retiree or retirement-eligible LTD recipient dies and is survived by an eligible pre-Medicare spouse/partner/child, the survivor would be able to participate in this plan when Medicare-eligible, provided they are considered an eligible dependent as outlined above. The deceased retiree's or retirement-eligible LTD recipient's remaining HRA balance would be available to the spouse/partner when the spouse/partner becomes eligible for this plan; the balance would not be available for an eligible child.

Upon Your Death if You are an Employee Who is Eligible to Retire

If an employee who is retirement-eligible dies, the surviving spouse/partner/child would be eligible to participate in this plan when Medicare-eligible, provided they are considered an eligible dependent as outlined earlier in this summary. If the spouse/partner/child is Medicare-eligible when the employee dies, the survivor would be eligible to participate in this plan provided the survivor enrolls in Medicare and medical coverage through Via Benefits. Your survivor would receive a prorated HRA contribution in the year you die, based on when they enroll in coverage through Via Benefits.

Upon Your Spouse or Partner's Death

If the spouse or partner dies before the retiree, the joint HRA Account shall continue and the retiree can continue to submit eligible medical expenses for reimbursement. The retiree will continue to receive his or her own annual HRA credits. The deceased spouse/partner's estate or representatives may submit claims for eligible medical expenses incurred by the spouse/partner before his or her death. Claims must be submitted within one year following his or her death.

If the spouse or partner dies after the retiree, the deceased spouse/partner's estate or representatives may submit claims for eligible medical expenses incurred by the spouse/partner before his or her death. Claims must be submitted within one year following his or her death. After one year, any remaining account balance would be forfeited.

When Participation Ends

If you are a retiree, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be a retiree for any reason;
- the date you or your spouse/partner who is covered by this plan are rehired by RIT as an active employee; however, if you or your covered family member is hired by RIT as an employee in an adjunct position or in a regular full-time or part-time employee position that is expected to last less than six months, participation in this plan will be suspended until such time as the individual is no longer an employee of RIT. Suspension of participation means that you and your eligible family members will not have access to reimbursements from the plan for claims incurred during the period of employment at RIT, but any remaining account balance will remain available for claims once employment has ended (subject to the terms of the Plan); no additional benefit credits will be added to your account while you are an active RIT employee, but will be added to your account when you are no longer an RIT employee; if you were working for RIT as an adjunct or for less than 6 months, this annual amount will not be prorated, but will be prorated in all other cases;
- the date you cease to be eligible for Medicare (unless you remain eligible under another provision of the Plan);
- the date you no longer have medical coverage through Via Benefits;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

If you are an LTD recipient, you will cease being a Participant in the Plan on the earliest of:

- the date you cease to be an LTD recipient for any reason; however, if you had met the eligibility requirements for retirement from RIT prior to the date you became an LTD recipient, then upon the termination of your LTD recipient status, you will become a retiree;
- two years from the LTD effective date if your LTD effective date is January 1, 2019 or after; if were eligible to retire on your LTD effective date, you will become a retiree;
- the date you or your spouse/partner who is covered by this plan are rehired by RIT as an active employee; however, if you or your covered family member is hired by RIT as an employee in an adjunct position or in a regular full-time or part-time position that is expected to last less than six months, participation in this plan will be suspended until such time as the individual is no longer an employee of RIT. Suspension of participation means that you and your eligible family members will not have access to reimbursements from the plan for claims incurred during the period of employment at RIT, but any remaining account balance will remain available for claims once employment has ended (subject to the terms of the Plan); no additional benefit credits will be added to your account while you or your family member are an active RIT employee, but will be added to your account when you are no longer an RIT employee; if you were working for RIT as an adjunct or for less than 6 months, this annual amount will not be prorated, but will be prorated in all other cases;
- the date you cease to be eligible for Medicare (unless you remain eligible under another provision of the Plan);
- the date you no longer have medical coverage through Via Benefits;
- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

If you are an eligible dependent, you will cease being a participant in the Plan on the earliest of:

- the date you cease to be an eligible dependent for any reason;
- the date you cease to be eligible for Medicare (unless you remain eligible under another provisions of the Plan);
- the date you become divorced from the retiree, if you are the spouse;
- the date the retiree completes and files with RIT Human Resources a Statement of Termination of Domestic Partnership, if you are the domestic partner;
- the date you reach the age limit of the plan, if you are a child;
- the date you, if you are the spouse or partner, or the retiree are hired by RIT as an active employee; however, if you or your covered family member is hired by RIT as an employee in an adjunct position or in a regular full-time or part-time position that is expected to last less than six months, participation in this plan will be suspended until such time as the individual is no longer an employee of RIT. Suspension of participation means that you and your eligible family members will not have access to reimbursements from the plan for claims incurred during the period of employment at RIT, but any remaining account balance will remain available for claims once employment has ended (subject to the terms of the Plan); no additional benefit credits will be added to your account while you or your family member are an active RIT employee, but will be added to your account when you are no longer an RIT employee; if you were working for RIT as an adjunct or for less than 6 months, this annual amount will not be prorated, but will be prorated in all other cases;
- the date the LTD recipient is no longer an LTD recipient, unless he or she then becomes a retiree under this Plan;
- the date the LTD recipient loses eligibility, unless he or she then becomes a retiree under this Plan;
- the date you no longer have medical coverage through Via Benefits;

- your date of death;
- the effective date of any amendment terminating your eligibility under the Plan; or
- the date the Plan is terminated.

Your eligible dependents may be able to continue coverage under the Plan beyond the date that their coverage would otherwise end if coverage is lost or reduced for certain reasons. Their continuation of coverage rights and responsibilities are described in the following section, “COBRA Continuation of Coverage.”

COBRA Continuation of Coverage

Under a federal law called “COBRA,” eligible dependents under the Plan who are the spouse, former spouse or dependent child of a Participant may elect to continue coverage under the Plan for a limited time after the date they would otherwise lose coverage because of a divorce or legal separation from the Participant, the Participant’s death or a dependent child ceasing to be an eligible dependent. These are called “qualifying events.”

Note that the eligible dependents are required to notify the Plan Administrator in writing of a divorce or legal separation or a dependent child losing dependent status within 60 days of the event or they will lose the right to continue coverage under the Plan.

If an eligible dependent elects to continue coverage, he or she is entitled to the level of coverage under the Plan in effect immediately preceding the qualifying event. At the time the eligible dependent elects COBRA continuation coverage, a separate account will be established for the COBRA continuee. He or she may be entitled to an amount in his or her HRA Account equal to the amounts credited to the previously joint HRA Account prior to the qualifying event, and continuation of annual benefit credits, so long as he or she continues to pay the applicable premium.

In order to continue coverage, the qualified beneficiary must pay a monthly premium equal to 102% of the cost of the coverage, as determined by the Plan Administrator. The Plan Administrator will notify qualified beneficiaries of the applicable premium at the time of a qualifying event.

Coverage may continue for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events

- The date the Qualified Beneficiary’s HRA Account is exhausted;
- The date the Qualified Beneficiary notifies the Plan Administrator that he or she wishes to discontinue coverage;
- Any required monthly COBRA premium is not paid when due or during the applicable grace period;
- The date, after the date of the Qualified Beneficiary’s COBRA election, that he or she becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of the Qualified Beneficiary;
- The date the Qualified Beneficiary dies; or
- RIT ceases to provide any group health plan to any employee.

Duration of the Plan

Although RIT expects to maintain the Plan indefinitely, it has the right to modify or terminate it at any time for any reason, including the right to change the classes of persons eligible for participation, and to reduce or eliminate the amounts credited to HRA accounts in the future.

Interaction with Other Medical Plans

Only medical, dental and vision care expenses that have not been or will not be fully reimbursed by any other source may be eligible medical expenses (to the extent all other conditions for eligible medical expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the remaining expenses to this Plan for reimbursement.

If you are also a participant in a health flexible spending account sponsored by an employer, the expenses covered both by this Plan and the health flexible spending account must be submitted first to the health flexible spending account.

Tax Status

Benefit credits allocated to a Participant's HRA Account are not taxable. Reimbursements of eligible Expenses from an HRA Account are not taxable unless the claim was on behalf of an eligible domestic partner of a retiree. In such cases, RIT will provide Form 1099 to the retiree reflecting the domestic partner's benefit as taxable income for tax reporting purposes.

Overpayments

From time to time, overpayments may occur in the administration of the Plan. This includes any payment of Plan benefits to which the Participant was not entitled under the terms of the Plan. In the event of an overpayment, immediate repayment shall be required. Current or future Plan benefits may be reduced, in whole or in part, at any time to recover an overpayment. If deemed necessary, the Plan may pursue legal action to recover an overpayment.

Statement of ERISA Rights

This Plan is an employee welfare benefit plan as defined in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that you, as a Plan Participant, will be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.

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

Continue Plan Coverage

Continue Plan coverage for your eligible spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, your spouse or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing 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 the Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the 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 (e.g., if it finds your claim is frivolous).

Assistance with Your Questions

If you have any questions about the 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 obtaining documents from the

Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Section 1. Introduction

The Plan is dedicated to maintaining the privacy of your health information. The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information or “Protected Health Information” (“PHI”) and to inform you about:

- the Plan’s uses and disclosures of PHI;
- your privacy rights with respect to your PHI;
- the Plan’s duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan’s privacy practices.

The term “Protected Health Information” or “PHI” includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic). The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices.

The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all PHI received or maintained by the Plan, including PHI received or maintained prior to the change. If a privacy practice described in this Notice is materially changed, a revised version of this notice will be provided to all individuals then covered under the Plan for whom the Plan still maintains PHI. The revised notice will be provided by mail or by another method permitted by law.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual’s rights, the duties of the Plan or other privacy practices stated in this notice.

Please note that the Plan Sponsor obtains summary PHI, enrollment and disenrollment, termination of coverage and specific appeals information from the Plan. Most records containing your PHI are created and retained by the Third Party Administrator for the Plan. In the event that the Plan Sponsor receives PHI, the Plan has been amended to require that the Plan Sponsor only use and disclose PHI received from the Plan for plan administrative purposes or as otherwise permitted by federal law. This notice only applies to Protected Health Information or PHI as defined in the applicable HIPAA privacy rules.

Section 2. Notice of PHI Uses and Disclosures

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

A. Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

The Plan also will disclose PHI to the Plan Sponsor for plan administrative purposes or as otherwise permitted by law. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

The Plan contracts with business associates for certain services related to the Plan. PHI about you may be disclosed to the business associates so that they can perform contracted services. To protect your PHI, the business associate is required to appropriately safeguard the protected health information. The following categories describe the different ways in which the Plan and its business associates may use and disclose your PHI.

B. Uses and disclosures to carry out treatment, payment and health care operations

The Plan and its business associates will use PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating cardiologist the name of your treating physician so that the cardiologist may ask for your lab results from the treating physician.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

C. Authorized uses and disclosures

You must provide the Plan with your written authorization for the types of uses and disclosures that are not identified by this notice or permitted or required by applicable law.

Any authorization you provide to the Plan regarding the use and disclosure of your health information may be revoked at any time **in writing**. After you revoke your authorization, the Plan will no longer use or disclose your health information for the reasons described in the authorization, except for the two situations noted below:

- The Plan has taken action in reliance on your authorization before it received your written revocation; or

- You were required to give the Plan your authorization as a condition of obtaining coverage.

D. Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. The Plan may also disclose PHI when disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- For research, subject to conditions.

- When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Notwithstanding the above, and to the extent provided in applicable law, the Plan shall not use or disclose your PHI that is classified as genetic information for purposes of any underwriting activity.

Section 3. Rights of Individuals

A. Right to Request Restrictions on PHI Uses and Disclosures

You may request that the Plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

With respect to a health care provider, you have a right to request that a health care provider restrict disclosure of your PHI and not disclose such PHI and related claim information to the Plan, if the PHI pertains solely to a health care item or service for which you or another person on your behalf has paid the health care provider and you have not requested reimbursement from the Plan.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations as required by law. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Plan at the address provided at the end of this Notice specifying the requested method of contact or the location where you wish to be contacted.

B. Right to Inspect and Copy PHI

With certain exceptions described below, you have the right to inspect and copy your PHI if it is part of a "Designated Record Set" or "DRS." The DRS is the group of records maintained by or on behalf of the Plan contained in the enrollment, payment, claims adjudication, and case or medical management record systems of the Plan, and any other records which are used by the Plan to make decisions about individuals. This right does not extend to psychotherapy notes, information gathered for certain civil, criminal or administrative proceedings, and information maintained by the Sponsor that duplicates information maintained by a Plan business associate in its DRS.

The Plan must provide you with access to the PHI contained in a DRS in the form and format requested by you. However, if the PHI is not readily producible in such form or format, it must be produced in a readable hard copy form or such other form as agreed to by the Plan and you. Further, if the PHI is maintained in an electronic DRS, you may request an electronic copy of the PHI in an electronic form or format. However, if the PHI is not readily producible in a specific electronic form and format requested by you, the Plan and you must agree on the electronic form or format in which it will be produced.

If you request a copy of your PHI contained in a DRS, the Plan may charge you a reasonable, cost-based fee for the expense of copying, mailing and/or other supplies associated with your request. To inspect and obtain a copy of your PHI that is part of a DRS, you must submit your request in writing.

If you exercise your right to access your PHI, the Plan will respond to your request within 30 days, subject to a one-time extension of an additional 30 days. In the case of an extension, the Plan must provide you with a written explanation for the delay and the date by which it will respond to your request.

The Plan may deny your request to inspect and copy your PHI in certain limited situations. If you are denied access to your PHI, you will be notified in writing. The notice of denial will include the basis for the denial, and a description of any appeal rights you may have and the right to file a complaint with the Plan or with the Department of Health and Human Services. If the Plan does not maintain the PHI that you are seeking but knows where it is maintained, the Plan will notify you of where to direct your request.

C. Right to Amend PHI

If you believe that your PHI in a DRS is incorrect or incomplete, you may request that the Plan amend the PHI. Any such request must be made in writing and must include a reason that supports your requested amendment. The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

In limited situations, the Plan may deny your request to amend your PHI. For example, the Plan may deny your request if (1) the PHI was not created by the Plan (except where you are unable to request an amendment from the person or entity that created the PHI because the person or entity is no longer available); (2) the Plan determines the information to be accurate or complete; (3) the information is not part of the DRS; or (4) the information is not part of the information which you would be permitted to inspect and copy, such as psychotherapy notes. If your request is denied, you will be notified in writing. The notice of denial will include the basis for the denial, a description of your right to submit a statement of disagreement and a description of your right to file a complaint with the Plan or with the Department of Health and Human Services.

D. Right to Receive an Accounting of PHI Disclosures

You have the right to request an accounting of certain types of disclosures of your PHI made by the Plan during a specified period of time. You do not have the right to request an accounting of all disclosures of your PHI. For example, you do not have the right to receive an accounting of (1) disclosures for purposes of Treatment, Payment or Health Care Operations; (2) disclosures to you or your personal representative regarding your own PHI; (3) disclosures pursuant to an authorization; or (4) disclosures prior to April 14, 2003 (or the inception of the Plan, whichever is later).

Your request must indicate the time period for which you are seeking the accounting, such as a single month, six months or two calendar years. This time period may not be longer than six [6] years and may not include any disclosures of PHI made before April 14, 2003 (or the inception of the Plan, whichever is later). The Plan must respond to your request within 60 days. If the Plan is not able to respond within this 60-day period, it may have a one-time 30-day extension by providing you with a written explanation for the delay and the date by which it will respond to your request.

The Plan will provide the first accounting you request in any 12-month period free of charge. The Plan may impose a reasonable, cost-based fee for each subsequent accounting request within the 12-month period. The Plan will notify you in advance of the fee and provide you with an opportunity to withdraw or modify your request.

E. The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice at any time contact the Plan Administrator. The Notice is also posted on the Plan Sponsor's intranet site. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

F. A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: Notice of Breaches of Unsecured PHI

Under HIPAA, the Plan and its business associates, are required to maintain the privacy and security of your PHI. The goal of the Plan and its business associates is to not allow any unauthorized uses or disclosures of your PHI. However, regrettably, sometimes an unauthorized use or disclosure of your PHI occurs. These incidents are referred to as “breaches.” If a breach affects you and is related to unencrypted PHI, the Plan or its applicable business associate will notify you of the breach and the actions taken by the Plan or the business associate to mitigate or eliminate the exposure to you.

Section 5. Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Plan Administrator. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 6. Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan Administrator.

Section 7. Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

If you wish to exercise one or more of the rights listed in this Notice, contact the Plan Administrator.

Group Definitions

The different groups are described below.

Group 1:

- Employees who retired before December, 2004, AND who were Medicare-eligible on or before December 31, 2004, and
- Eligible spouses/partners/children of retirees described above who themselves were Medicare-eligible on or before December 31, 2004, and
- Employees who reached age 65 by June 30, 2005, provided written notice by December 31, 2004 of their intent to retire by June 30, 2005, and did retire by that date.

Note that Group 1 does not include the following: Employees who retired at age 50-59 between April 15, 1986 and June 30, 1996. Note that Group 1a is a subset of Group 1 who were participating in the BlueCross BlueShield Comprehensive Plan as of December 31, 2018.

Group 2:

- Employees who were hired before January 1, 2004 who were age 35 or older on January 1, 2008 who retired after December 31, 2004,
- Employees who retired before December 31, 2004 but were not Medicare-eligible as of December 31, 2004, and
- Eligible spouses/partners/children of retirees in either Group 1 or Group 2 who themselves were not Medicare-eligible as of December 31, 2004.

Group 3:

- Employees who were hired on or after January 1, 2004, and
- Employees hired before January 1, 2004 who were under age 35 on January 1, 2008.

Annual HRA Amounts-2024

<u>Group</u>	<u>Employee Type</u>	<u>Retiree</u>	<u>Spouse/Partner</u>
Grandfather	Full-Time	\$2,759.55	\$2,759.55
Grandfather-BCBS Comp	Full-Time	\$3,714.78	\$3,714.78
Group 2	Full-Time	\$2,016.59	\$1,804.31
Group 2	Part-Time	\$1,512.45	\$1,353.24
Group 3	Full-Time	\$1,804.31	\$1,592.05
Group 3	Part-Time	\$1,353.24	\$1,194.05

Note: HRA amounts will be reduced by any outstanding unpaid pre-Medicare medical premiums that a participant owes to RIT.

Full-time and part-time categories are determined at the time of retirement based on the employee's status and duration of full and part-time employment as described at the beginning of this summary.

If two RIT retirees are a married couple or a domestic partner couple, they would each be eligible for the retiree amount and it would be a joint account. If, however, the spouse/partner HRA amount is larger than the applicable retiree HRA amount (e.g., one retiree was part-time so the spouse/partner amount is larger), the retiree would be eligible for the larger spouse/partner amount.

For couples who retired prior to January 1, 2019, the older person is the primary account holder and the younger person is secondary. For those who retire after January 1, 2019, the person who retires first will be the primary and the person who retires second will be the secondary. If both retire on the same day, the older person will be the primary and the younger person will be secondary.

General Plan Information

Name of Plan:	Rochester Institute of Technology Retiree Only Health Reimbursement Arrangement Plan
Effective Date:	January 1, 2019
Name, address, and telephone number of the Plan Sponsor:	Rochester Institute of Technology 8 Lomb Memorial Drive Rochester, NY 14623 585-475-2424
Name, address, and telephone number of participating Employers (other than Sponsor):	n/a
Name, address, and telephone number of the Plan Administrator:	Director of Benefits and Wellness 8 Lomb Memorial Drive Rochester, NY 14623-5604 585-475-2424
The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	
Agent for Service of Legal Process:	Office of Legal Affairs Rochester Institute of Technology 154 Lomb Memorial Drive Rochester, New York 14623-5608
	Service of legal process may also be made on the Plan Administrator.
Sponsor's federal tax identification number:	16-0743140
Plan Number:	518
Plan Year:	January 1 – December 31
Third Party Administrator:	Willis Towers Watson 10975 South Sterling View Drive South Jordan, UT 84905 1-888-586-0693my.viabenefits.com/RIT