

# ROCHESTER INSTITUTE OF TECHNOLOGY

## Beneflex Plan

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## Key Features of the Beneflex Plan

### Pretax Premium Contributions

- Your contributions to the RIT medical/prescription drug, vision and dental plans are deducted from your pay on a pretax basis. In addition, you can elect to pay your RIT parking fee by a pretax deduction from your paycheck; the fee will be applied in equal increments for the entire academic year.

### Health Care Spending Account

Contribute up to \$2,750 per year, on a pretax basis, to the Health Care Spending Account. Receive tax-free reimbursement of eligible health care expenses such as:

- Medical and dental deductibles
- Medical and dental copays
- Vision and hearing expenses
- Prescription drug copays
- Over the counter medications
- Other covered expenses that are tax-deductible

### Dependent Care Spending Account

Contribute up to \$5,000 per year, on a pretax basis, to the Dependent Care Spending Account. Receive tax-free reimbursement of eligible dependent care expenses that are necessary for both you and your spouse to work or attend school full-time. Expenses include:

- Child care centers
- Family day care providers
- Child care givers
- Nursery schools
- Caregivers for a disabled dependent

Care must be for a dependent child under age 13 or for a dependent who is disabled and incapable of self-support.

*RIT reserves the right to modify or terminate all or any portion of the employee benefits package at any time with or without notice. Such changes automatically will apply to you and your employment relationship with RIT. Participation in these plans is provided to eligible employees and does not constitute a guarantee of employment, and requires continued employment and eligibility.*

## **Introduction**

Under the Rochester Institute of Technology Beneflex Plan, most employees can use tax-free money for eligible expenses as outline below. These tax-free amounts mean you pay less in taxes and your spendable income increases by the amount of your tax savings. If your RIT income is not taxable (e.g., treaty wages, workers' compensation), you will not have any pretax deductions from your pay. In these cases, you will pay with after-tax dollars.

### ***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 polices and standards.

### ***Pretax Contributions for Medical, Vision and Dental Coverage***

If you elect medical, vision, and/or dental coverage, you are required to pay a portion of the cost. Your contributions for medical, vision and dental coverage are automatically deducted from your pay on a pretax basis. Refer to the Medical, Vision, and/or Dental summaries for details about the plans.

### ***Pretax Deduction for RIT Parking Fee***

You can elect to pay your RIT parking fee by a pretax deduction from your paycheck; the fee will be applied in equal increments for the entire academic year. Refer to the RIT Parking and Transportation at [www.rit.edu/Parking](http://www.rit.edu/Parking) for details about parking, fees, and how to sign up or pretax deduction.

### ***Health Care and Dependent Day Care Flexible Spending Accounts (FSAs)***

You may choose to open a *Health Care Spending Account (HCSA)* and/or a *Dependent Day Care Spending Account (DCSA)*. Under the HCSA, you can pay your portion of health care expenses not covered by your medical, vision, and/or dental plan, such as copays. Under the DCSA, you can pay for eligible dependent care expenses, such as day care for your dependent children.

Through these accounts, you select a certain amount of your earnings to be payroll deducted before taxes are calculated on your pay. This tax-free deducted amount is placed in your Health Care Account and/or Dependent Day Care Account and can be used to pay eligible health care and dependent care expenses.

It is important to estimate your health care and dependent care expenses carefully. Under Federal law, if you do not use all the money put into a health care or dependent care account by the end of any year, ***you will lose this money***. But with thoughtful planning, you can minimize this risk.

This summary addresses important topics about the Flexible Spending Accounts, which is referred to as "Beneflex" in this summary.

## **General Information**

### ***Who is Covered and When***

Regular full-time and part-time employees are eligible to participate in the Plan for pretax health care contributions. In addition, adjunct employees are eligible to participate in the Plan for pretax health care contributions in terms in which they work. If the employee's paycheck is not large enough to take the employee contributions, they will be billed by RIT's billing administrator. All regular full-time and part-time employees who are scheduled to work 750 or more hours per year are eligible to participate in the Health Care and/or Dependent Day Care Spending Accounts. Participation can begin on the first day of the month on or after your date of hire.

### ***You Need to Enroll***

If you want to participate in the Health Care or Dependent Care Spending Accounts, you need to complete the enrollment form and return it to the Human Resources Department within 31 days of your date of employment.

It is important for you to return the completed enrollment form within 31 days of your employment. If you wait beyond the 31 days to enroll, you will not have another opportunity to enroll until the next open enrollment, or if you have a qualified change in status event.

### ***Open Enrollment***

If you do not enroll in Beneflex when you are first eligible, you will not have another opportunity to enroll until the next open enrollment period (unless you have a qualified change in status event). Open enrollment will be held once a year.

During open enrollment, all employees wanting to participate in the HCSA and/or DCSA must enroll *each year*, even if you already are a Plan member. The contribution rates you selected for the prior year do *not* automatically stay at the same level for the following year.

When you re-enroll you may select the same contribution rate as for the previous year or you may change the amount you contribute to either or both accounts. Changes will not be allowed at any other time during the year unless you experience a qualified change in status event.

### ***Election Changes During the Plan Year***

In general, once you have enrolled in the Plan, you cannot change your elections or withdraw from the Plan until the beginning of the next plan year. However, pursuant to federal regulations, you may be able to make mid-year election changes if you meet certain criteria, as explained below. Your requested election change must be consistent with the reason for the change, as defined by the Internal Revenue Service. For example, it would be consistent for an employee without a DCSA to enroll in the DCSA after the birth of a child. Changes must be made within 31 days after the event that gives you the right to make a new election, except that in the case of a DCSA mid-year election change, changes must be made within 60 days after the date of the event that gives you the right to make a new election. The Plan Administrator may require you to submit certain documentation related to your reason for making a mid-year election change.

Your Beneflex elections may be changed – consistent with the event - to reflect the following events:

1. Qualified Change in Status

The following events constitute a qualified change in status:

- a change in legal marital status: for example, a marriage or divorce
- a change in the number of dependents: for example, the birth of a child, an adoption, a death, and so on
- you, your spouse or your child become eligible for continued health coverage under federal law (COBRA) or similar state law
- you, your spouse or your child become entitled to or lose Medicare or Medicaid coverage

2. Change in Employment Status

The following events constitute a change in employment status where they affect you or your spouse or child:

- termination of employment
- commencement of employment
- commencement or return from an unpaid leave of absence
- change in employment classification that makes the person either eligible or ineligible to participate in a plan (for example, a change from full-time to part-time status, or the reverse, if such a change affects one's eligibility to participate in a plan).

3. Changes in Dependent Care Flexible Spending Account

You may make a change in your elections under the Dependent Care Spending Account consistent with the following types of coverage changes:

- If you obtain a new child care provider, you may change your election to reflect the cost of the new provider (who is not a family member)
- If the number of hours worked by the child care provider changes, you may change your election to reflect the new number of hours (e.g. if less care is needed because the child starts school mid-year, a new election can be made to reflect the lower number of child care hours required.)
- Any other change allowable under IRS regulations

4. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Losing eligibility for coverage under a non-RIT plan may allow you to exercise special enrollment rights provided by HIPAA and make a mid-year election change.

**NOTE:** You may not reduce your election amount to an amount less than either your then-current account balance or your year-to-date contributions.

With respect to a Health Care Spending Account, a change to your election constitutes the end of your prior election period and the beginning of a new election period. Expenses incurred during the period prior to the election change are subject to the initial Health Care Spending Account election amount; expenses incurred during the period after the election change are subject to the new Health Care Spending Account election amount.

### **When Your Participation Ends**

For medical, vision and dental pretax premiums, your participation ends when your participation in the medical, vision, and/or dental plan ends.

Your Beneflex participation ends

- On your termination date\*;
- On your termination date under the RIT Severance Plan (coverage does not continue during the severance period, unless you elect coverage under COBRA-Health Care Spending Account only);
- On the date you retire;
- On the date you no longer meet the Plan's eligibility requirements; this includes transfer to an employment category that is not eligible for coverage under the Plan, such as part-time employees and adjunct faculty;
- On the date you stop making required contributions;
- On the date you die; or
- On the date RIT discontinues the Plan.

\* *Special Note for 9-month faculty:*

- *Participation will end on June 30 for a faculty member on a 9-month contract, provided that the faculty member works until the end of the contract period, and the contract is not being renewed for the following academic year;*
- *Participation for a faculty member on a 9-month contract will continue during the summer between the two academic years, provided that the contract is being renewed for the following academic year.*

**IMPORTANT NOTE:** If you cancel participation (change your contribution amount to zero) in a flexible spending account during the plan year, you will not be eligible for reimbursement for claims with dates of service after the cancellation date. For example, if you cancel participation (stop contributing to the plan) August 31, you would not be eligible for reimbursement for claims with dates of service between September 1 and December 31.

See the section "Continuation of Participation in the Health Care Spending Account Under COBRA" for details on extending Health Care Spending Account coverage after termination of employment.

### **Other Considerations**

Neither the contributions toward your health care coverage, parking fee, or the dollars you set aside into your FSAs will be taxed for Social Security purposes. If your salary is at or below the Social Security taxable wage base, your Social Security wages for the year will be lower, which could result in slightly lower Social Security benefits in the future. For most people, though, the tax savings will more than outweigh any small reduction in Social Security benefits.

Your other salary-based benefits, such as retirement plan [403(b)] contributions and life insurance, will not be affected by this reduction in your taxable salary.

Pretax contributions toward your medical, vision and dental insurance coverages, parking fee, and reimbursement amounts paid from your FSAs cannot be claimed on your personal income tax return.

The tax-savings features of Beneflex are based on current federal tax laws. The Plan could be modified or terminated as a result of future action by Congress or the Internal Revenue Service.

### **Health Care Spending Account**

Money in your Health Care Spending Account may be used to reimburse you for eligible health care expenses for eligible family members. An eligible family member includes your spouse and your children and step-children up to the age of 26.

You may be reimbursed for health care expenses that are not covered or are not fully reimbursed by RIT's medical, vision, and dental plans, or other coverage you may have. Such expenses can include deductibles, copays and any expenses not covered or not reimbursed by your medical, vision, or dental plan; vision and hearing care expenses including routine exams, prescription glasses and sunglasses, contact lenses, and hearing aids; and any other expenses that would normally qualify as itemized deductions for purposes of federal income tax. By law, premiums you pay for coverage under medical, vision or dental programs are not eligible for reimbursement.

In addition, effective January 1, 2020, many over-the-counter (OTC) drugs can be paid for with pre-tax dollars through RIT's Beneflex Plan. This could be very beneficial to you, as you could save federal, state, and FICA taxes on your OTC expenses. OTC drugs include many drugs that used to be prescription drugs, such as Claritin and Advil, as well as items like cold or cough medicine, pain relievers, allergy medications, and antacids. In addition, under the Coronavirus Aid, Relief, and Economic Security Act (CARES) certain menstrual care products (e.g., pads and tampons) are considered eligible expenses. OTC items that are merely beneficial to your general health are not covered through Beneflex, and include vitamins, toiletries (toothpaste, mouthwash, etc.), cosmetics, and nutritional or dietary supplements.

If you decide to contribute to your Health Care Spending Account, you may contribute up to \$2,550 of your pay each year. If your spouse is employed (including those employed at RIT), he or she can participate in his or her employer's health care flexible spending account program without the type of combined absolute maximum that applies to dependent care spending accounts (described below).

Before deciding how much to contribute to the Health Care Spending Account, you may want to first consider your health care expenses from last year. You can use last year's expenses as your guide for estimating this year's expenses. Consider your health and your family's health, and that some expenses incurred last year—like maternity or surgery—may not apply this year. Also, consider the coverage provided last year and this year by RIT's medical, vision and dental plans or other coverage you may have.

Keep in mind that if you do not use all the money in your health care account for eligible expenses by the deadline, you will lose this money. Also, all expenses submitted for reimbursement must be incurred during your participation period – the date you joined the plan through the March 15 of the following calendar year (under the IRS grace period rules, described later in this summary).

For information on eligible health care expenses, contact the Beneflex administrator – Lifetime Benefit Solutions (LBS) – or see Internal Revenue Service Publication 502, which is available on the IRS website: <http://www.irs.gov/pub/irs-pdf/p502.pdf>.

### **Dependent Care Spending Account**

You may open a Dependent Care Spending Account for:

- Children under 13 who you claim as dependents for federal income tax purposes
- or*
- Your spouse, children of any age or other dependents who are disabled, incapable of self-support (or who need full-time attention) and who are at home at least eight hours each day.

If you are married, you may have a dependent care spending account only if both you and your spouse work during the time your children receive care, unless your spouse is a full-time student or qualifies for dependent care because of a disability. You also may open a dependent care spending account if you are single with an eligible child.

A dependent care spending account will reimburse you for amounts spent on qualified expenses for the care of a dependent that allows you and your spouse (if applicable) to work or attend school full-time, including:

- Child care, in or out of your home;
- Approved day care centers;
- Home care specialists who care for the disabled; and
- Approved centers that care for the disabled.

*Expenses paid to a provider who does not claim the payment as income may be determined ineligible for tax-free reimbursement by the IRS.*

To estimate your qualified dependent care expenses, multiply your weekly qualified dependent care expenses by the number of weeks such care is required each year. The absolute maximum you may contribute to a dependent care account for any year, on a pretax basis, equals the lesser of

- The earned income of you or your spouse  
**or**
- \$5,000  
**or**
- \$2,500, if you and your spouse file separate tax returns.

By law, if your spouse participates in a dependent care flexible spending account through his or her employer (including RIT), your and your spouse's combined contributions cannot exceed the \$5,000 or \$2,550 absolute maximum described in the preceding paragraph.

It is important for you to know that, under current tax law, qualified dependent care expenses that you pay on an after-tax basis may qualify for a credit on your federal income tax return. Therefore, the tax savings for some people may be greater if they pay for dependent care on an after-tax basis rather than on a pretax basis under a dependent care account. For others, the tax savings will be greater under a dependent care account. For more information, you should check with a financial advisor or tax professional.

Keep in mind that if you do not use all the money put into a dependent care account by the end of any year, you will lose this money. Also, all expenses submitted for reimbursement must be incurred during that calendar year regardless of when the expense is billed or paid.

For information on eligible dependent care expenses, contact the Beneflex administrator – Lifetime Benefit Solutions (LBS)– or see Internal Revenue Service Publication 503, which is available on the IRS website: <http://www.irs.gov/pub/irs-pdf/p503.pdf>.

**Example: Advantage of Paying for Expenses Pretax Using a Flexible Spending Account**

	<u>HCSA</u>		<u>DCSA</u>	
	<u>With HCSA</u>	<u>Without HCSA</u>	<u>With DCSA</u>	<u>Without DCSA</u>
Annual Base Salary	\$30,000	\$30,000	\$30,000	\$30,000
HCSA/DCSA annual contribution	<u>-\$2,550</u>	<u>\$0</u>	<u>-\$5,000</u>	<u>\$0</u>
Taxable Salary	\$27,500	\$30,000	\$25,000	\$30,000
Federal income tax (estimated)	-\$5,500	-\$6,000	-\$5,000	-\$6,000
Social Security and Medicare tax (7.65%)	-\$2,103	-\$2,295	-\$1,913	-\$2,295
State income tax (estimated)	-\$2,007	-\$2,205	-\$1,838	-\$2,205
After-tax expenses	\$0	-\$2,550	\$0	-\$5,000
Take-home salary	\$17,890	\$17,000	\$16,250	\$14,500
<b>Tax Savings</b>	<b>\$1,050</b>		<b>\$1,750</b>	

**Important Features of Your Flexible Spending Accounts**

Once you select the amount you will be contributing to your accounts, you cannot change or stop the amount you are contributing during the plan year unless a change in family status occurs.

Other than for a qualified change in status, changes in your contribution amount may only be made *once each year* during the open enrollment. You elect each year, during the open enrollment, whether or not to participate and, if you participate, the amount you will contribute to each account. All open enrollment changes will take effect on January 1.

If you do not enroll *each year* during open enrollment, you will not be able to participate during the next year, even if you participated previously.

If you contribute to both accounts, you cannot use money from the health care account to pay for dependent care expenses, and vice versa. Money from the dependent care account can only be used for dependent care expenses and money from the health care account can only be used for health care expenses.

Your contributions to the FSAs will be payroll deducted, on a pretax basis, from each paycheck and will be credited to your account each pay period.

The maximum amount of reimbursement available at any time from the health care account will equal your annual elected contribution *less any amounts already reimbursed*. Of course, once you receive the maximum reimbursement, you would continue to have payroll deductions for the account for the rest of the plan year. However, you would not be eligible for any further reimbursement since you would have already received your entire election amount.

Expenses reimbursed through your health FSA cannot be claimed as a deduction on your income tax return or reimbursed later through a health care plan. *Only the part of a bill not covered by any health insurance will be reimbursed.*

The maximum amount of reimbursement available at any time from the dependent care account will equal your actual account balance at the time of reimbursement. If you request more than the amount in your account, you will be reimbursed up to the account balance, with remaining amounts being reimbursed as your contributions accumulate.

Remember, you cannot use both the Federal dependent care tax credit and dependent care FSA for the same dependent care expenses.

### ***Use the Flex Card to Pay Your Claims***

When you join Beneflex, LBS, the administrator, will automatically send you two “Flex Cards.” The Flex Card is a convenient way for you to pay for your health care and dependent day care expenses. It automates the process of paying for your eligible expenses by paying your provider at the point of service. This way, you avoid having to pay cash for your service and waiting for your reimbursement check to arrive.

Instead, you simply use your Flex Card for eligible expenses wherever MasterCard is accepted, from physician and dental offices to pharmacies and vision care providers, as well as at certain dependent day care providers. Your contributions for these eligible expenses are first deducted from your paycheck and then added to your Beneflex account to fund your Flex Card. You may use your Flex Card as often as you like to pay for your eligible expenses.

*How it works:* When you seek eligible services (such as doctor’s office visit, prescription or over-the-counter drugs, eyeglasses or contacts), present your Flex Card and the charge will automatically be deducted from your pretax account after your card has been swiped. If requested, indicate that this is a credit card, and not a debit card. You do not need a PIN when you use your Flex Card, and you cannot withdraw cash with your card.

Here is some important information you need to know about using the Flex Card:

- The Flex Card is programmed to be used only at approved health care and dependent care providers. If you attempt to use it elsewhere, it will not be accepted.
- It is critical that you save your receipts and supporting detailed information from each Flex Card transaction, as your Beneflex claims are subject to review and audit, especially certain pharmacy and over-the-counter drug claims. LBS will conduct audits during the year, as required by the Internal Revenue Service.
- You should also save claim reimbursement documentation since LBS does not retain this beyond the current year.
- Be sure to use your Flex Card for eligible expenses only. If you are purchasing both allowable and non-allowable items, such as at the pharmacy, please separate your items and use your Flex Card for allowable expenses only.
- If you inadvertently pay for a non-allowable expense with your Flex Card, you will be required to repay the non-allowable amount back to keep your account tax-free.
- Your Flex Card can be used only for the portion of the health care service or supply that is not being reimbursed from a health or dental plan. You will typically use it for copays, coinsurance and deductibles, and for items such as over-the-counter drugs that are not covered by health plans.
- You can submit a claim form for reimbursement if you do not have your Flex Card with you when you incur an eligible expense and pay for it. Reimbursements are typically processed weekly with a \$30 minimum payment amount.

Two Flex Cards will automatically be sent to you when you enroll in Beneflex; there is a card for you and one for an eligible family member (e.g., your spouse). Please be sure to sign the back of your card; if you give a card to an eligible family member, have your family member sign the back of the card with his/her signature. LBS has informed us that the family member using an additional card should not have a problem as long as he/she has signed the card with his/her own signature; they have advised us that this is standard procedure.

If you wish to have an additional card for another eligible dependent, you may request one by completing the "Request Form for Issuance of LBS Flex Card to Dependent" found on the HR website, and mailing it to LBS at the address indicated on the form. It takes several weeks to receive additional cards, so be sure to do this as soon as possible once you have enrolled in Beneflex.

### ***Claims for Benefit Payment***

You are responsible for retaining records of all FSA expenses. LBS is not responsible for retaining copies of your receipts. If you do not use the Flex Card to pay for your eligible expenses, you can complete a claim form for reimbursement.

Beneflex claim forms are available on the RIT Human Resources web page, or at the Human Resources Department. You can submit claims only for eligible expenses that have been incurred after your Beneflex participation begins and before March 15 of the following calendar year. You have until March 15 because RIT has adopted the grace period allowed by the IRS.

If you sign up for Beneflex in a subsequent year and still have funds in your prior year account, any reimbursements will first come from the prior year account. For example, if you incur an eligible health care expense on January 30, 2020, your claim for that expense will be paid from your remaining 2019 account, if any, before the 2020 account.

If you cancel participation (change your contribution amount to zero) in a flexible spending account during the plan year due to a qualifying event, you will not be eligible for reimbursement for claims with dates of service after the cancellation date. For example, if you cancel participation (stop contributing to the plan) August 31, you would not be eligible for reimbursement for claims with dates of service between September 1 and the following March 15.

All claims for a calendar year must be submitted by April 30 of the following year. For example, claims for services during 2020 and through March 15, 2021 must be submitted by no later than April 30, 2022.

Health care expenses must be submitted first to any medical, dental, vision, prescription drug or other health plan in which you participate. Once that plan has paid its share, if any, the remainder can be submitted for reimbursement from your health care Beneflex account. When you file your Beneflex claim, you will need to attach the Explanation of Benefits (EOB) from your health plan showing how much that plan has paid and how much you are responsible for paying. If an eligible expense is not of a kind covered by any other plan (e.g. dental services if you do not have dental plan coverage), then you need to attach a written statement from the provider of the service (e.g. the dentist) which shows:

- the date, description and amount charged for the service
- the name and address of the provider
- the name, relationship and date of birth of the person for whom the service was rendered (you or your dependent).

Claims will be reimbursed weekly. There is a \$30.00 minimum reimbursement. If your claim is for less than \$30.00, it will be held until another claim is submitted which brings the total to at least \$30.00.

#### Special Rule for 2019 Health Care and Dependent Care Account Claims

Due to the COVID-19 pandemic, the Federal government has published a rule stating that the claim runout period is to be extended beyond April 30, 2020 for the 2019 accounts. The rule is that the new deadline will be four months after the “Outbreak Period” ends, a date that has not yet been determined. The Outbreak Period began on March 1, 2020 and ends 60 days after the Federal government declares there is no longer an emergency. We encourage participants to file any eligible claims as soon as possible to avoid missing the new deadline.

#### Special Rule for 2020 Health Care and Dependent Care Account Claims

The grace period for claims incurred for 2020 will end December 31, 2021 instead of March 1, 2021.

#### **Direct Deposit**

You can elect to have your Beneflex reimbursements directly deposited to your checking or savings account when you complete a manual claim form (this does not apply if you use the Flex Card). No more biweekly trips to the bank just to deposit your Beneflex reimbursement checks! And get your money back faster, too! To do so, simply complete a Beneflex Direct Deposit form (found on the HR website or available in HR) and mail the form to the address indicated with a voided check or deposit slip from your bank account. If you enroll in direct deposit then change your bank account at a later date, be sure to notify LBS at least 14 days in advance of closing your account to stop the direct deposit reimbursements from going to your old account.

If you do not wish to have your reimbursements directly deposited, you do not need to take any action (other than enrolling in Beneflex), and you will receive checks in the mail when your Beneflex claims are processed. You can change your mind – either way – at any time.

And, once you have signed up for direct deposit for your Beneflex accounts, then direct deposit will automatically continue in future years – you don’t have to do anything except enroll in Beneflex each year – remember your Beneflex election does not carry over from one year to another.

#### **Website Functionality**

Information about your health care and dependent care flexible spending accounts is at your fingertips. Through a confidential web-site located at [www.lifetimebenefitsolutions.com](http://www.lifetimebenefitsolutions.com) you can easily access information about your Beneflex (FSA) account(s). From this website, you will be able to:

1. View your Beneflex claims activity (Detailed listing of claims you have submitted for reimbursement including the claim status);
2. View your account activity (Deposits posted to your account and reimbursements made to you);
3. Submit your claims online and receive an instant confirmation that LBS has received your claim.

#### **When Coverage Ends**

##### **Continuation of Participation in the Health Care Spending Account under COBRA**

You may not have incurred health care expenses at the time of your termination. In order to access the money, which you have contributed to the account, you may continue your participation in the Plan under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). If you have received reimbursement for more than your contributions, you will not be offered COBRA continuation coverage. Under COBRA you could

continue to contribute to the account with after-tax dollars for the remainder of the Plan year in which you terminated. This would allow you time in which to incur expenses that can be reimbursed from your account.

COBRA continuation is not available for the Dependent Care Spending Account.

### **When You Are Eligible for COBRA**

The following contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This information explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### **What is COBRA Continuation Coverage?**

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

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

- You no longer meet the Plan's eligibility requirements; this includes transfer to an employment category that is not eligible for coverage under the Plan, such as part-time employees and adjunct faculty;
- Your approved leave of absence ends (personal, professional, Family and Medical Leave Act) and you do not return to work; or
- Your approved leave of absence continues, but the maximum benefits continuation period is reached (i.e., coverage ends); or
- Your employment ends for any reason other than your gross misconduct.

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

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

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

- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as an eligible child.

**Note regarding domestic partners and their children:** Under federal law, the domestic partner and/or children of a domestic partner are not considered qualified beneficiaries. However, RIT does extend continuing coverage to these individuals as though they were COBRA-eligible.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Rochester Institute of Technology, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and eligible children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

### **When is COBRA Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan's COBRA Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA administrator of the following qualifying events:

- the end of employment or change in employment or benefits eligibility;
- death of the employee;
- commencement of a proceeding in bankruptcy with respect to the employer; or
- the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you must notify RIT Human Resources in writing within 60 days after the qualifying event occurs.** The employee or family member can provide notice on behalf of themselves, as well as other family members affected by the qualifying event. Written notice of the qualifying event should be sent to RIT Human Resources, at the address provided at the end of this summary, and should include the following information:

Request Date (month/day/year)

Employee Name

Employee ID Number

Name of person losing coverage

Relationship to employee

Address for person losing coverage

Reason for loss of coverage (additional documentation may be requested)

Date coverage was lost (month/day/year)

### **How is COBRA Coverage Provided?**

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or the employee becoming ineligible for coverage. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage; these events include the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or an eligible child's losing eligibility as an eligible child.

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

### ***Disability extension of 18-month period of continuation coverage***

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

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

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

### **Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

### **Paying for Continuation Coverage**

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

For disability extensions up to 29 months if an individual is determined to be disabled (for Social Security disability purposes) Rochester Institute of Technology reserves the right to charge an additional 50% of the regular premium. There is a grace period of at least 30 days for payment of the regularly scheduled premium. The law also says, that at the end of the 18 month or 3 year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under your insurance carrier.

The amount paid for most coverage under COBRA is the value of your premiums (plus a 2% administration fee) associated with each benefit. If you have not incurred claims sufficient to spend-down your Health Care Spending Account balance as of your date of termination, you may continue your participation in the Health Care Spending Account for the remainder of the Plan Year in which you terminate employment. Payment for continuation of your Health Care Spending Account benefit is based on the contribution you made to your

account while employed. Your premium is the same amount of those contributions withheld from your paycheck during employment plus the 2% administration fee. **COBRA will be offered only to those who have “underspent” their Medical Spending Account.**

### **Grace period for monthly payments**

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

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

### **Termination of Continuation Coverage**

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

1. Rochester Institute of Technology no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have Rochester Institute of Technology must limit pre-existing exclusion period to no more than 12 months (18 for a late entrant)). A plan's pre-existing conditions exclusion period will be reduced by each month that you and your family had continuous health coverage (including COBRA continuation coverage) with no break in coverage greater than 63 days. Please note that exclusions and limitations with respect to pre-existing condition requirements have been eliminated for children 19 years of age and under through the Patient Protection and Affordable Care Act (also known as Health Care Reform). Pre-existing conditions exclusions and limitations will no longer apply after 2014;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

### **If You Have Questions**

If you have questions, contact your benefits representative in the Human Resources Department. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

### **Keep Your Plan Informed of Address Changes**

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

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

P&A Group  
17 Court Street, Suite 500  
Buffalo, NY 14202  
Attn: RIT COBRA

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

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

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

#### **Statement of ERISA Rights**

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

#### **Receive Information about Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as other work-sites, all documents governing the plan, including insurance contracts, 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 Benefit Security Administration.

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

#### **Continue Group Health Plan Coverage**

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

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

#### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them in 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

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

### **Assistance with Your Questions**

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

### **Notice of Privacy Practices**

This Notice describes how some of the Rochester Institute of Technology (the “Plan Sponsor”) employee benefit plans administered by our carriers, vendors and/or any third-party administrator (collectively referred to in this notice as the “Plan,” “we,” “us,” or “our”), may use and disclose Protected Health Information, as defined below, to carry out payment and health care operations, and for other purposes that are permitted or required by law. The plans covered by these regulations are RIT’s Medical Care and Prescription Drug Plan, Dental Care Plan, Vision Care Plan, Beneflex, Employee Assistance Program, and Long Term Care Insurance (the “Plan”).

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide individuals covered under the Plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to

change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be provided to all participants in the Plan. Copies of RIT's current Notice may be obtained by using the contact information below, or can be found on RIT's HR website at <http://www.rit.edu/benefits>.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

### **Uses And Disclosures Of Your Protected Health Information**

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – We will not use or disclose your PHI for marketing purposes or sell your PHI unless you have signed a written authorization. Additionally, any other uses or disclosures not described in this Notice will be made only after you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that (1) we have taken action in reliance upon the authorization or (2) the authorization was obtained as a condition of obtaining coverage under the Plan and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – There may be requests, uses, and disclosures of your PHI as necessary for payment purposes. For example, information regarding your medical procedures and treatment may be used to process and pay claims. Your PHI may also be disclosed for the payment of a health care provider or a health plan.

Uses and Disclosures for Health Care Operations – Your PHI may be used as necessary for our health care operations. Examples of health care operations include activities relating to the creation, renewal, or replacement of your Plan coverage, reinsurance, compliance, auditing, rating, business management, quality improvement and assurance, and other functions related to the Plan.

Treatment – Although the law allows use and disclosure of your PHI for purposes of treatment, as a group health plan, your information generally does not need to be disclosed for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your PHI for purposes of treatment, payment and health care operations.

Family and Friends Involved in Your Care – If you are available and do not object, your PHI may be disclosed to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and it is determined that a limited disclosure is in your best interest, limited PHI may be shared with such individuals. For example, the Plan's claims administrator may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits under the Plan. Examples of these outside persons and organizations might include vendors that

process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations. Business Associates are also required by law to protect PHI.

Plan Sponsor – PHI may be disclosed to certain employees of the Plan Sponsor for the purpose of administering the Plan. These employees will use or disclose the PHI only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Other Uses and Disclosures – There are certain other lawful uses and disclosures of your PHI without your authorization. Disclosures are allowed

- for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect, or domestic violence, your PHI may be disclosed to the proper authorities.
- if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- for law enforcement purposes, your PHI may be disclosed to the proper authorities.
- to coroners, medical examiners, and/or funeral directors consistent with law.
- for cadaveric organ, eye or tissue donation.
- for research purposes, but only as permitted by law.
- to avert a serious threat to health or safety.
- if you are a member of the military as required by armed forces services, and for other specialized government functions such as national security or intelligence activities.
- to workers' compensation agencies for your workers' compensation benefit determination.
- if required by law, your PHI will be released to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

In the event applicable law, other than HIPAA, prohibits or materially limits our uses and disclosures of PHI, as described above, uses or disclosure of your PHI will be restricted in accordance with the more stringent standard.

### **Rights That You Have**

Access to Your PHI – You have the right of access to copy and/or inspect your PHI that we maintain in designated record sets. You have the right to request that we send a copy of your PHI that we maintain in designated record sets to another person. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI or that you want your PHI sent to another person (who must be named in the request), and must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). We may charge you a fee for copying and postage.

Amendments to Your PHI – You have the right to request that PHI that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful

consideration. To be considered, your amendment request must be in writing, must be signed by you or your representative, and must state the reasons for the amendment/correction request.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your PHI – You have the right to request restrictions on certain uses and disclosures of your PHI for insurance payment or health care operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that your PHI not be disclosed to your spouse. Your request must describe in detail the restriction you are requesting. Your request will be considered, but in most cases there is no legal obligation to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations and the PHI pertains solely to a health care item or service that you have paid for out-of-pocket and in full. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the telephone number or address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to be Notified of a Breach – You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

Right to a Copy of the Notice – If you have agreed to accept this Notice electronically, you have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

### **For Further Information**

If you have questions or need further assistance regarding this Notice, you may contact your benefits representative in RIT's Human Resources Department. The mailing address is 8 Lomb Memorial Dr., Rochester, NY 14623.

## **Special Enrollment Rights**

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), you have a right to apply for medical coverage with Rochester Institute of Technology (RIT). You should read this information even if you waive coverage.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the RIT medical coverage if you or your dependents lose eligibility for the other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must contact RIT Human Resources and request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the RIT medical coverage. However, you must contact RIT Human Resources and request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment in RIT medical coverage for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in an RIT medical plan if you or your dependents lose eligibility for that other coverage. However, you must contact RIT Human Resources and request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage, you may be able to enroll yourself and your dependents in that plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request a special enrollment or obtain more information, feel free to contact the Human Resources Department.

## **Administrative Claim Procedures**

Claims concerning eligibility, participation, contributions, or other aspects of the operation of the Plan should be in writing and directed to the Plan Administrator; this section does not apply to claims for benefits under the Plan. The Plan Administrator will generally notify you of its decision within 90 days after it receives your claim.

However, if the Plan Administrator determines that special circumstances require an extension of time to decide your claim, the Plan Administrator may obtain an additional 90 days to decide the claim. Before obtaining this extension, the Plan Administrator will notify you, in writing and before the end of the initial 90-day period, of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

If your claim is denied in whole or in part, the Plan Administrator will provide you with a written or electronic notice that explains the reason or reasons for the decision, including specific references to Plan provisions upon which the decision is based, a description of any additional material or information that might be helpful to decide the claim (including an explanation of why that information may be necessary), a description of the appeals procedures and applicable filing deadlines and your right to bring an action under Section 502(a) of ERISA.

If you disagree with the decision reached by the Plan Administrator, you may submit a written appeal to the Plan Administrator requesting a review of the decision. Your written appeal must be submitted within 60 days of receiving the Plan Administrator's decision and should clearly state why you disagree with the Plan Administrator's decision. You may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for benefits. Additionally, upon request and free of charge, you may have reasonable access to and copies of all documents, records and other information relevant to the claim.

The Plan Administrator will generally decide your appeal within 60 days after it is received. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may obtain an additional 60 days to decide the claim. Before obtaining this extension, the Plan Administrator will notify you, in writing and before the end of the initial 60-day period, of the special circumstances requiring the extension and the date by which it expects to render a decision.

The Plan Administrator will provide you with written or electronic notice of its decision. In the case of an adverse decision, the notice will explain the reason or reasons for the decision, include specific references to Plan provisions upon which the decision is based, and indicate that you are entitled to, upon request and free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim. Additionally, the notice will include a statement regarding your right to bring an action under Section 502(a) of ERISA. Generally, you must exhaust your internal administrative appeal rights before you can bring a legal action against the Plan. The Plan Administrator has full discretionary power to construe and interpret the Plan and its decisions are final and binding on all parties.

## Important Information about the Plan

**Employer** Rochester Institute of Technology

**Employer Identification Number:** 16-0743140

**Plan Sponsor:** Rochester Institute of Technology  
8 Lomb Memorial Drive  
Rochester, NY 14623  
(585) 475-2424

**Plan Name:** Beneflex Plan

**Plan Number:** 506

**Plan Year:** January 1 - December 31

**Plan Administrator:** Associate Director  
Human Resources, Benefits  
Rochester Institute of Technology  
8 Lomb Memorial Drive  
Rochester, NY 14623  
(585) 475-2424

**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.