
**NAZARETH COLLEGE OF ROCHESTER
NAZFLEX PLAN**

SUMMARY PLAN DESCRIPTION

*Of the Provisions of the Plan
in Effect on January 1, 2005*

EBS Benefit Solutions is providing this form summary plan description to assist the sponsoring employer with its disclosure obligations to plan participants. However, the employer, as plan sponsor and plan administrator, is responsible for the accuracy and distribution of the summary plan description, as well as the overall operation and administration of the plan. The employer should review the summary plan description carefully to ensure that it accurately reflects all of the terms and provisions of the employer's plan. If it does not, the employer should make appropriate changes. The employer should also have the summary plan description reviewed by its own legal counsel for compliance with the Employee Retirement Income Security Act of 1974 ("ERISA") and other applicable laws and regulations.

INTRODUCTION

This Summary Plan Description ("SPD") presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection at the Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790 during regular business hours.

The information in this SPD may be modified by a "Summary of Material Modification" ("SMM") attached. Check to see if there are any SMM's attached when you refer to this SPD.

IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name: Nazareth College of Rochester
NazFlex Plan

Plan Number: 512

Plan Type: Cafeteria (Section 125) Plan

Plan Year: The Plan Year begins on January 1 and ends on December 31.

Employer and Plan Sponsor: Nazareth College of Rochester
4245 East Avenue
Smyth Hall #183
Rochester, New York 14618-3790
(585) 389-2060

Employer Identification Number: 16-0743088

Plan Administrator: Nazareth College of Rochester
4245 East Avenue
Smyth Hall #183
Rochester, New York 14618-3790
(585) 389-2060

Type of Plan Administration: The Plan is administered by the Employer through a Committee appointed by the Employer. All benefits are paid from the general assets of the Employer. The Employer is responsible for determining the types of benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting the amount of Employer and participant contributions. The Department of Human Resources, Nazareth College of Rochester is the primary source for information about these aspects of the Plan.

Plan Agent for Service of Legal Process: Nazareth College of Rochester
4245 East Avenue
Smyth Hall #183
Rochester, New York 14618-3790

Legal process may also be served upon the Plan Administrator.

1. What is the advantage to me of the NazFlex Plan?

You can use the Plan to pay for certain expenses on a pre-tax basis. For example, you can pay your share of premiums for the group insurance coverage listed in Question & Answer 4. You can also make pre-tax contributions to the Plan to be used to pay (or reimburse you for) health care expenses and dependent care expenses described in Question & Answer 5. These amounts are deducted from your pay and are not reported as taxable income on your W-2 form, so you do not pay income tax or Social Security taxes on them.

The Employer also makes contributions to the Plan, which you can elect to use for group insurance premiums or health care or dependent care expenses or receive in cash.

2. Who is eligible to participate in the Plan?

You are eligible to participate in the Plan if you are:

a full time faculty or staff member of Nazareth College of Rochester working at least 32 hours per week and at least 32 weeks per year.

Notwithstanding the above, the following persons are not eligible to participate in the Plan: (i) any person providing services to the Employer through a temporary agency, leasing organization, or independent contractor arrangement, even though he subsequently may be classified as an employee for employment tax, unemployment insurance, or other purposes by a government agency or a court; (ii) if the Employer is not incorporated, any person who is the sole owner, or a co-owner or joint owner, of the Employer; (iii) if the Employer is a limited liability corporation ("LLC"), any member of the LLC; (iv) if the Employer is a Subchapter S corporation, and any person who owns directly or indirectly more than 2% of the Employer.

3. When can I begin participating in the Plan?

If you meet the eligibility requirements listed above, you may begin participating in the Plan as follows:

Medical Insurance, Dental Insurance, Vision Insurance, Dependent Care and Health Care Flexible Spending Accounts, Life Insurance, and Accidental Death and Dismemberment Insurance - on the first of the month following the date of hire or transfer date to a benefit eligible class.

Long Term Disability Insurance - one year from your date of hire or transfer to a benefit eligible class.

However, before you can participate, you must complete the enrollment process. You must indicate the amount of your contributions to the Plan for the Plan Year, and your elections for Employer contributions. Failure to complete enrollment by the date specified by the Committee will be considered an election not to contribute to the Plan that Plan Year. In that case, you will not be able to contribute to the Plan until the next Plan Year, unless a change in status occurs that allows you to change your election. See Question & Answer 9 (When can I change my elections?). If you complete enrollment, but fail to make any election for some or all Employer contributions, those Employer contributions may be paid to you in cash (see Question & Answer 8), and will be subject to income and Social Security taxes.

Except as explained in Question & Answer 12 (What happens if I terminate employment during the Plan Year?), your contributions to the Plan stop and you cease participation in the Plan when you are no longer an eligible employee.

4. What insurance premiums can I pay through the Plan?

You can pay your share of premiums for the following types of group insurance sponsored by your Employer:

- accidental death and dismemberment insurance
- dental insurance
- life insurance
- long-term disability insurance coverage
- medical insurance
- vision insurance

Notwithstanding the foregoing, due to restrictions imposed by federal tax law, premiums attributable to coverage provided to your domestic partner cannot be paid under the Plan, unless your domestic partner is also your legal dependent. You will have to pay that portion of your premiums on an after-tax basis.

5. What other expenses can be paid with Plan contributions?

Contributions can also be used to pay, or reimburse you for, the following types of expenses, provided they are not payable or reimbursable from any other source:

- dependent care expenses that would otherwise qualify for a dependent care credit on your federal income tax return if they were not paid or reimbursed under the Plan.

- health care expenses, other than insurance premiums, that would otherwise be deductible on your federal income tax return if they were not paid or reimbursed under the Plan (but without regard to any minimum amount of health care expenses required to take a deduction).
- non-prescription medicines and drugs, such as antacid, allergy medicine, pain reliever and cold medicine purchased for you, your spouse or any person who qualifies as your dependent for federal income tax purposes. Note that Plan contributions cannot be used to pay or reimburse you for toiletries, cosmetics, sundry items, dietary supplements, vitamins and other items that are merely beneficial to a person's general health.

Notwithstanding the foregoing, due to restrictions imposed by federal tax law, health care expenses attributable to your domestic partner cannot be paid under the Plan, unless your domestic partner is also your legal dependent. Expenses attributable to dependent care provided to your domestic partner's dependent generally will be reimbursable under the Plan subject to the usual rules if your domestic partner's dependent qualifies as your legal dependent under the dependent care tax credit rules. If your domestic partner's dependent does not so qualify, dependent care expenses for that child are not reimbursable under the Plan.

6. How much does my Employer contribute?

Before you can first participate in the Plan, and at the beginning of each Plan Year, you will be notified of the maximum Employer contribution for the Plan Year, as well as the maximum Employer contribution for any particular benefit under the Plan, and whether the maximum amounts are prorated if you are not a participant for the entire Plan Year. Employer contributions are made in installments based on payroll periods. The Employer contribution for each payroll period will equal your maximum Employer contribution for the Plan Year divided by the number of pay periods in the Plan Year or, if you are not a participant during the entire Plan Year, divided by the number of the pay periods in the Plan Year in which you are a participant.

The Plan Year is the 12 consecutive month period beginning each January 1.

7. How much can I contribute to the Plan?

Before you can first participate in the Plan, and at the beginning of each Plan Year, you will be notified of the minimum and maximum amount you can contribute for that Plan Year, as well as your maximum contribution for any particular benefit under the Plan. Your contributions are made through equal payroll deductions throughout the Plan Year.

8. How can I have Employer contributions paid to me in cash?

Before you can first participate in the Plan, and at the beginning of each Plan Year, you will be notified of the maximum Employer contributions you can elect to receive in cash.

Any Employer Contributions you elect to receive in cash will be paid to you at the end of the Plan Year for which the election is made and **only** if you are an employee or a retired employee of the Employer on the last day of the Plan Year. These payments are subject to income and Social Security taxes.

9. When can I change my elections?

You can change your *elections* before the beginning of each new Plan Year. Once the Plan Year has started, federal tax laws permit you to change your *elections* only when one of the following "changes in status" occurs:

- You exercise special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You, your spouse or dependent becomes eligible for continued health coverage under federal law (COBRA) or similar state law under a group health plan of your Employer.
- A court issues a judgment, decree or order, resulting from a divorce, legal separation, annulment or change in legal custody, requiring you to provide health coverage for a child or foster child, or requiring someone else to provide the coverage.
- You, your spouse or dependent becomes entitled to or loses Medicare or Medicaid coverage (other than only the program for distribution of pediatric vaccines).
- Insurance premiums increase significantly. (However, if there is an ordinary increase or decrease in premiums, your contributions will automatically be adjusted to reflect the change.) Note, a significant increase in insurance premiums allows you to change the amount of those premiums you pay through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other *elections*.

- There is a significant curtailment in, or cessation of, your insurance coverage. (In the case of health insurance, there must be reduced coverage for employees generally.) Note, that a significant curtailment in, or cessation of, your insurance coverage allows you to change the amount of the premiums you pay for that insurance through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other *elections*.
- A new insurance coverage option is added or an insurance option you have selected is eliminated. Note, that the addition or elimination of an insurance option allows you to change the amount of the premiums you pay for that insurance through the Plan, but does not allow you to change the amount of any other premiums you pay through the Plan or any other *elections*.
- Your legal marital status changes (including a change resulting from marriage, divorce, death of a spouse, legal separation, or annulment).
- The number of your dependents changes (including a change resulting from a birth, death, adoption or placement for adoption of a child).
- There is a change in your employment status, or in the employment status of your spouse or dependent, resulting from termination or commencement of employment, strike or lockout, commencement of or return from an unpaid leave of absence, change in worksite, or other change that causes you, your spouse or dependent to become or cease to be eligible for coverage under the Plan or other employer plan providing the same type of benefits. However, if your employment terminates and resumes in the same Plan Year within a period of 30 days or less, your *elections* in effect before the termination will automatically be reinstated upon resumption of your employment, unless some other intervening event has occurred that would permit a change in your *elections*.
- A change in your place of residence, or the place of residence of your spouse or dependent, that makes you, your spouse or dependent ineligible for insurance coverage at the new place of residence. Note, a change in residence allows you to change the amount of the premiums you pay through the Plan for the insurance for which you, your spouse or dependent is no longer eligible, but does not allow you to change the amount of any other premiums you pay through the Plan or any other *elections*.
- Your dependent's eligibility for health coverage changes due to the dependent's age, student status or marital status or similar circumstance.

- There is a change in your dependent care provider or a change in the cost of services provided by a dependent care provider who is not a relative.
- A person's status as a dependent for purposes of your dependent care election changes.
- Your spouse, former spouse or dependent makes a change under another plan which is either (i) consistent with one of the events described above, or (ii) for the normal election period under the other plan and that election period is different from the Plan Year of this Plan.
- You, your spouse or dependent loses group health coverage sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act, a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, a tribal organization, a State health benefits risk pool, or a foreign government group health plan. Note, loss of such coverage allows you to change the amount of premiums you pay through the Plan for dental, medical and vision insurance, but does not allow you to change the amount of any other premiums you pay through the Plan or any other elections.

Note, that whenever any of the events described above occurs, you can only make *election* changes that conform to and are consistent with that event.

Also, if you are allowed to change your health care expense reimbursement election, you may not reduce the annual contribution elected to less than the amount of health care expenses already reimbursed to you for the Plan Year.

10. How do I receive benefits from the Plan?

Contributions used for insurance premiums are sent directly to the insurance company. Employer contributions to be paid in cash will be paid as described above.

Your employer may make arrangements for automatic payment or reimbursement of health or dependent care expenses covered under the Plan. Otherwise, these expenses will be reimbursed at least monthly, provided you file a written request for payment or reimbursement at least five business days before a scheduled payment/reimbursement date.

The Committee will inform participants of the scheduled payment/reimbursement dates. Requests for reimbursement must be made on forms provided by the Committee. You may request forms from Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790.

Note:

- Only expenses incurred on or after the date you begin participating in the Plan are covered under the Plan.
- The amount of dependent care expenses paid or reimbursed cannot exceed the contributions you have made to the Plan for dependent care expenses, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.
- The amount of health care expenses paid or reimbursed cannot exceed the amount of your health care expense contribution election for the Plan Year, less the amount of such expenses already paid or reimbursed from the Plan for the Plan Year.
- If you are employed through the end of the Plan Year, a claim for reimbursement for expenses that you incurred during the Plan Year must be received by your Flexible Spending Account Plan Administrator by April 15 following the end of each Plan Year. Also, see Question & Answer 12 (What happens when I terminate employment during the Plan Year?).

By January 31 of each year, you will receive a statement showing the amount of your contributions to the Plan for the previous calendar year.

11. What happens if contributions for health or dependent care expenses for a Plan Year are greater than my actual expenses for that Plan Year?

If contributions for health or dependent care expenses exceed the expenses you actually incur during the Plan Year, or the amount you claim before the deadlines described in Question & Answer 10 (How do I receive benefits from the Plan?) or Question & Answer 12 (What happens when I terminate employment during the Plan Year?), you will forfeit the excess contributions. Therefore, you should be careful to contribute only the amount you think will be needed to cover your anticipated expenses for the Plan Year.

12. What happens if I terminate employment or my spouse, dependent or I otherwise no longer qualify for coverage under the Plan?

You may request reimbursement for expenses incurred on or before your last day of employment, provided you submit your written request for reimbursement no later than 105 days after your last day of employment or the date you otherwise no longer qualify for coverage under the Plan.

You may also have a right under "COBRA" to continue to participate in the health care expense reimbursement portion of the Plan by continuing to make payments to the Plan, plus an administrative charge, on after-tax instead of a pre-tax basis. COBRA continuation coverage is a temporary extension of the health care expense reimbursement portion of the Plan only. 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 to other members of your family who are covered under the health care expense reimbursement portion of the Plan when you would otherwise lose that coverage. Below is a summary of 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 Plan Administrator is Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790, phone (585) 389-2060.

The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

Domestic Partners are not eligible for COBRA Continuation Coverage.

COBRA continuation coverage is a continuation of the health care expense reimbursement portion of the Plan when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose coverage under the health care expense reimbursement portion of the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced; or
- (2) 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 will lose coverage under the health care expense reimbursement portion of the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the health care expense reimbursement portion of the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

When the qualifying event is a divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, the Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Plan requires you to notify the Plan Administrator within 60 days after any of these qualifying events occur. You must send this notice to Department of Human Resources, Nazareth College of Rochester, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790. You may be asked to provide additional information regarding the qualifying event.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage, which lasts no longer than the last day of the Plan Year in which the qualifying event occurs. Furthermore, COBRA continuation coverage is not available to a qualified beneficiary even for that Plan Year unless the qualified beneficiary could become entitled to reimbursement for health care expenses incurred during the remainder of that Plan Year which exceeds the amount that he or she could be required to pay for COBRA continuation coverage under this Plan for the remainder of that Plan Year.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Department of Human Resources, Nazareth College of Rochester, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790 or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website www.dol.gov/ebsa.

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.

13. What happens if I take a leave of absence during the Plan Year?

A paid leave of absence is not itself a change in family status, so your *elections* will stay in place unless you have another reason to change them. However, a leave under the Family and Medical Leave Act or the Uniform Services Employment and Reemployment Rights Act is a change in status, so you may change your *elections* as explained in Question & Answer 9 (When can I change my elections?). Also, see Question & Answer 17 (What additional rights do I have as a participant?) for special rules applicable to a leave under the Family and Medical Leave Act.

14. Can the Employer amend or terminate the Plan?

The Employer can amend or terminate the Plan at any time, but will notify you in advance. Amendment or termination of the Plan will not affect your right to payment or reimbursement for expenses incurred before the date of the change.

15. Who controls the operation of the Plan?

A Committee appointed by the Employer controls and manages the operation of the Plan. The Committee decides all questions arising in the interpretation and application of the Plan, and may establish rules for the operation of the Plan.

16. What if I have questions about coverage or benefits, or want to make a claim for benefits?

You should contact the Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790 if you have questions about any insurance coverage sponsored by the Employer. Claims for insured benefits should be filed in accordance with the procedures applicable to the insurance coverage. See the Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790 if you need information on how to file a claim for an insured benefit.

You should contact the Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790 if you have questions about the operation of this Plan.

If you disagree with a decision concerning your right to participate in the Plan or wish to make a claim for a benefit, you may file a claim in writing with the Committee. If you wish, you may appoint someone to file the claim and act on your behalf, provided you give the Committee signed written notification of the appointment. The claim procedure is different depending on whether the claim is related to a health care expense or is any other type of claim. If any part of the claim is denied, the Committee will provide you with a written notice, within 30 days after the receipt of a health claim or 90 days after the receipt of any other type of claim. However, if an extension is necessary due to reasons beyond the Committee's control, the time to make the determination may be extended for up to another 15 days for a health claim or 90 days for any other type of claim. (If an extension for a health claim is necessary because additional information is needed from you, then you will be given 45 days from the date you receive the notice to

provide the information.) In any case, you will receive written notice of the reasons for the extension, any additional information required for the Committee to make the determination, and the date the determination is expected.

If a claim is denied in whole or in part, you will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (iv) a description of the Plan's review procedures and time limits; and (v) a statement that you have a right to sue following an adverse determination upon review. In the case of a health claim, the notice will also state the names of any medical care or vocational experts whose advice was obtained by the Plan in connection with the determination. If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

If a claim is denied and you want a review, you must notify the Committee in writing within 180 days after you receive the written notice of denial of health claim, or 60 days after you receive the written notice of denial of any other type of claim. You may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. You will be notified of the determination on review within 60 days after the Committee receives the request for review. A notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, you are entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; and (iv) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." If the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination on a health claim, the notice shall also contain the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request. If the determination on a health claim is based upon a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain an explanation of the

scientific or clinical judgment for the determination (applying the terms of the Plan to your medical circumstances), or a statement that such explanation will be provided free of charge upon request.

17. What additional rights do I have as a participant?

Federal law gives you rights with regard to coverage and certain specific benefits. The following is a summary of those rights.

Health Insurance Portability and Accountability Act of 1996 and Uniformed Services Employment and Reemployment Rights Act

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or the Uniformed Services Employment and Reemployment Rights Act (“USERRA”). Information concerning your HIPAA and USERRA rights is available from the Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York, 14618-3790.

Family and Medical Leave Act

If you are eligible for and take a leave of absence under the Family and Medical Leave Act (“FMLA Leave”), you may continue your Plan contributions during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave. Plan coverage will continue as if you were actively employed by the Employer until the earlier of the date (1) the FMLA Leave ends, or (2) you notify the Employer that you will not return to work. If you choose not to continue Plan coverage during an FMLA Leave, you may resume Plan contributions when you return to work (provided you return when the FMLA Leave expires).

Information concerning your right to and obligations during a leave is available from the Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790.

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act (“HIPAA”) regarding the use and disclosure of your protected health information (“PHI”). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care

provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan's privacy notice or more information about the Plan's privacy practices, or you want to file a privacy violation complaint, please contact the Assistant Director of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York, 14618-3790, phone (585) 389-2060, fax (585) 389-2063.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health coverage. If the Plan receives a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan's QMCSO procedures are available, without charge, from the Department of Human Resources, Nazareth College of Rochester, 4245 East Avenue, Smyth Hall #183, Rochester, New York 14618-3790.

Health Insurance Portability & Accountability Act

The health expense reimbursement portion of this Plan is subject to the health care privacy rules established by the Health Insurance Portability & Accountability Act of 1996 (the "HIPAA Privacy Rules"). The HIPAA Privacy Rules will apply to this portion of the Plan beginning on April 14, 2004, and will require this portion of the Plan to take certain precautions in using and disclosing specified information about your health and that of your dependents, and place limitations on the disclosure of such information to the College and other third parties. You can obtain more information from the HIPAA Privacy Notice that will be provided to you, or from the Plan's HIPAA Privacy Officer (identified in the HIPAA Privacy Notice). The healthcare plans (i.e., group health, dental, and vision plans) offered through this Plan are also subject to the HIPAA Privacy Rules. Again, you can obtain more information from the HIPAA Privacy Notice that will be provided to you by those plans in which you participate, or from the relevant plan's HIPAA Privacy Officer.

Your Rights Under ERISA

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

This includes the ability to:

- 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 and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- 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, if applicable.

Continue Group Health Plan Coverage

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

You may have a right to a reduction or elimination of exclusionary periods of health care coverage for preexisting conditions, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from the plan or health insurance issuer when you lose coverage, 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 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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits 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, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone

directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.