

**Summary Plan Description
of
Employee Benefit Programs**

January, 2006

Nazareth College of Rochester

Summary of Employee Benefit Programs

This booklet has been designed to provide a single source for administrative information and procedures concerning your current benefit programs. **This booklet, when combined with other descriptive materials for each plan, is intended as an informational summary; the plan documents for each program will govern in case of discrepancy. For information concerning eligibility and a summary of plan benefits, consult the descriptive brochures for each plan.** If, upon review of this material, you have any questions, contact the Department of Human Resources. The Plan Administrator has final and exclusive authority to decide all questions arising in connection with each plan.

Plan Administrator

The employer, Nazareth College of Rochester (the "College") will serve as Plan Administrator for all benefit programs contained in this booklet. The address is:

Nazareth College of Rochester
4245 East Avenue
Rochester, New York 14618-3790
(585) 389-2060

Employee & Employer Contributions for Welfare Benefit Plans

The benefit plan credits provided to you by the College will be based on the medical option you choose along with your life and may include a disability allocation, which is based on your salary. Your specific benefit credits and your specific cost for each benefit option are shown on your personal NazFlex Enrollment Form. Please refer to your current NazFlex Enrollment Form and Confirmation Form for specific benefit costs.

Eligibility for Benefits

Please see the descriptive materials for each individual plan for more information about the types of benefits provided. The information provided in the following paragraphs is intended as a general guide, and may not apply to a particular plan or your particular situation. Also, please note that some plans require you to pay some or all of the cost, and you may not be eligible to participate unless you make those payments.

Except as otherwise provided in each contract, a person is eligible to participate in the College's employee benefit programs if he or she is regularly in active employment of the College on a full-time basis. Unless otherwise provided in the relevant contract, participation in life insurance, major medical, basic medical plans, dental plans, the NazFlex plan, the Flexible Spending Account and the 20/20 Vision plan begins the first day of the month following hire date or transfer date to a benefit eligible class. Unless otherwise provided in the relevant contract, participation in the long-term disability plan begins one year from the date of hire or transfer to a benefit eligible class. Participation in the Travel Accident Plan commences on date of hire. Coverage under AFLAC and the Long Term Care Plan depends on the date you are enrolled in the Plan and begin paying premiums.

Participation in the TIAA/CREF Retirement Plan begins the first of the month following two years of service and attainment of age 21. Years of service with an institution of higher education will be counted for satisfying this requirement, provided the service was performed within the 60-month period immediately preceding employment with Nazareth College. You should refer to the Summary Plan Description for the purpose of determining how years of service is counted.

Please note that members of faculty with rank & time are eligible for the TIAA/CREF Retirement Plan, the TIAA/CREF Tax Deferred Annuity Plan, and the Life Insurance/Accidental Death & Dismemberment Plan.

Participation in the TIAA/CREF Tax Deferred Annuity Plan may begin the first of the month following employment.

Special Information About Group Health Plan Maternity Benefits

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

Special Information About Mastectomy-Related Mandated Benefits

Plans providing medical and surgical benefits with respect to mastectomies are required to permit a participant or covered dependent who undergoes a mastectomy to receive coverage for reconstruction of that breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Usual deductibles and coinsurance rules apply.

Special Information About the Health Insurance Portability & Accountability Act

The plans which provide health benefits are subject to special rules established by the Health Insurance Portability & Accountability Act of 1996 (the "HIPAA Rules"). The HIPAA Rules require these plans to take certain precautions in using, disclosing, transmitting and storing 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 by those plans in which you participate, or from the relevant plan's HIPAA Privacy Officer (identified in the HIPAA Privacy Notice).

HIPAA also established certain limits on group health plans' ability to deny coverage for pre-existing conditions, and gives you and your dependents the right to obtain evidence of your coverage under a group health plan when your coverage stops and under certain other conditions. You should review the descriptive materials for your group health plan coverage for more information.

Loss or Change of Benefits

Although the College expects to continue the benefit programs indefinitely, it reserves the right to amend, modify, or discontinue any or all plans at any time and for any reason. See the descriptions for each plan to determine whether there may be other circumstances which would cause change in or loss of your benefits.

Qualified Medical Child Support Orders and Qualified Domestic Relations Orders

A Qualified Medical Child Support Order ("QMCSO") is a court order for one parent to provide a child or children with health insurance. If the Plan Administrator receives a QMCSO for your child or children, the Plan Administrator will contact you concerning the relevant plan's procedures for such an order. You may also receive a copy of a plan's QMCSO procedures, free of charge, upon written request to the Plan Administrator.

A Qualified Domestic Relations Order (“QDRO”) is a court order awarding some or all of your retirement benefits to someone else (usually a spouse or child) pursuant to state domestic relations law. QDRO’s most often are used in connection with property settlements connected to divorce or separation, child support, or alimony obligations. If the Plan Administrator receives a QDRO relating to your retirement benefits, the Plan Administrator will contact you concerning the relevant plan’s procedures for such an order. You may also receive a copy of a plan’s QDRO procedures, free of charge, upon written request to the Plan Administrator.

How to File a Claim

You (or your beneficiary) should contact the Plan Administrator if you have any questions regarding a claim or need claim forms. Read the instructions on the forms carefully. Before returning the completed form, be sure that you have answered all questions and included any required attachments. After your claim has been processed, you (or your beneficiary) will be notified in writing if any benefits have been denied, in whole or in part, or if any additional information is required. You will generally be notified within 90 days from the date of your claim, 180 days if the Plan Administrator determines that more detailed review is necessary and notifies you of this decision. (A shorter timeframe may apply to group health or disability benefits.) The Plan Administrator may delegate claim-processing responsibilities to an insurer or other claims administrator. If your claim is denied, you will be provided with a detailed explanation and more information about what to do if you wish to appeal the claim.

Any special claims procedures applicable to a plan should be described in the description of that plan that has been provided to you, free of charge, along with this booklet. Please contact the Plan Administrator if you have any questions.

How to Appeal a Claim

If you (or your beneficiary) have any questions about a claim payment, see the Plan Administrator. If you do not agree with the reason why your claim was denied, in whole or in part, you should write within 60 days to the Plan Administrator. (You may have up to 180 days for appeals related to group health or disability benefits.) Be sure to state why you believe the claim should not have been denied and submit any data, questions or comments you think are appropriate. You have the right to review and receive copies (free of charge) of relevant documents and to submit issues and comments in writing. Your appeal will then be given a full and fair review. You will be notified of the final decision within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be notified within 120 days. (A shorter timeframe may apply to group health or disability benefits.)

If a plan has special appeals procedures, those procedures should be described in the description of that plan that has been provided to you, free of charge, along with this booklet. Please contact the Plan Administrator if you have any questions.

If you are not satisfied with the final decision and wish to review or receive copies (free of charge) of the documents pertinent to an appealed claim, you should write to the Plan Administrator. You will also have the right to file suit in a state or federal court if your claim is denied on appeal.

Special Information About Continuation of Group Health Plan Coverage

COBRA Continuation Coverage is the extension of health insurance coverage for a certain period of time. The law that requires Continuation Coverage to be offered is the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA may apply to you if you participate in one of the College’s medical plans. Information regarding COBRA Continuation Coverage is set forth in the COBRA rights description delivered to you at the commencement of your coverage. If you do not have a copy of that notice, you may receive a new copy, free of charge, by making a written request to the Plan Administrator. Please note that, under federal law, COBRA applies to you, your legal spouse, and your qualifying children

(as defined in the relevant health insurance plan). It does not apply to your domestic partner. Consult the descriptive materials for your health plan to determine whether your domestic partner may nonetheless be eligible for Continuation Coverage under the terms of your particular plan.

Briefly, COBRA allows you to elect to continue your health coverage, if you lose coverage due to termination of employment (other than for gross misconduct) or a reduction in hours. Your qualifying dependents may also elect to continue coverage, even if you do not. Your dependents also may elect COBRA coverage if they lose coverage due to your death or divorce or legal separation, your entitlement to Medicare, or if a dependent child ceases to be a dependent child for purposes of the relevant plan. Special rules apply to retirees and their surviving dependents.

You and your dependents have the obligation to notify the Plan Administrator of a marriage, divorce, legal separation, new birth or adoption, or other change that affects your dependents' eligibility for coverage (such as your dependent child becoming too old to continue coverage, or ceasing to be a full-time student) within 60 days of the date of the event (or the date your dependent would lose coverage in the absence of COBRA, if later). If you do not do so, you may lose your eligibility for COBRA coverage. Your notice must be in writing and mailed or hand-delivered to Human Resources at the Plan Administrator's address above. Your notice must include the name and Social Security number of the employee and the names of any affected dependents, must identify the event with respect to which the notice is being provided, and provide the date of the divorce, legal separation, new birth or adoption or other change.

COBRA coverage is generally available for 18 months from the end of your coverage if you or your dependents lose coverage due to your termination or reduction in hours. If you or one of your qualifying dependents is disabled (as determined by the Social Security Administration) at the time that you lose coverage or within 60 days thereafter and you satisfy certain administrative requirements, you may be eligible to extend coverage up to 29 months. In order to take advantage of this extension, you must notify Human Resources that the Social Security Administration has found you or one of your qualifying dependents to be disabled. Your notice must be in writing and mailed or hand-delivered to Human Resources at the Plan Administrator's address above within 60 days of the date of the determination (or the date on which you or your dependent would have lost coverage in the absence of COBRA, if later) and before the end of the 18 months of regular COBRA Continuation Coverage. Your notice must include the name and Social Security number of the employee along with the name of the disabled dependent, if any, and must be accompanied by a copy of the Social Security Administration's determination of disability. If the Social Security Administration later determines that you or your disabled dependent, as applicable, have ceased to be disabled, you must notify Human Resources in writing within 30 days of that determination. If you cease to be disabled, your coverage will end as of the first day of the month beginning 30 days after the Social Security Administration's determination that you or your dependent are no longer disabled or at the time your coverage would have ended had you or your qualifying dependent never become disabled, whichever is later.

If your dependents lose coverage due to your death, divorce or legal separation, or if a dependent child ceases to qualify as a dependent child, coverage is generally available for up to 36 months. If your dependents were receiving COBRA coverage for 18 or 29 months due to your termination of employment or reduction in hours and an event occurs that would entitle them to 36 months of coverage (e.g. you and your spouse divorce), your dependents must notify the Plan Administrator of that event as described above. If your qualifying dependents lose coverage because you became entitled to Medicare, they also may be eligible for coverage for up to 36 months. Special rules may apply to retirees and their surviving

dependents. In some circumstances, such as if you become covered under another comparable group health plan, you fail to pay your premiums on time, or if the College ceases to offer group health coverage, the COBRA coverage period may be shorter.

If you or your dependent(s) elect COBRA coverage, you are required to pay the full premium along with an additional charge. Generally, your payment will be 102% of the full group health premium, and you may be required to pay as much as 150% if you extend your coverage beyond the initial COBRA period due to disability.

You will be furnished a new COBRA notice and election forms at the time you lose coverage. Please contact the Plan Administrator promptly if you lose coverage and do not receive these documents, and make sure that you keep the Plan Administrator informed of current address information for you, your spouse, and your dependents. Generally, you only have 60 days in which to elect COBRA coverage. However, special rules may apply if your employment is adversely affected due to the effects of foreign trade, as described by the Trade Act of 2002. If you did not initially elect COBRA coverage but the Trade Act of 2002 applies, you may have a second chance to elect prospective COBRA coverage within 60 days of the date it is determined that the Trade Act of 2002 applies, if that occurs within six months of your original loss of coverage. At this time, the College does not expect any of the situations covered by the Trade Act of 2002 to occur, but you may obtain more information from the Plan Administrator if you are interested in finding out more about what rights you would have if the Trade Act does become applicable to you. Please contact the Plan Administrator if you have questions regarding COBRA eligibility or the election process.

Statement of ERISA Rights

As a participant in a Nazareth pension or welfare 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 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) 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) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plan must provide this statement free of charge.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- 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, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a pension or 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 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 domestic relations order or 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, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Address and Phone Numbers of Plans

The following insurance carriers administer the claims for benefits under their plans:

<u>Carrier</u>	<u>Type of Benefit(s)</u>
AFLAC New York 1 Marcus Blvd. Albany, NY 12205 (800) 366- 3435	Cancer Financial Protection
CNA Insurance Att: Group Long Term Care PO Box 946760 Maitland, FL 32794 (800) 266-2904	Long Term Care Insurance
Excellus Blue Cross Blue Shield 165 Court Street Rochester, NY 14647 (585) 325-3630	Health, Dental, Vision and Major Medical Insurance
The Hartford PO Box 2999 Hartford, CT 06104-2999	Travel Accident Insurance
INA Life Insurance Company of New York 140 East 45 th Street New York, NY 10017 (800) 732-1603	Life and Accidental Death/Dismemberment Insurance
Preferred Care 259 Monroe Avenue Rochester, NY 14607 (585) 325-3113	Health Insurance
Q Dental Group, PC 1100 Long Pond Road, Suite 115 Rochester, NY 14626 (585) 225-7790	Dental Insurance
The Standard Insurance Company of New York PO Box 5031 White Plains, NY 10602 (800) 426-4332	Long Term Disability Insurance
TIAA-CREF 730 Third Avenue New York, NY 10017 (800) 842-2776	Retirement and Tax Deferred Annuity Plans