

**Wraparound Summary Plan Description
for
Union College Business Travel Accident Plan**

Union College has a Business Travel Accident plan financed through a group insurance contract with Chubb who has developed a certificate to describe the coverage available under the plan. The certificate does not contain all the information that ERISA (Employee Retirement Income Security Act) requires for summary plan descriptions (SPDs). This “wraparound” SPD provides the missing information.

This wraparound SPD and certificate only describes the Union College Business Travel Accident Plan in a summary manner. The plan document for the Union College Business Travel Accident Plan governs the plan and includes more details on how it operates. If there is any conflict between (i) the wraparound SPD and certificate and (ii) the plan document, then the plan document will control. Participants and beneficiaries should not rely on any oral description of the plan because the written terms of the plan will always govern.

Plan Identification Information

Plan name:	Union College Business Travel Accident Plan
Plan number:	CHB 9906-00-92
Type of plan:	The group insurance plan provides business travel accident insurance and is considered a "welfare benefit plan" under ERISA.
Funding Medium:	The plan is insured by Chubb Policy Number: 9906-00-92 Effective Date: 3/1/05
Type of administration:	Chubb administers the group insurance contract. The Union College collects premiums and remits them to Aon Consulting, Inc.
Claims administrator:	Chubb Group of Insurance Companies 15 Mountain View Road, P.O. Box 1615 Warren, NJ 07061-1615
Plan year:	The plan year begins on 3/1 and ends on 2/28. The plan's financial records are based on the calendar year.
Plan administrator:	Union College 807 Union Street Schenectady, NY 12308

Plan Identification Information, continued

Union College who sponsors the plan:	Union College 807 Union Street Schenectady, NY 12308
Union College's EIN (Union College Identification Number):	14-1338580
Plan establishment:	Union College established the Business Travel Accident Plan for the exclusive benefit of its eligible employees March 1, 2005.
Wraparound SPD Revision Date:	This wraparound SPD was last revised on 8/22/05.

Coverage and Claims Procedures

Coverage. All claims for benefits under the plan are processed by Chubb under a group insurance contract. Chubb has developed a certificate that describes the coverage under the plan. The certificate also describes the rules determining eligibility to participate in the plan and eligibility to receive benefits from the plan. This wraparound SPD incorporates by reference the certificate. It is available on the Human Resources website.

Claims procedures. You must file claims for benefits under the plan with Chubb. The certificate describes the procedure for filing claims and the procedure for requesting a review of denied claims. As part of the claims administration process, Chubb will:

- pay claims for benefits due under the plan;
- provide written explanations of the reasons for denied claims;
- handle claimant requests for reviews of denied claims; and
- make the final decision on denied claims.

Under the Employee Retirement Income Security Act (ERISA) of 1974, you have the right to appeal a denied claim. Effective for claims submitted on or after January 1, 2002, the claim review procedures have changed for life, accident and disability plans.

See the following claims review charts:

Claims Review Chart	
Type of Claim	Steps to Take
OTHER CLAIMS	
IF YOUR CLAIM IS CORRECT AND COMPLETE OR NEEDS AN EXTENSION	
Other claims, including claims for Life Insurance, Accidental Death and Dismemberment Insurance, Travel Accident Insurance, Long Term Care Insurance	Step 1: The Plan has 90 days after receiving your initial claim to notify you if your claim is denied. If the Plan needs an extension for special circumstances and provides an extension notice during the initial 90-day period, the Plan has 180 days after receiving your claim to notify you if your claim is denied. (The time the plan waits for claimant information is not counted in totals.)
	Step 2: You have 60 days after receiving the claim denial to appeal the Plan's decision.
	Step 3: The Plan has 60 days after receiving your appeal to notify you of its appeal decision. If the Plan needs an extension, it has 120 days after receiving the appeal to notify you of its appeal decision.

Claim Denials. If your claim for benefits is wholly or partially denied, any claim denial notice under the plan will:

- state the specific reasons for the determination;
- reference specific plan provisions on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court.

If your claim for benefits is under a group disability policy or the disability waiver provision of a group life policy, the claim denial notice will also:

- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request).

Appeals. If you believe your claim was denied in error, you may appeal this decision to the plan. You have 180 days after receiving a disability claim denial (60 days for other claims) to appeal the plan's decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the plan will consult with a health professional with appropriate

training and experience. This health care professional will not be the individual who was consulted during the initial claim review or work under their authority. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If your appeal is denied, the denial notice will contain the following information:

- the specific reasons for the appeal determination;
- a reference to the specific plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about these procedures;
- a statement describing your right to bring a civil lawsuit under federal law;

If your claim for benefits is under a group disability policy or the disability waiver provision of a group life policy, the appeal denial notice will also include:

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request); and
- a statement that “You or 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.”

The appeal determination notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Contributions and Funding

Employee contributions. Union College pays the full cost for the plan.

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Funding. The plan is insured and unfunded. Union College sends the premiums to Chubb.

Role of Insurer. Chubb is responsible for investing the premiums and paying benefit claims. Chubb guarantees the payment of claims incurred before the group insurance contract terminates.

Plan Administration and Amendments

Named fiduciary and plan administrator. Union College is the named fiduciary and plan administrator authorized to control and manage the operation and administration of the plan. Union College, as named fiduciary, has allocated to Chubb responsibility for administering the plan's claims procedures and for exercising other fiduciary functions described in the certificate.

Plan interpretations. In exercising their fiduciary functions, the plan fiduciaries have discretionary authority to determine eligibility for benefits and to interpret the terms of the plan. Using their discretionary authority, the plan fiduciaries may correct defects, rectify any omission, or reconcile any inconsistency or ambiguity in the plan. This wraparound SPD does not constitute a contract of employment.

Plan amendments. Pursuant to the plan, Union College can amend or replace the group insurance contract through which benefit claims are paid under the plan. Union College also can amend the plan. Union College's decision to amend or replace the group insurance contract or to amend the plan is not a fiduciary decision that must be made solely in the interest of the employees, but is a business decision that can be made solely in Union College's interest. Plan amendments include amendments to terminate coverage for some or all employees. If the plan is terminated, the rights of a participant covered under the plan are limited to the payment of eligible expenses incurred prior to termination.

Information about sponsors of plan. Union College is the sponsor of the plan.

Rights Under Federal Law

Benefits under Family Medical Leave Act (FMLA). If your benefits are not maintained while you are on FMLA leave, upon return to work, you will be reinstated to the same level of benefits that you would have had if working continuously.

Mid-Year Changes Under Section 125 Plan. After the enrollment deadline has passed, you may make certain benefit changes during the year only if a change in status occurs (as outlined below). You must make the benefit change within 30 days of the change in status. Any change you make must be on account, and consistent with, the change in status.

Changes in status are:

- a change in your marital status (such as marriage, divorce, legal separation or annulment);
- a change in the number of your dependents for tax purposes (such as birth, legal adoption of your child, placement of a child with you for adoption, or death of a dependent);
- certain changes in employment status that affect benefits eligibility for you, your spouse or child(ren), such as: termination of employment, a strike or lockout, the start of or return from an unpaid leave of absence, a change in worksite, a change in work schedule (for example, between full-time and part-time work, decrease or increase in hours);
- a change in your, your spouse's or child's place of residence;
- a significant increase in the cost of coverage or a significant reduction in the benefit coverage under your or your spouse's plan;
- the addition, elimination, or significant curtailment of, a coverage option;
- a change in your spouse's or child's coverage during another Union College's annual enrollment period when the other plan has a different period of coverage;

For details about benefit options, restrictions and administrative considerations that apply for specific status changes, see **Appendix 1** at the end of this SPD or contact the Plan Administrator.

Rights under ERISA. As a participant in the Union College Business Travel Accident 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.

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 Union College, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare plan 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 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 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.

Appendix 1

Mid-Year Changes Under Section 125 Plans

The benefit elections you make when you enroll in **Union College's** programs will be in effect for the entire calendar year (or portion of the calendar year that remains, if you are a new employee), unless you have a qualified mid-year event. You will *not* be able to change your coverages unless you file a written request for a change with your Human Resource Department within 30 days of any of the following mid-year events:

1. Change in Status. If one or more of the following Changes in Status occur, you may revoke your old election during the year and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences which qualify as a Change in Status include the events described below, as well as any other events which the plan administrator determines are permitted under subsequent IRS regulations:

- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse);
- a change in the number of your dependents for tax purposes (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent);
- any of the following events that change the employment status of you, your spouse, or your dependent that affects benefit eligibility under a cafeteria plan (including this plan) or other employee benefit plan of yours, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching between salaried and hourly-paid, union and non-union, or part-time and full-time; incurring a reduction or increase in hours of employment; or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit;
- a change in your, your spouse's, or your dependent's place of residence.

If a Change in Status occurs, you must inform the plan administrator and complete a payroll deduction form within 30 days of the occurrence. Your coverage change will be effective on the date you notify the plan administrator. However, if your Change in Status is a birth, adoption, or placement for adoption of a Dependent child, coverage will be retroactively provided to the date of the event.¹

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The plan administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility. In addition, you must also satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Gain of Coverage Eligibility Under Another Employer's Plan*. For a Change in Status in which you, your spouse, or your Dependent gain eligibility for coverage under another Employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change

¹ *Note:* Union College may always provide retroactive coverage to employees, but it cannot take retroactive pretax contributions (other than for a change in status as a result of birth, adoption or placement for adoption).

in your, your spouse's, or your dependent's employment status, your election to cease or decrease coverage for that individual under the plan would correspond with that Change in Status *only* if coverage for that individual becomes effective or is increased under the other Employer's plan.

- For group term life insurance benefits, disability income coverage, and accidental death and dismemberment coverage, if you have a change in status, you may elect either to increase or decrease coverage.

2. Change in Cost. If the plan administrator notifies you that the cost of your coverage under the plan *significantly* increases during the plan year or there is a loss of coverage mid-year, you may choose either to make an increase in your contributions or revoke your election if there is no other plan option which provides similar coverage. You may also revoke your election if there is a *significant* curtailment that amounts to a loss of coverage and there is no other plan option which provides similar coverage. However, if there is a *significant* curtailment that does not amount to a loss of coverage, you may not drop your coverage but only switch to a similar coverage. If the cost of coverage under the plan *significantly* decreases, all eligible employees, even those who previously did not participate in the cafeteria plan, may elect coverage under the plan. For *insignificant* increases or decreases in the cost of benefits, however, the plan administrator will automatically adjust your election contributions to reflect the minor change in cost.

3. Change in Coverage. If the plan administrator notifies you that your coverage under the plan is significantly curtailed you may revoke your election and elect coverage under another plan option which provides similar coverage. Also, if during the plan year the plan adds or eliminates a coverage option, you may elect the newly-added option or elect another plan option (when a plan option has been eliminated), and may do so on a pre-tax basis by making a corresponding election change under another plan option which provides similar coverage. Additionally, you may make an election change when there is a significant improvement in coverage provided under an existing benefit option. Further, you may make an election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's, or dependent's employer, so long as: (a) his or her employer's plan permits its participants to make an election change permitted under the IRS regulations; or (b) this plan permits you to make an election for a period of coverage which is different from the period of coverage under his or her employer's plan.

Appendix 2

Copy of Insurance Certificate – See Union College Human Resources website.