

UNION COLLEGE
RETIREE HEALTH REIMBURSEMENT ARRANGEMENT
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

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ARTICLE I INTRODUCTION

1.1 Establishment and Purpose of Plan

This Plan is intended to permit all Participants to obtain non-taxable reimbursement of certain Medical Care Expenses incurred by the Participant, as applicable.

1.2 Legal Status

This Plan is intended to qualify as an employer-provided health reimbursement arrangement, as defined under IRS Notice 2002-45, under Code §§ 105 and 106 and regulations issued thereunder, as well as a “retiree-only” plan exempt from certain provisions of the ACA and will be interpreted to accomplish that objective. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants’ gross income under Code § 105(b). However, the Code requires that Medical Care Expenses reimbursed under the Plan which are attributable to a Domestic Partner or the child of a Domestic Partner shall be included in the Eligible Retiree’s gross income unless the Domestic Partner and/or the child of the Domestic Partner is the Eligible Retiree’s Dependent as defined below.

ARTICLE II DEFINITIONS

2.1 Definitions

“**ACA**” means the Affordable Care Act, which is comprised of the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and any subsequent amendments, and regulations promulgated pursuant thereto.

“**Benefits**” means the reimbursement of Medical Care Expenses described under Article VI.

“**Claimant**” means a Participant, or an authorized representative acting on behalf of a Participant, asserting a claim for eligibility or benefits.

“**Code**” means the Internal Revenue Code of 1986, as amended, and regulations promulgated pursuant thereto.

“**Dependent**” means a dependent of an Eligible Retiree who is (1) a dependent as defined as in Code §152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof, and (2) any child of the Participant to whom IRS Revenue Procedure 2008-48 applies (regarding certain children of divorced or separated parents who receive more than half of their support for the calendar year from one or both parents and are in the custody of one or both parents for more than half of the calendar year).

“Domestic Partner” means any person who meets the definition of a domestic partner of an Eligible Retiree as set forth in the records of the Employer. To qualify as a Domestic Partner under this Plan, the Eligible Retiree and his/her Domestic Partner must also fulfill any additional criteria required by the Employer.

“Effective Date” of this Plan is January 1, 2018.

“Eligible Retiree” means an individual who retired from employment with the Employer with the required years of service as set forth in the Employer’s Retirement Policy or who is considered “grandfathered” on a list maintained by the Employer’s Human Resources Department.

“Employer” means Union College.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended, and regulations promulgated pursuant thereto.

“Group Health Plan” means the Employer’s active employee group health plan.

“Health Reimbursement Account” means the account described in Section 5.4.

“Highly Compensated Individual” means an individual defined under Code § 105(h), as amended, as a “highly compensated individual” or “highly compensated employee.”

“HRA” means a health reimbursement arrangement as defined in IRS Notice 2002-45.

“Medical Care Expense” has the meaning defined in Section 5.2.

“Participant” means an individual who is an Eligible Retiree, Spouse, Domestic Partner and/or Dependent and who is participating in this Plan in accordance with the provisions of Article III.

“Period of Coverage” means the Plan Year, with the following exceptions: (a) for an individual who first become a Participant, it will mean the portion of the Plan Year following the date participation commences, as described in Section 3.2; and (b) for Participants who terminate participation, it will mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.3. A different Period of Coverage may be established by the Plan Administrator and communicated to Participants.

“Plan” means the health reimbursement arrangement set forth in this document, as amended from time to time.

“Plan Administrator” means the Plan Administrator as that term is defined under ERISA. The Plan Administrator is the Employer.

“Plan Year” means January 1 through December 31 of each calendar year.

“Retirement Policy” shall mean the policy established by the Employer that sets forth eligibility for Benefits under this Plan.

“Spouse” means an individual who is legally married to an Eligible Retiree as determined under federal law. The definition of “Spouse” shall also include a surviving spouse of a deceased Participant who meets the requirements of a Spouse under the Plan.

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual shall be eligible to participate in this Plan for purposes of reimbursement of Medical Care Expenses if the individual:

- satisfies the definition of a Retiree, Spouse, Domestic Partner or Dependent; and
 - in lieu of electing COBRA under the Group Health Plan, remains enrolled in the Group Health Plan for retiree coverage; or
 - in lieu of electing COBRA under the Group Health Plan, is enrolled for health plan coverage through Mercer Marketplace 365 or is enrolled in an individual AARP plan facilitated by the Employer prior to January 1, 2018.

3.2 Entry Date

An individual will become eligible to participate in the Plan, for the Benefits specified, on the effective date if he/she has satisfied the eligibility requirements on or before such date, or as of the first of the month following the date the individual satisfies the eligibility requirements of the Plan.

3.3 Termination of Participation

A Participant shall no longer be entitled to receive Benefits upon the earlier of:

- Upon the Eligible Retiree’s attainment of age 65 or Medicare-eligibility of a Spouse, Domestic Partner or Dependent, an individual’s failure to enroll for health plan coverage on the Mercer Marketplace 365 (unless enrolled in an individual AARP plan facilitated by the Employer prior to January 1, 2018);
- an individual’s disenrollment from the Mercer Marketplace 365 (as applicable);
- an individual’s disenrollment from the Group Health Plan (as applicable);
- the date the individual opts out of coverage as provided in Section 3.4;
- the date the Eligible Retiree is rehired by the Employer as an active employee (in such case coverage also terminates for a Spouse, Domestic Partner and/or Dependent);

- a Dependent no longer satisfying the definition of Dependent under the Group Health Plan;
- the termination of this Plan; or
- the individual's death.

3.4 Opt Out/ Opt In

The Employer will permit a Participant to temporarily waive or opt out of participating in the Plan by notifying the Plan Administrator in writing. If a Participant opts out of participating in the Plan, the Employer will discontinue contributions to the Plan for that Participant. Reimbursements from the Health Reimbursement Account after termination of participation will be made pursuant to Section 5.7 (relating to a run-out period for submitting claims incurred prior to termination and relating to continuation coverage).

The Employer will also permit the Participant to temporarily waive and opt out of reimbursements under the Plan.

A Participant will be entitled to opt back into the Plan under the following circumstances:

- An Eligible Retiree's coverage under the Plan was terminated due to he or she being rehired by the Employer and then such individual becoming an Eligible Retiree again after reemployment terminates; or
- A Participant's coverage terminated due to inadvertent or involuntary failure to pay any required premiums and new coverage is obtained at next available date.

3.5 Resumed Participation Following Loss of Eligibility

If a Participant terminates his or her participation in the Plan and then is reinstated as a Participant under the Plan as permitted under Section 3.4, such individual's coverage under the Plan will be reinstated with the same Health Reimbursement Account balance and cumulative Benefits paid toward the Plan limits that such individual had before termination.

3.6 Individual Accounts/Reimbursement of Medical Care Expenses

The Employer contributions provided under this Plan shall be contributed to a separate account for each Participant covered under the Plan. The balance in an individual Participant's account shall be used to reimburse only his or her own share of Medical Care Expenses.

ARTICLE IV
BENEFITS OFFERED AND METHOD OF FUNDING

4.1 Benefits Offered

When an eligible individual becomes a Participant in accordance with Article III, a separate Health Reimbursement Account will be established for each individual eligible to receive Benefits in the form of reimbursements for Medical Care Expenses as described in Article V. In no event will Benefits be provided in the form of cash or any other taxable or nontaxable benefit.

4.2 Employer and Participant Contributions

(a) *Employer Contributions.* The Employer funds the full amount of the Health Reimbursement Accounts.

(b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan.

(c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan, nor will salary reduction contributions or employer contributions under a cafeteria plan be treated as Employer contributions to the Plan.

4.3 Funding This Plan

All of the amounts payable under this Plan will be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any individual, and no Participant, individual or other person will have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

ARTICLE V
HEALTH REIMBURSEMENT ARRANGEMENT BENEFITS

5.1 Benefits

The Plan will reimburse eligible individuals for their Medical Care Expenses up to the Plan limits (Maximum Benefit), as well as any supplemental contribution for Catastrophic Medicare Part D, as applicable and provided for under this Plan. Reimbursement for Catastrophic Medicare Part D shall not be subject to the Maximum Benefit under the Plan.

5.2 Eligible Medical Care Expenses

Under the Health Reimbursement Account, eligible Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage, subject to the Maximum Benefit.

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan or after a Participant terminates participation are not eligible. No expense will be reimbursed before it is actually incurred.

(b) *Medical Care Expenses.* “Medical Care Expense” means those expenses incurred by a Participant for services and items which are set forth below and which are expenses incurred for medical care, as defined in Section 105(b) of the Code, as applicable. Except for Catastrophic Medicare Part D coverage which shall be reimbursed through a supplemental contribution made by the Employer, reimbursements due for Medical Care Expenses incurred by the Participant will be charged against the Participant’s Health Reimbursement Account.

“Medical Care Expenses” include -

For eligible Participants:

- who are Eligible Retirees under age 65 or a Spouse, Domestic Partner or Dependent who is not Medicare-eligible -
 - reduction of Group Health Plan premiums;
- who are Eligible Retirees over age 65 or a Spouse, Domestic Partner or Dependent who is Medicare-eligible –
 - Individual health insurance premiums for health plan coverage obtained on the Mercer Marketplace 365 or for an individual AARP plan facilitated by the Employer prior to January 1, 2018;
 - Reimbursement of Medicare Part D Premiums, provided eligible Participant –
 - Enrolled in medical and Medicare Part D through Mercer Marketplace 365; or
 - Enrolled in AARP medical plan facilitated by the Employer prior to January 1, 2018 and purchased Medicare Part D (Medicare Part D does not need to be secured through Mercer Marketplace 365 to have premium reimbursed);
 - Code Section 213(d) medical expenses; and
 - Catastrophic Medicare Part D coverage.

(c) *Medical Care Expenses Exclusions.* “Medical Care Expenses” will not include any expense that is not specifically listed above as a covered expense for this Plan.

(d) *Cannot Be Reimbursed From Another Source.* Medical Care Expenses may be reimbursed from this Plan only to the extent that the Participant incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through any other source, after considering the coordination of benefits rules in Section 5.10. If only a portion of a Medical Care Expense has been reimbursed elsewhere (i.e., because other insurance imposes deductible or coinsurance limitations), the Health Reimbursement Account may reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article V.

5.3 Maximum Benefits

(a) *Maximum Benefits.* The maximum dollar amount that may be reimbursed under this Plan with respect to certain services within a Period of Coverage is the Participant's account balance reduced by amounts reimbursed under the Plan during the Plan Year

(b) *Changes.* Notwithstanding Section 8.2, the annual maximum dollar limits, contribution amounts and the type of reimbursable expenses under the Plan may be changed by communicating to Participants through a summary of material modification, or another communication, without the need for a formal amendment to this Plan.

(c) *Nondiscrimination.* Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Plan Administrator in its sole discretion.

5.4 Establishment of Account

The Plan Administrator will establish and maintain a Health Reimbursement Account for each Participant, but will not create a separate fund or otherwise segregate assets for this purpose. The Health Reimbursement Account is solely a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) *Crediting of Accounts.* A Participant's Health Reimbursement Account will be credited as set forth below. An amount will be credited only if the Participant is eligible at the time such amount is scheduled to be contributed by the Employer.

For Eligible Retirees who retired from the Employer on or after January 1, 2018:

- An Eligible Retiree shall receive a one-time, lump sum Employer contribution. Any eligible Spouse/Domestic Partner and/or eligible Dependent shall each receive a one-time, lump sum Employer contribution equal to 50% of the amount contributed for the Eligible Retiree. The amount of the Employer contribution shall be set by Employer and shall be communicated to each Eligible Retiree by the Employer's Human Resources Department.

For Participants who enrolled in the Group Health Plan, the Employer will self-administer the Employer contribution by applying available funds, until exhausted, toward the full premium cost of medical insurance under the Group Health plan. Thereafter, the Eligible Retiree, eligible

Spouse/Domestic Partner and/or eligible Dependent will be responsible for the full cost of coverage. In the event any funds remain in a Participant's individual account under the Plan upon an Eligible Retiree attaining age 65 or the Medicare-eligibility of a Spouse, Domestic Partner or Dependent, such balance will be contributed to a Health Reimbursement Arrangement (HRA) administered by Mercer Marketplace 365 and available for reimbursement as set forth below.

For Eligible Retirees who have attained age 65 or a Medicare-eligible Spouse, Domestic Partner or Dependent, the Employer will contribute the Employer contribution to a Health Reimbursement Account (HRA) administered by Mercer Marketplace 365 for reimbursement of eligible Medical Care Expenses set forth in Section 5.2.

For Eligible Retirees who retired from the Employer prior to January 1, 2018:

Such Eligible Retiree, eligible Spouse/Domestic Partner and/or eligible Dependent (as applicable) shall be given the option of electing the one-time, lump sum Employer contribution set forth above reduced by any amount he/she already received from the Employer as a medical insurance premium subsidy as a Retiree, provided the eligible Participant has not already received Employer contributions equal to more than the lump sum, or continue with the following Employer contribution for reimbursement of Medical Care Expenses, as applicable:

- For Eligible Retirees who retired prior to January 1, 1996, an annual Employer contribution that will be trended forward based upon Milliman's projected health care trend rates for post-65 retirees. The dollar amount of the annual contribution can be obtained by Eligible Retirees by contacting the Mercer Marketplace 365.
- For Eligible Retirees who retired on or after January 1, 1996 but before January 1, 2018, a monthly Employer contribution equal to \$65.00 per month. If such Eligible Retiree has an eligible Spouse/Domestic Partner and/or eligible Dependent covered by the Plan, such individuals shall each also receive a monthly Employer contribution equal to \$65.00 per month.

(b) *Debiting of Accounts.* Except as provided in Section 5.2 with respect to Catastrophic Medicare Part D coverage, a Participant's Health Reimbursement Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses, as applicable, incurred during the Period of Coverage.

(c) *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount credited to the Participant's Health Reimbursement Account under subsection (a) reduced by prior reimbursements debited under subsection (b).

5.5 Carryover or Forfeiture of Accounts

If any balance remains in the Participant's Health Reimbursement Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, then any unused amounts may be carried over into the next Period of Coverage. Further, upon loss of eligibility under the Plan, a Participant forfeits his entire Health Reimbursement Account and cannot be reimbursed for Eligible Expenses incurred after loss of eligibility, unless he/she opts back into the Plan in accordance with Sections 3.4 and 3.5. Notwithstanding the foregoing, the following shall apply in the event of loss of eligibility due to the death of a Participant:

- In the event of the death of the Eligible Retiree, any lump-sum amount contributed to the Eligible Retiree that remains in the Eligible Retiree's Health Reimbursement Account shall be available for reimbursement of Medical Care Expenses of an eligible surviving Spouse or Domestic Partner. If no surviving Spouse or Domestic Partner, the balance shall be available for reimbursement of Medical Care Expenses of an eligible surviving Dependent. In the event of no surviving Spouse, Domestic Partner or Dependent, the balance shall revert back to the Employer. The death of the Eligible Retiree will not cause a Spouse, Domestic Partner or Dependent to stop any monthly Employer contribution he/she is receiving under the plan so long as he/she remains otherwise eligible to receive such Employer contribution.
- In the event of the death of the eligible Spouse, Domestic Partner or Dependent, the Eligible Retiree retains the balance of any lump-sum contribution that remains in the Health Reimbursement Account.
- In the event of the death of the eligible surviving Spouse, Domestic Partner or Dependent, following the death of the Retiree/Eligible Retiree, any remaining Health Reimbursement Account balance shall revert back to the Employer.
- In the event a Dependent loses eligibility under this Plan, all Employer contributions will cease and any remaining Health Reimbursement Account balance shall revert back to the Employer unless the Dependent elects COBRA.

In the event of the marriage of a surviving Spouse or Domestic Partner, the full Health Reimbursement Account balance shall remain with the surviving Spouse or Domestic Partner.

In the event of divorce between the Eligible Retiree and the eligible Spouse, or the end of a domestic partnership between the Eligible Retiree and the eligible Domestic Partner, each Participant shall retain his/her full Health Reimbursement Account balance.

Any Health Reimbursement Account payments that are unclaimed (e.g., uncashed Benefits checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred will be forfeited.

5.6 Claims Submission (For Certain Medical Care Expenses)

(a) *Timing.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Plan Administrator in such form as the Plan

Administrator may prescribe by no later than the March 31st following the end of the current Plan Year. Within a reasonable period of time, but not more than 30 days after receipt by the Plan Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Plan Administrator approves the claim), or the Plan Administrator will notify the Participant that his claim has been denied. The 30-day time period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a reimbursement claim is incomplete. The Plan Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim. See Appendix A for details regarding the Claims Procedures. Additionally, please refer to the Mercer Marketplace 365 HRA Instruction Guide.

(b) *Claims Substantiation.* The application for Benefits must set forth:

- the individual(s) on whose behalf Medical Care Expenses have been incurred;
- the provider or insurance carrier;
- the nature and date of the Medical Care Expenses so incurred;
- the amount of the requested reimbursement;
- the proof of payment;
- the Participant's affirmation that such Medical Care Expenses have not otherwise been reimbursed; and
- a copy of the bill, explanation of benefits, receipt, pharmacy statement and/or other documentation from an independent third party supporting the reimbursement.

(c) *Claims Denied.* For reimbursement claims that are wholly or partially denied, see the appeals procedure in Appendix A.

5.7 Reimbursements After Termination; Continuation Coverage

When a Participant ceases to be a Participant under Section 3.3, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim by the March 31st following the end of the current Plan Year. The deadline may be extended by the Plan Administrator if, through no fault of the Participant, the application for reimbursement is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late applications for reimbursement will not be accepted if they are filed more than two years from the date the services

relating to the application for reimbursement were performed or the event that gave rise to the benefit occurred. In the case of deceased Participants, the deadline may be extended by the Plan Administrator in its sole discretion by up to 12 months if the estate could not have reasonably submitted the claim by the deadline.

If applicable, extended continuation coverage shall also be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

5.8 Named Fiduciary

The Plan Administrator is the named fiduciary for the Plan for purposes of ERISA §402(a).

5.9 Compliance with Laws Applicable to Group Health Plans

Benefits shall be provided in compliance with the Code, ERISA, COBRA, ACA, and other laws governing group health plans and the Plan shall be interpreted in a manner to effect compliance with such laws.

5.10 Coordination of Benefits

Benefits under this Plan are solely intended to reimburse Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible reimbursement is payable from another source, this Plan will pay or reimburse prior to payment or reimbursement from the other source so long as the other source has not already reimbursed the Medical Care Expense, and so long as the coordination of benefits rules of that plan do not provide it would otherwise pay first. If a Participant receives benefits under the Plan and is subsequently reimbursed for the expenses from any other source at any time, the Participant shall remit these benefits to the Plan to the extent of the reimbursement.

5.11 Compliance with MMSEA Reporting

If the Plan is subject to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), the Plan Administrator or its delegate is the responsible reporting entity (“RRE”) for the Plan as that term is defined pursuant to Section 111 MMSEA. In order to fulfill its RRE obligation, the Plan Administrator or its delegate requires information from the Employer, including, but not limited to, Social Security Numbers of Participants. To the extent the Employer has not provided the required information, the Plan Administrator or its delegate shall notify the Employer and the Employer shall obtain the information from Participants that is required to be reported. In the event a Participant refuses to provide a Social Security Number, the Employer shall have the Participant sign the Centers for Medicare & Medicaid Services (CMS) refusal form, which allows individuals to explain their refusal to provide requested information, and shall return the signed form to the Plan Administrator or its delegate for its files. In the event the Participant refuses to sign the form, the Plan Administrator or its delegate may deny Plan eligibility.

**ARTICLE VI
CLAIM PROCEDURES**

6.1 Claim Procedures

If a claim for reimbursement under this Plan is wholly or partially denied, notice of that denial and appeals will be administered in accordance with the Claim Procedures set forth in Appendix A.

**ARTICLE VII
RECORDKEEPING AND ADMINISTRATION**

7.1 Plan Administrator

The administration of this Plan will be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

7.2 Powers of the Plan Administrator

The Plan Administrator will have such duties and powers as it considers necessary or appropriate to discharge its duties. It will have the exclusive right to interpret the Plan and to decide all matters thereunder, including making factual determinations, and all determinations of the Plan Administrator with respect to any matter hereunder will be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator will have the following discretionary authority:

- (a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan;
- (b) to prescribe procedures to be followed and the forms to be used by Participants to submit claims pursuant to this Plan;
- (c) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;
- (d) to request and receive from all Participants such information as the Plan Administrator will from time to time determine to be necessary for the proper administration of this Plan;
- (e) to furnish each Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate;

(f) to receive, review, and keep on file such reports and information concerning the Benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including the Plan Administrator, legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

7.3 Reliance on Information Provided by Participants, Plan Advisors

The Plan Administrator may rely upon the information submitted by the Employer or a Participant as being proper under the Plan and will not be responsible for any act or failure to act because of a direction or lack of direction by the Employer or a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

7.4 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan will remain the obligation of the Employer.

7.5 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

7.6 Right to Recover Overpayments and Other Erroneous Payments

If, for any reason, any Benefits under the Plan are erroneously paid or exceeds the amount appropriately payable under the Plan, the Participant shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms

of the Plan, should not have been made, the Plan Administrator or the Employer (or designee) may recover that incorrect payment, whether or not it was made due to the Employer's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. If the Plan has paid Benefits and the Participant is subsequently reimbursed for the Medical Care Expense from another source, the Plan shall have the right to recover such payment from the Participant receiving the double recovery.

As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment; (b) as a reduction of the amount of future Benefits otherwise payable under the Plan; (c) as automatic deductions from pay; or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator. The Plan may also seek recovery of the erroneous payment or Benefits overpayment from any other appropriate party.

ARTICLE VIII GENERAL PROVISIONS

8.1 Expenses

All reasonable expenses incurred in administering the Plan are paid by the Employer.

8.2 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time and for any reason in writing.

8.3 Governing Law

This Plan will be construed, administered and enforced according to the laws of the State of New York to the extent not superseded by the Code, ERISA or any other Federal law.

8.4 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan will be construed, operated and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA will be deemed controlling, and any conflicting part, clause, or provision of this Plan will be deemed superseded to the extent of the conflict. Special rights under ERISA are described in Appendix B.

8.5 Maternity and Newborn Infant Coverage Statement

Under Federal law, a group health plans offering maternity or newborn infant coverage may not 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 normal vaginal delivery, or less than 96 hours

following a cesarean section, or require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the above periods. This requirement does not prevent an attending physician or other provider, in consultation with the mother, from discharging the mother or newborn child prior to the expiration of the applicable minimum period.

8.6 Women's Health and Cancer Rights Act

All group health plans and their insurance companies or health maintenance organizations that provide coverage for medical and surgical benefits with respect to a mastectomy must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. Group health plans, insurance companies, and HMOs may impose deductible or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductible and coinsurance are consistent with those established for other benefits under the plan or coverage.

8.7 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal, state, or local income tax purposes. It will be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for Federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

8.8 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant will indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

8.9 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan will not be alienable by the Participant by assignment or any other method and will not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

8.10 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

8.11 Gender and Number

Except when otherwise indicated by the context, any masculine terminology shall also include the feminine and the definition of any terms in the singular shall also include the plural.

8.12 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan will be controlling.

8.13 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan will be given effect to the maximum extent possible.

8.14 Administrative Information

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and Benefits. The Plan Administrator's failure to enforce any provision of the Plan will not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents.

APPENDIX A CLAIMS PROCEDURES

ELIGIBILITY CLAIMS PROCEDURES

Any Participant, or an authorized representative acting on behalf of a Participant, may assert a claim for eligibility. Throughout this section, any of these individuals are referred to generically as a “Claimant.”

The following procedures shall apply if a Claimant is inquiring about eligibility to participate in the Plan. These rules do not apply if a Claimant is also claiming the right to receive Benefits under the Plan rather than just inquiring about eligibility. If a Claimant is also filing a claim for Benefits, the Claimant shall use the Benefits Claims Procedures that follow.

A. Determination of Eligibility

A claim for eligibility must be submitted to the Plan Administrator in writing. The Plan Administrator will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may take an additional 90 days to decide the claim. If an extension is needed, the Plan Administrator will notify the Claimant, 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.

B. Notification of Adverse Claim Determination

If the claim is denied in whole or in part, the Plan Administrator will provide the Claimant, within the time period described above, with a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- references to the specific Plan provisions upon which the Benefits determination is based;
- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary; and
- a description of the Plan’s appeals procedures and applicable time limits, including the right to bring a civil legal action under ERISA (if applicable) if the claim continues to be denied on review.

C. Appeal of Adverse Claim Determination

If the claim for eligibility is denied by the Plan Administrator, the Claimant may submit a written appeal to the Plan Administrator requesting a review of the decision. The written appeal must be submitted within 60 days of the Claimant receiving the initial adverse

decision. The written appeal should clearly state the reason or reasons why the Claimant disagrees with the Plan Administrator's decision. The Claimant 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 eligibility. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

The Plan Administrator will generally decide an appeal within 60 days. If special circumstances require an extension of time for reviewing the claim, the Claimant will be notified in writing. The notice will be provided prior to the commencement of the extension, describe the special circumstances requiring the extension and set forth the date the Plan Administrator will decide the appeal, which date will be no later than 60 days from the end of the first 60-day period.

D. Notification of Decision on Appeal

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the adverse determination;
- references to the specific Plan provisions upon which the determination is based;
- a statement that the Claimant is entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to the Claimant's eligibility claim upon request; and
- a statement describing the voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA (if applicable).

BENEFITS CLAIMS PROCEDURES

Any Participant or beneficiary, or an authorized representative acting on behalf of a Participant or beneficiary, may assert a claim for Benefits. Throughout this section, any of these individuals are referred to generically as a "Claimant."

This procedure applies only to claims submitted for Benefits under the Plan. The Plan does not permit any rescission of coverage (as defined under the ACA), which would be subject to this procedure and to external review procedures, if the Plan were to permit rescissions.

Claimants who need assistance with a claim, appeal of a denied claim, or the external review process, may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

All claims and appeals under the Plan will be adjudicated in such a manner as to maintain the independence and impartiality of all those involved in making a Benefits decision. Decisions regarding the hiring, compensation, termination, promotion, incentives or other similar matters regarding any individual or organization making decisions in the claims and appeals process (such as a claims adjudicator, medical expert, or Independent Review Organization) will not be made based upon the likelihood that the individual or organization will support the denial of Benefits.

Certain aspects of the claims procedures apply only to Plans that are not grandfathered medical plans under 26 CFR § 54.9815-1251T and that are subject to the expanded claims procedure requirements under the ACA. Such provisions apply only to the extent mandated by the ACA, and in cases where the Department of Labor has indicated that there is a delayed enforcement deadline for a particular ACA requirement described in this section, the Plan Administrator may delay implementation of the particular delayed provision until the enforcement deadline.

The Plan will continue to provide coverage pending the outcome of an appeal, to the extent required by the ACA, in accordance with the requirements of 29 CFR 2560.503-1(f)(2)(ii), which generally provides that Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review.

I. Internal Review

A. Determination of Benefits

Claims must be submitted and substantiated in accordance with the terms of Section 5.6 of the Plan document. The Plan Administrator will notify the Claimant of the Benefits determination within a reasonable period of time after receiving the claim, but not later than 30 days after the claim is received. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Plan expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making a Benefits determination is tolled from the date the Plan Administrator sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

B. Notification of Adverse Claim Determination

If the Claimant's claim for Benefits is denied, in whole or in part, the Claimant will receive a written notice of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;

- sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;
- references to the specific Plan provisions upon which the Benefits determination is based;
- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for Benefits;
- a description of the Plan's internal appeals procedures, any applicable external review process, information regarding how to file an appeal, and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the Benefits determination, regardless of whether the advice was relied upon in making the Benefits determination;
- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim; and
- the contact information for the Employee Benefits Security Administration, any applicable office of health insurance consumer assistance, or ombudsman established under the Public Health Service Act.

The notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

C. Appeal of Adverse Claim Determination

If a claim for Benefits is denied, the Claimant may appeal the denied claim in writing to the Plan Administrator within 180 days after receiving the written notice of denial. The Claimant may submit with this appeal any written comments, documents, records and any other information relating to the claim. Upon request, the Claimant will also have access to, and the right to obtain copies of, all Plan documents, records and information relevant to the claim free of charge. The Claimant is entitled to review the Plan's claim file and to present evidence and testimony in support of his claim.

A full review of the information in the claim file and any new information submitted to support the appeal, including all comments, documents, records, and other information will be conducted. The claim determination will be made by the Plan Administrator. The individual making the decision on behalf of the Plan Administrator will not have been involved in the initial Benefits determination nor will the subordinate of the person making the initial determination. This review will not afford any deference to the initial claim determination.

If the initial adverse decision was based in whole or in part on a medical judgment, the Plan Administrator will consult a healthcare professional who has appropriate training and experience in the relevant field of medicine and who was not consulted in the initial adverse Benefits determination and is not a subordinate of the healthcare professional who was consulted in the initial adverse Benefits determination. If a healthcare professional is contacted in connection with the appeal, the Claimant will have the right to learn the identity of such individual.

D. Interim Notification of New Evidence or Rationale during pendency of Internal Appeal

If during the pendency of the claim or appeal the Plan obtains any new or additional evidence that is considered, relied upon, or generated by or at the direction of the Plan in connection with the claim, the Plan will provide the Claimant with the new or additional evidence at no cost as soon as possible and sufficiently in advance of the date when the Plan must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the Plan Administrator must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

E. Notification of Final Internal Decision on Appeal

After an appeal is filed, the Plan Administrator will respond to the claim within a reasonable period, but no more than 60 days after receiving Claimant's appeal request.

If the claim on appeal is denied in whole or in part, the Claimant will receive a written notification of the denial. The notice will be written in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the denial;
- sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;
- references to the specific Plan provisions upon which the Benefits determination is based;
- a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for Benefits;
- a description of any voluntary review procedures, internal appeals and the external review process, including information on how to initiate an appeal and applicable time limits;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request.
- if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the particular medical circumstances, or a statement that this will be provided free of charge upon request;
- identification of any medical or vocational experts whose advice was obtained in connection with the Benefits determination, regardless of whether the advice was relied upon in making the Benefits determination;
- the denial code and its corresponding meaning (if applicable), as well as a description of the Plan's standard, if any, that was used in denying the claim;

- a discussion of the decision to deny the claim;
- disclosure of the availability of, and the contact information for, the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793; and
- a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

The notice will also be written in a culturally and linguistically appropriate manner as defined by applicable regulations.

The Plan will provide the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, upon request as soon as practicable. The Plan will not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

II. External Review

Where the Code requires a determination of medical necessity regarding whether a particular item or service constitutes medical care under Code Section 105(b) and 213(d), the Plan Administrator shall not apply its own medical judgment, but rather shall defer to the following:

- With respect to any determination involving reimbursement of cost-sharing under the Employer's Group Health Plan, the Plan shall defer to the medical judgment exercised under the Employer's Group Health Plan, and if a Claimant seeks external review regarding the Employer's Group Health Plan's determination, to the determination of the Independent Review Organization utilized in those procedures.
- With respect to any determination involving reimbursement of Medical Care Expenses under Code Section 105(b) and 213(d) beyond cost-sharing under the Employer's Group Health Plan, then the Plan Administrator shall defer to the determination of the Participant's own physician regarding whether items or services are medically necessary, and the Plan Administrator's only role shall be to determine whether the Participant has submitted documentation from his or her own physician regarding whether the item or service constitutes medical care in the medical judgment of his or her own personal physician.
- In either case, no external review for such determinations is required because the Plan Administrator is not applying any medical judgment in the decision of the Claim.

The Plan does not permit rescissions of benefits, and therefore external review for such determinations is not applicable.

STATUTE OF LIMITATIONS AND EXHAUSTION OF ADMINISTRATIVE REMEDIES

All claims for Benefits must be submitted by the claims filing deadline specified under Section 5.6. This requirement may be waived by the Plan if, through no fault of the Participant, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances.

The Claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the Plan Sponsor, the Board of Trustees or any other person, with respect to a claim without first exhausting the claims procedures set forth above. A Claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in an appropriate court to review the Plan Administrator's decision on appeal, but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the decision on appeal.

Notwithstanding the previous paragraph, if the Plan fails to adhere to all of the requirements of the procedures set forth above for health Plan claims or rescissions of health Plan coverage, then to the extent mandated by the ACA, the Claimant may initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA, but only if the action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the first anniversary of the Plan Administrator's decision on appeal. However, the Claimant cannot initiate an external review or bring an action in an appropriate court under state law or section 502(a) of ERISA without first exhausting the claims procedures set forth above if the violation by the Plan was:

- (a) De minimis;
- (b) Not likely to cause, prejudice or harm to the Claimant;
- (c) Attributable to good cause or matters beyond the Plan's control;
- (d) In the context of an ongoing good-faith exchange of information; and
- (e) Not reflective of a pattern or practice of non-compliance by the Plan.

Within 10 days of the Plan's receipt of a written request by the Claimant, a Claimant is entitled to an explanation of the Plan's basis for asserting that it meets the above exception that includes a specific description of its bases, if any, for asserting the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the requirements for the exception, then the Plan will provide the Claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim within a reasonable time after the external reviewer or court rejected the claim for immediate review (but not to exceed ten days). Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice

APPENDIX B
ERISA GENERAL INFORMATION AND STATEMENT OF RIGHTS

GENERAL INFORMATION

Formal Plan Name, Plan Number and Plan Type:

Plan No.: 505

Plan Name: Union College Retiree Health Reimbursement Arrangement

Plan Type: The Plan is a welfare benefit plan providing retiree medical reimbursement.

Employer/Plan Sponsor/Plan Administrator:

Union College
807 Union Street
Schenectady, NY 12308
(518) 388-6108

Plan Year:

The Plan year runs from January 1 to December 31.

Employer Identification Number:

14-1338580

Agent for Service of Legal Process:

The Plan Administrator is the Agent for Service of Legal Process.

Discretionary Authority:

The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.

The Plan Administrator has full discretionary authority to interpret the Plan and to determine all questions relating to the Plan as they relate to eligibility to participate in the Plan or the level of stipend offered under the Plan. The Plan Administrator may delegate decision-making authority.

Type of Funding, Administration and Source of Contributions:

Benefits are paid from the Employer's general assets. There is no trust or other fund from which benefits are paid.

Future of the Plan:

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the program at any time for any reason, including the right to change the classes of persons eligible for participation, the amount credited to Health Reimbursement Accounts or to reduce or eliminate any amounts currently credited to a Participant's Health Reimbursement Account. Participants have no vested rights to benefits under the Plan. 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 worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) (should it become necessary for the Plan to file a Form 5500), filed by the Plan with the U.S. Department of Labor.
- Obtain upon written request to the Plan Administrator copies of documents governing the administration of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (should it become necessary for the Plan to file a Form 5500) 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.

Prudent Action by Plan Fiduciaries:

In addition to creating rights for 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 in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance,

if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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. 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, 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 C COBRA RIGHTS

This Section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. Please be advised, the COBRA rights available under this Plan are not like COBRA rights under the Group Health Plan. To the extent you have a right to elect COBRA, the Human Resources Department will provide you with additional information.

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. For more information about your rights and obligations under the Plan and under federal law, you should review this SPD or contact the Plan Administrator.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” certain Participants in the Plan 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.

A Dependent will become a qualified beneficiary if he or she loses coverage under the Plan.

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 Union College, and that bankruptcy results in the loss of coverage of any Eligible Retiree covered under the Plan, the Eligible Retiree will become a qualified beneficiary. The Eligible Retiree’s Spouse and/or Dependent will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

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 employer must notify the Plan Administrator of the commencement of a proceeding in bankruptcy with respect to the employer.

When a Dependent loses eligibility for coverage as a dependent child, you must notify the Human Resources Department within 60 days after the qualifying event occurs.

How is COBRA continuation 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 a maximum of 36 months of coverage.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Human Resources Department. For more information about your rights under the Employee Retirement Income Security Act (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 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.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about 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.