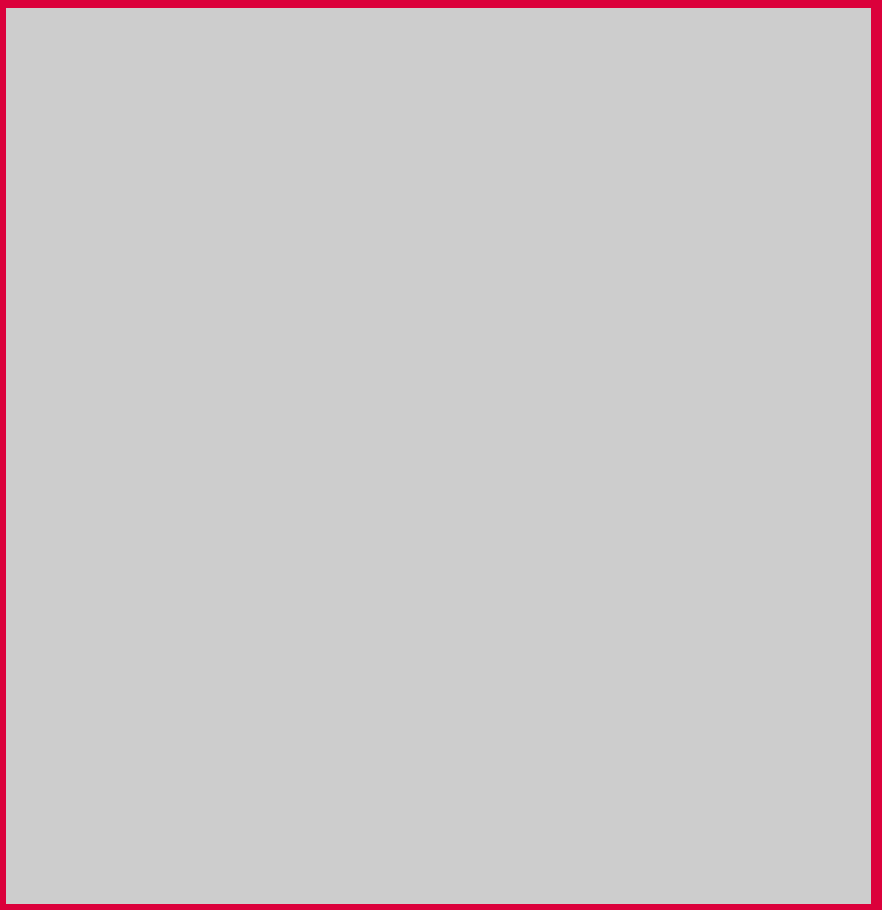
The Research Foundation

Benefits Handbook

Fall 2004



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GUIDE

The Research Foundation
of State University of New York

Guide to Using the Research Foundation *Benefits Handbook*

ABOUT THIS HANDBOOK

About the Research Foundation

The Research Foundation (RF) is a private, nonprofit educational corporation whose primary responsibility is the administration of externally funded contracts and grants for and on behalf of the State University of New York (SUNY). Since being chartered in 1951, the RF has facilitated research, education, and public service at 30 state-operated SUNY locations. The RF carries out its primary responsibilities pursuant to a 1977 agreement with SUNY.

The RF is separate from the university and does not receive services provided to New York state agencies or state appropriation to support corporate functions. The RF is responsible for its own financial, legal, and business systems, its personnel policies and employee fringe benefits program, and its payroll services. Employees of the RF are not indemnified under the New York State Public Officers Law, are not entitled to representation by the New York State Attorney General, and do not participate in the state's retirement and fringe benefits programs.

The RF provides high-quality, cost-effective services to SUNY campuses, campus-based foundations, affiliated corporations and other research foundations.

The RF assumes fiduciary responsibility for sponsored and agency fund activities on SUNY's behalf, in an environment in which the integrity of all is assumed and each individual is treated with dignity, respect, and fairness.

About the *Benefits Handbook*

Employee benefits represent an important part of your total compensation. Your Research Foundation *Benefits Handbook* provides a summary of each benefits plan and tells you where to find detailed information. This handbook, in combination with handbooks and certificates from the insurance companies, constitutes your summary plan description. The handbook aims to:

- Provide a comprehensive source of information about RF benefit plans and programs.
- Make your RF benefits plans and programs easier to access and understand when you need them most.
- Help you do personal benefits and financial planning.

Please retain this handbook for future reference and share it with your family.

The Research Foundation of SUNY may terminate, suspend, withdraw, amend, or modify the plans described in this handbook, in whole or in part, at any time. As the plan administrator, it has the discretionary authority necessary to administer these plans in accordance with their terms. This includes the power to interpret the plans, to construe any missing or disputed terms, to answer all questions that arise under the plans, to determine the eligibility of any person to participate in and/or to receive benefits under the plans, and to determine the amount of benefits due for self-insured plans. These decisions shall be final, conclusive and binding; shall be given deference in a court of law; and shall not be overturned unless found to be arbitrary and capricious.

This Benefits Handbook supersedes the Summer 1999 Benefits Handbook as well as all previous Research Foundation Benefits Handbooks and addenda. All previous handbooks and addenda issued by the Research Foundation are now void.

RESEARCH FOUNDATION BENEFIT PLAN GUIDELINES

The following rules apply in order for you to be eligible for Research Foundation benefits.

Benefit	Coverage Waiting Period	Eligible/Ineligible	Break-in-Service	When Coverage Ends	Coverage Cost
Health (Active Employees)	42 days Coverage begins on day 43 from date of employment or eligibility unless you have a break-in-service. Refer to pages 8 and 9 for late enrollment rules.	***Eligible*** An employee working at least 50 percent of full-time on a regular appointment ***Ineligible*** An employee working less than 50 percent of full-time or A summer-*only* appointment or A full-time SUNY employee or A full-time SUNY student working in one of the following titles: Project Instructional Assistant Research Project Assistant Research Aide Graduate Assistant	*Prior* to meeting the 42-day waiting period, if a break-in-service of any number of days occurs, a new waiting period must be met. *After* meeting the 42-day waiting period, if a break-in-service of more than 28 days occurs, a new waiting period must be met.	28 days after your employment or eligibility ends	The RF pays 90% of the cost for individual coverage and 75% of the cost for dependent coverage, however, the Foundation's contribution is limited to the amount it pays for the Regular Health Insurance Plan (PPO Plan). You pay the balance through biweekly payroll deductions.
Health (Retirees)	N/A	An employee who ■ is enrolled in RF Health Benefits (PPO or HMO) at the time he or she retires, *and* ■ has a minimum of 10 years of continuous, full-time equivalent service, *and* ■ is at least age 55.	*Prior* to meeting the eligibility criteria, if a break of 1 year or more occurs, a new service requirement must be met. Refer to *Chapter 9: Continuing Benefits.*	Refer to *Chapter 9: Continuing Benefits.*	Same as Health (Active Employees) for employees hired *after* January 1, 1986. There is no charge for employees hired before January 1, 1986. Refer to *Chapter 9: Continuing Benefits.*
Dental	***Preventive/Basic/Orthodontics*** 6 months ***Major and Prosthodontic*** 12 months Coverage begins 6 months from date of employment or eligibility for Preventive/Basic/Orthodontics and 12 months from eligibility for Major and Prosthodontic services. Refer to pages 8 and 9 for late enrollment rules.	Same as Health (Active Employees)	*Prior* to meeting the waiting period, if a break-in-service of 28 days or more occurs, a new waiting period must be met. *After* meeting the waiting period, if you become ineligible, but return to eligible employment *within 1 year,* coverage is reinstated on the date you return. If you return *after* a 1-year break-in-service, a new waiting period must be met.	28 days after your employment or eligibility ends	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.

Vision Care	6 months Refer to pages 8 and 9 for late enrollment rules.	Same as Health (Active Employees)	Same as Dental	28 days after your employment or eligibility ends	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
Basic Life (Accidental Death and Dismemberment)	6 months Enrollment in Basic Life is automatic after 6 months of eligible service. Refer to pages 8 and 9 for late enrollment rules.	Same as Health (Active Employees)	Same as Dental	On the day your employment or eligibility ends	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
Optional Life (Accidental Death and Dismemberment)	6 months Refer to pages 8 and 9 for late enrollment rules.	Same as Health (Active Employees)	Same as Dental	Same as Basic Life (above)	You pay for this benefit through biweekly payroll deductions.
Workers' Compensation	Coverage begins on the first day of active work. Income replacement benefits begin 7 days after the day the disability begins. If the disability extends beyond 14 days, income replacement benefits will be paid retroactive to the first day of the disability. Refer to *Chapter 7: Disability Plans* for detailed information.	All employees	N/A	On the last day of your employment	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
New York State Disability	None, if eligibility was established with previous employer. If eligibility was not previously established, coverage begins: ■ *After* 4 consecutive weeks of service for full-time employees. ■ *After* 25 regular work days for part-time employees. There is a 7-day waiting period before these benefits begin, starting with the first day you are unable to work because of your disability.	All employees	N/A	Coverage will continue for 4 weeks after your last day of employment. If you are covered by a new employer within that time period, your RF coverage will end.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
Long-Term Disability	Coverage begins on the first day of the month following 1 year of full-time service. Benefits begin on the first day of the month following 6 consecutive months of a certified total disability, or when full sick leave payments end, if later.	Full-time employees	*Prior* to meeting a 1-year waiting period, if a break-in-service of 4 months or more occurs, a new waiting period must be met. *After* meeting a 1-year waiting period, if you become ineligible, but return to eligible full-time employment *within 1 year*, coverage is reinstated on the day you return. If you return *after* a 1-year break-in-service, a new waiting period must be met.	On the last day of full-time employment	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.

HELP

Where to Get Help

The Research Foundation has contracts with the following companies to ensure your benefits and administer your claims, according to the terms of the plans as authorized by the Research Foundation. Contact these benefits administrators for information on service providers, claim reimbursement, or pension benefits. Contact your local Research Foundation office administering benefits for additional information, if you have questions on your benefits coverage or need enrollment forms.

COVERAGE	BENEFITS/CLAIMS ADMINISTRATOR	PHONE NUMBER	WEB SITE
Dental	Delta Dental of New York, Inc.	800-932-0783	www.midatlanticdeltadental.com
Health Maintenance Organizations (HMOs)	Various	Call your local HMO office.	
Life Insurance	Prudential Insurance Company of America	800-524-0542	www.prudential.com
Long-Term Disability	The Standard Life of New York	866-388-5660 Option 2	www.standard-ny.com/tiaa
New York State Disability	Zurich Insurance Company	Contact campus RF office.	www.wcb.state.ny.us/content/main/workers/wc06003.htm
Pension Benefits	TIAA-CREF	800-842-2776 *or* 800-842-2733	www.tiaa-cref.org
	Fidelity Investments	800-343-0860 *or* 888-836-7655	www.fidelity.com/atwork
Preferred Provider Organization (PPO)	Empire Blue Cross:		
	Member Services	800-342-9816	www.empireblue.com
	To locate providers in Eastern New York State, including downstate	800-342-9816	www.empireblue.com
	To locate providers in Central and Western New York State *or* outside New York State	800-810-BLUE *or* 800-810-2583	www.empireblue.com
	Mental Health or Substance Abuse	800-626-3643	
	Pre-certification	800-982-8089	
	Personal Health Advisor	877-TALK2RN	
Prescription Drugs (Research Foundation PPO Health Plan)	Mail Order: Medco By Mail	800-711-0917	www.medco.com
	Retail: Medco	800-711-0917	www.medco.com
Unemployment Insurance	New York State Department of Labor	Contact your local unemployment office.	www.labor.state.ny/business_ny/unemployment_insurance/uionline.html
Vision Care	Davis Vision	800-999-5431	www.davisvision.com
Workers' Compensation	Chubb Insurance Company	Contact campus RF office.	www.wcb.state.ny.us/content/main/workers/wc06002.htm
OTHER BENEFITS			
College Savings Program	Vanguard / U Promise	1-877-NYSAVES	www.nysaves.org
Consumer's Medical Resource (Assistance for Serious Illnesses)	CMR	1-888-4CMRHELP 1-888-426-7435	www.consumersmedical.com
Flexible Spending Accounts (Health Care) (Dependent Care)	Fringe Benefits Management Company	1-800-342-8017	www.fbmc-benefits.com
Group Long-Term Care	CNA	1-877-777-9072	www.ltcbenefits.com password: trfsunyltc

SUMMARY OF PLANS

Plan Name	Plan Number	Plan Type	Type of Administration	Funding	End of Plan Year
Health					
Health Insurance for Regular Employees	501	Preferred Provider Organization (PPO)	Group insurance contract with Empire HealthChoice	Insured	December 31
		Prescription drug benefits	Administrative services agreement with Medco Health	Self-insured*	December 31
		Health Maintenance Organizations	Insurance contracts with various health maintenance organizations	Insured	December 31
Dental Plan	504	Dental benefits	Administrative services agreement with Delta Dental of New York, Inc.	Self-insured*	December 31
Vision Care Plan	508	Vision care benefits	Vision care services agreement with Davis Vision	Self-insured*	December 31
Health Care Flexible Spending Account	N/A	Part of the RF Flexible Benefits Plan	Administrative services agreement with Fringe Benefits Management Company	Self-insured*	December 31
Life and Accidental Death and Dismemberment (AD&D) Insurance					
Basic and Optional Life Insurance	505	Life and AD&D insurance	Group insurance contract with Prudential Insurance Company	Insured	December 31
Disability Insurance					
Workers' Compensation Insurance	N/A	Disability insurance	Insurance contract with Chubb Insurance Company	Insured	June 30
New York State Disability Insurance	N/A	Disability insurance	Insurance contract with Zurich Insurance Company	Insured	June 30
Long-Term Disability Insurance	506	Disability insurance	Insurance contract with The Standard Insurance Company	Insured	December 31
Pension Benefits					
Basic Retirement Plan	001	Defined contribution	Retirement annuity contracts issued by Teachers Insurance and Annuity Association and College Retirement Equities Fund (TIAA-CREF)	Insured	December 31
Optional Retirement Plan	003	Tax-Deferred Annuity (TDA)	Retirement annuity contracts issued by TIAA-CREF	Insured and Custodial Accounts	N/A
		Group Supplemental Retirement Annuity (GSRA)	Retirement annuity contracts issued by TIAA-CREF	Insured and Custodial Accounts	N/A
		Tax-deferred mutual funds	Tax-deferred custodial accounts managed by Fidelity Investments	Custodial Accounts	N/A
New York State Unemployment Insurance	N/A	Unemployment insurance	Self-insured plan through New York State Department of Labor	Self-insured*	N/A
Dependent Care Flexible Spending Account	N/A	Part of the RF Flexible Benefits Plan	Administrative services agreement with Fringe Benefits Management Company	Self-insured*	December 31

Note: The Research Foundation of State University of New York, Post Office Box 9, Albany, NY 12201-0009, is the plan administrator for all plans. The telephone number for the corporate office for benefits administration is 518/434-7080. The executive vice president of the Research Foundation, at the above address, is the agent for service of legal process for all plans. The Research Foundation's Employer Identification Number is 14-1368361.

**"Self-insured" means that the Research Foundation assumes financial responsibility for claims payment from employer general assets.*

Chapter 1

General Information on Health, Dental, Vision Coverage and Flexible Spending Accounts

Chapter 1

General Information on Health, Dental, Vision Coverage and Flexible Spending Accounts

This section provides the following information about your health, dental, and vision coverage and flexible spending accounts:

- enrollment
- late enrollment
- exceptions to when coverage begins
- coverage (dependent eligibility, adding dependents, and exceptions)
- changing coverage
- waiving coverage
- Flexible Benefits Program (pretax health insurance contributions)
- open enrollment
- coordinating your benefits
- health insurance rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Details about each of your Research Foundation benefits are provided within the specific chapters of this handbook. Insurance contracts and plan documents are on file at the Research Foundation Central Office of Human Resources and are available for viewing during normal business hours. Copies will be provided upon request. A reasonable copying charge may be imposed.

Enrollment

Health (PPO Plan/HMO), Dental, Vision Care

Enrollment in health care plans is not automatic. You must enroll at the beginning of employment or at the time you become eligible. Complete, sign, and submit a Research Foundation Benefits Enrollment Form and an HMO enrollment form (if applicable) to your local Research Foundation office administering benefits.

During the first two pay periods after your enrollment takes effect, double deductions will be taken for premium contributions, in order to cover the 28-day extension of benefits which is provided when your employment terminates or drops below eligibility requirements.

Late Enrollment

Health (PPO Plan/HMO)

If you delay enrollment more than 60 days after you become eligible, you must wait an additional 5 pay periods, in active employment, to be covered (unless you have a special enrollment right. Refer to page 9). Your coverage will start on the first day of the fifth pay period following the day your local Research Foundation office administering benefits receives the completed RF Benefits Enrollment Form.

EXAMPLE OF LATE HEALTH ENROLLMENT

Appointment/eligibility date	January 10
42-day waiting period	February 21
60-day enrollment period	January 10 - March 10
Enrollment received	March 17
Date of coverage	May 16

Dental, Vision Care

If you delay enrollment in the Dental and Vision Care Plans beyond 60 days from your date of eligibility and you have met the 6-month waiting period, your coverage becomes effective on the day your local Research Foundation office administering benefits receives the completed RF Benefits Enrollment Form.

Special Enrollment Rights

You normally may enroll for health care benefits during either your initial enrollment period or the annual open enrollment period. For medical (PPO Plan/HMO) coverage (but not Dental, Vision Care or Health Care Flexible Spending Accounts), you also may have a special enrollment period based on rules enacted by the Health Insurance Portability and Accountability Act (HIPAA). These rules are summarized below. (The term "dependent" includes a spouse or domestic partner.)

Special enrollment following loss of other medical coverage

Enrollment of employee

You may enroll during a special enrollment period if you had other medical coverage when you previously declined medical coverage under this plan and:

- COBRA Coverage: If the other coverage was COBRA coverage, and that coverage has since been exhausted; or
- Non-COBRA Coverage: If the other coverage was not COBRA coverage, and either: (A) the other employer's contributions toward the other coverage have been terminated; or (B) the other coverage has been terminated due to loss of eligibility – for reasons including legal separation, divorce, death, termination of employment, or reduction in hours of employment.

A "loss of eligibility" does not include loss due to non-payment of premiums on a timely basis, or termination of the other coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Therefore, these circumstances do not give rise to a special enrollment period.

Enrollment of dependent

A dependent who previously was not enrolled because of having other coverage also may be enrolled if that coverage is lost (see above).

Enrollment of employee and dependent

You may enroll both yourself and your dependent if either of you had other coverage when you declined coverage under this Plan, and that coverage later is lost as explained above.

Special enrollment period following loss of other coverage

Coverage under the special enrollment rules must be elected within the 30-day period after the other coverage ends. The application must be made under the same application rules that apply to other enrollments. If elected, coverage begins on the first day of the calendar month that begins after the date that the completed request is received by the Plan.

Special enrollment with respect to certain dependents

Enrollment of dependents (and yourself)
You may enroll dependents in the health insurance plans – and yourself if you are not already enrolled – by complying with the Plan's procedures for other enrollments, if an individual becomes your dependent through marriage (the spouse and any eligible stepchildren), birth, adoption or placement for adoption. In the case where a child is born, adopted or placed for adoption, your spouse also may be enrolled during such a special enrollment period.

Time of enrollment after acquiring a dependent
The special enrollment period for dependents is the 30-day period that begins on the date of the marriage, birth, adoption or placement for adoption, as applicable. The coverage is effective (i) in the case of marriage, the date the completed request for enrollment is received by the Plan; (ii) in the case of a dependent's birth, the date of the birth; and (iii) in the case of adoption or placement for adoption, the date of such adoption or placement.

Exceptions to When Coverage Begins

Health (PPO Plan/HMO), Dental, Vision Care

If you are not actively at work on the day you complete the waiting period, your coverage begins on the day you return to work. This exception does not apply if the reason you are not at work is due to a medical condition. Refer to *Research Foundation Benefit Plan Guidelines* on pages 2-4 for waiting periods.

Note: Your dependent's coverage cannot begin before your coverage.

Coverage

Health (PPO Plan), Dental, Vision Care

Effective January 1, 2005, you may choose one of the following coverage levels or you may waive coverage:

- employee only
- employee and spouse
- employee and child(ren)
- family

Dependent eligibility rules for the Foundation's Preferred Provider Organization (PPO) Plan, and for Dental and Vision Care, are shown below. HMO dependent rules are similar, but check with your HMO for certain details.

Dependents

The following dependents can be included if you choose employee and spouse, employee and child(ren), or family coverage:

- spouse
- unmarried children up to 19 years of age (or up to 25 years of age if still your dependent, and a registered full-time student in an accredited college or university), as follows:
  - natural children
  - stepchildren
  - children supported by you through legal guardianship and living at your home
  - children legally adopted by or placed for adoption with you or your spouse
- unmarried children of any age incapable of self-support because of a mental or physical disability, who become disabled before reaching the limiting age (plan requires periodic medical documentation)

- domestic partner who is
  - age 18 or older, and
  - unmarried and not related to you by marriage or blood in any way that would bar marriage, and
  - residing with you, and
  - financially interdependent with you, and
  - involved in the domestic partnership for a period of not less than 1 year

  Documentation of the above must be approved by the Research Foundation.
- children of domestic partners

  To be eligible for coverage under your benefit plans, children of domestic partners must meet the plans' eligibility requirements, must reside in your household, and must receive 51 percent or more of their support from you.

Exception
If two family members work for the Research Foundation, both can have employee-only coverage, but only one can choose a higher level of coverage. You cannot be covered as an employee and as a dependent of another employee.

Adding dependents

If you add a dependent (for example, through marriage, birth, or adoption or placement for adoption) within 60 days from the day he or she becomes eligible, coverage is effective on the date of his or her eligibility.

If you add a dependent after 60 days from the day he or she becomes eligible, coverage will begin on the first day of the fifth pay period from the date your local Research Foundation office administering benefits receives the new enrollment form, unless a special enrollment right applies *(see page 9)*.

Note: The Research Foundation is required by law to permit employees subject to a child medical support order to enroll dependent children in a health care plan without regard to late enrollment restrictions.

Changing from one coverage level to another – Health (PPO Plan/HMO)

Pretax health insurance deductions
You may change your health benefit coverage level anytime during the year, subject to a 5 pay-period wait unless you have a qualifying event *(see page 13)*. However, if your health benefit premium contributions are being deducted from pay on a pretax basis *(see page 12)*, then the change to the pretax deduction may only be made at open enrollment, unless you have a special enrollment right or other qualifying event. If you add dependents without a qualifying event, the employee portion of the premium will remain pretax and the dependent portion will be an after-tax deduction until the next plan year. You must complete and submit a new RF Benefits Enrollment Form to your local Research Foundation office administering benefits. (You must complete an additional enrollment form if you have HMO coverage.)

You may not change your dependent coverage pretax deduction to an individual pretax deduction during the year unless you have a qualifying event. Refer to the definition and list of qualifying events on page 13 and to Flexible Benefits Program information on restrictions in changing from family to individual coverage on page 12.

Aftertax health insurance deductions

If your health insurance deductions are being taken on an *aftertax* basis, you may change your coverage level anytime during the year, but coverage is subject to a 5 pay-period wait unless you have a qualifying event *(see page 13)*. If that is the case, you may change coverage anytime during the year. The change is effective the first day of the next pay period following receipt of the newly completed enrollment form by your local Research Foundation office administering benefits.

Changing from one coverage level to another – Dental, Vision Care

If you wish to change your coverage level, you must complete and submit a new RF Benefits Enrollment Form to your local Research Foundation office administering benefits. You may change coverage anytime during the year. Your new coverage will become effective on the day your local Research Foundation office administering benefits receives your completed form.

If the change involves a newly eligible dependent (for example, as a result of marriage), dependent coverage becomes effective on the date the dependent became eligible, provided a new enrollment form is completed within 60 days of this date.

Waiving coverage – Health (PPO Plan/HMO)

You may waive health insurance coverage at the time of employment or eligibility by checking the "I decline coverage" box in Part B of the RF Benefits Enrollment Form.

You may change from waiver of coverage to coverage anytime during the calendar year, but you must wait 5 pay periods in active employment for coverage to begin, unless you have a qualifying event *(see page 13)*.

Flexible Benefits Program (Pretax Health Contributions)

Under the Research Foundation's Flexible Benefits Program, you may pay your share of the health insurance premium with *pretax* earnings. This means that your contribution toward health insurance will reduce your taxable income by that amount, thereby reducing your federal and state income and Social Security taxes.

Participation in this program is automatic, unless you decline this option by signing a waiver form. This benefit is made available by the Foundation under Section 125 of the Internal Revenue Code.

Salary increases, life insurance, retirement contributions, and disability benefits will continue to be based on the amount of your salary *before* reduction. However, your salary *after* reduction is used as the basis for determining Social Security contributions and benefits.

Because of tax advantages under the Flexible Benefits Program, a few special rules apply. Under IRS regulations, once your pretax deduction becomes effective for a calendar year, you may not change your coverage election until the next open enrollment period. Refer to *Open Enrollment* on page 14.

The only exception is if you meet one of the *qualifying events* described on page 13. To change your election, complete a new RF Benefits Enrollment Form, and submit this within 60 days of the qualifying event.

Qualifying Events

Definition: qualifying event

A *qualifying event* is a change in an employee's or dependent's status that permits a change to be made in pretax health insurance elections outside of the annual open enrollment period. *The change in status must result in a gain or loss of coverage or coverage options.* The election change must be consistent with the change in status.

Qualifying events include:

- Qualification for special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You, your spouse and your dependents have special enrollment rights if you had other health insurance coverage at the time of the annual enrollment period and you are no longer eligible for that coverage, or if you acquire additional dependents as a result of marriage, birth, adoption or placement for adoption.
- A change in status that affects your, your spouse's or dependents' coverage including a change in:
  - legal marital status because of marriage, death of a spouse, divorce, legal separation, or annulment
  - number of dependents because of birth, adoption, placement for adoption, or death
  - employment status (termination or commencement of employment) by you, your spouse, or dependent
  - work schedule (reduction or increase in hours of employment) for you, your spouse, or dependent because of a switch between part time and full time, or commencement of or return from an unpaid leave of absence that results in acquiring or losing eligibility for health insurance
  - unmarried dependents' status (an event that causes your dependent to satisfy or cease to satisfy the requirements for coverage because of attainment of age or student status, or any similar circumstances as provided by the plan)
  - residence or worksite (a change in the place of the residence or work of you, your spouse, or dependent)
- Receipt by the plan of a court order, such as a qualified medical child support order under Section 609 of ERISA.
- Your, your spouse's, or dependents' qualification (or loss of qualification) for Medicare, Medicaid or other coverage sponsored by a governmental or educational institution.
- There is a significant cost change or a reduction or curtailment of the coverage available during the year. In such a case, you may elect coverage under another option providing similar coverage or to drop coverage if no similar option is available. If a coverage option is added or significantly improved or the cost of a coverage option has significantly decreased during the year, eligible employees (including those who have not previously elected coverage) may change their elections to enroll in the new, improved or decreased cost option.
- A change is made in the health coverage available to you, your spouse or dependents through another employer and either that employer plan has a different period of coverage (a different open enrollment period) or has rules allowing changes in election similar to the rules contained in this section.

Requests for enrollment changes are processed in accordance with IRS regulations by your local Research Foundation office administering benefits. These requests are subject to review by the Research Foundation Central Office of

Human Resources, which may require additional written documentation.

Health Care and Dependent Care Spending Accounts

Under the Research Foundation's Flexible Benefits Program, you can also enroll in a Health Care or Dependent Care Flexible Spending Account. A Flexible Spending Account (FSA) is an IRS-approved, tax-free account that saves you money on eligible health care and dependent care expenses. You authorize per pay-period deposits to your FSA from your before-tax salary. Then, as you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. If you incur both types of expenses, you can establish both accounts.

The Health Care Spending Account minimum annual deposit is $5.00 per pay period. The maximum annual deposit is $3,000 annually.

The Dependent Care Spending Account minimum annual deposit is $5.00 per pay period. The maximum annual deposit is based on your tax filing status and ranges from $2,500 to $5,000.

There is a six-month waiting period to participate in the Health Care Spending Account, but there is no waiting period for the Dependent Care Spending Account.

Fringe Benefits Management Company (FBMC) Flexible Benefits Plan Booklet

You should receive The Research Foundation of State University of New York and FBMC *Flexible Benefits Plan* booklet from your local Research Foundation office administering benefits. The *Flexible Benefits Plan* booklet, in conjunction with your Research Foundation *Benefits Handbook*, constitutes the ERISA Summary Plan Description (SPD). The *Flexible Benefits Plan* booklet describes in detail:

- Important information about eligibility and enrollment
- How to get more information
- Eligible expenses
- Ineligible expenses
- How to request reimbursement
- Permitted election changes during a plan year
- Appeal process
- FBMC Privacy Notice

In order to enroll, you must complete a Flexible Spending Account Enrollment Form and return it to your local Research Foundation office administering benefits. To stay in the plan you must complete a new enrollment form each calendar year.

Open Enrollment

Each year the Research Foundation schedules an open enrollment period to allow you to make changes to your health insurance coverage not usually permitted during the calendar year.

You may do the following only during open enrollment:

- change from one healthcare coverage option to another, for example, changing from HMO to PPO coverage.
- change your coverage level on a pretax basis
- change from pretax coverage to waiver of coverage
- change from pretax to aftertax deductions or from aftertax to pretax deductions

Other changes you make during open enrollment are subject to the same rules that apply during the calendar year. For example, when you add dependents more than 60 days after they become eligible, late enrollment rules apply unless you have a special enrollment right.

Note: If you do not make any changes during open enrollment, your coverage will remain in effect for the next plan year, except for Flexible Spending Accounts. You must re-enroll annually in the Flexible Spending Accounts.

Coordinating Your Benefits

The Research Foundation health and dental plans have rules for coordinating benefit payments when you or your covered dependents are entitled to benefits under more than one plan. These rules determine the order and amount of payment, and are designed so that the combined payment by all plans does not exceed the actual cost of the services.

The primary plan determines benefits first, as if there were no other plans. Any other plan is considered secondary, and pays allowable charges that are not covered by the primary plan.

If you have coverage under more than one health plan, refer to the certificate or handbook provided by each health plan for the rules on coordinating your benefits.

The following rules are followed by the Foundation's Dental Plan when it coordinates payment with another benefit plan. "The person" referred to below is the person for whom a claim is filed. "This plan" means the Foundation's Dental Plan. "Other plan" means any other group insurance benefit plan.

A. The plan covering the person as an employee is primary and determines benefits before the plan covering the person as a dependent.

B. If the person is a dependent child covered by both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year is primary. (If the parents are separated or divorced, see C below). If both parents have the same birthday, the plan covering the parent for the longest period is primary. If the other plan does not have this rule but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.

C. When the person is a covered dependent child of divorced or separated parents, benefits are determined in the following order:

   1. By the plan covering the parent with custody of the child
   2. By the plan of the spouse of the custodial parent
   3. By the plan of the non-custodial parent

   However, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child, that plan will be primary and will determine its benefits first.

D. The plan covering the person as an employee or as a dependent of an employee determines its benefits before the plan covering the person as a laid-off or retired employee, or as a dependent of a laid-off or retired employee. If the other plan does not have a rule concerning laid-off or retired employees, the rules of this paragraph will not apply.

E. If the other plan does not have rules establishing the same order as described above, or is a plan which is "excess" or always "secondary," the Foundation's plan will determine and pay its benefits in the following way:

1. If this plan is the first to determine its benefits, it will pay without regard to coverage under the other plan.
2. If the other plan determines its benefits first, this plan will pay any difference between what the other plan pays and the dentist's charge for the service, but no more than this plan would otherwise pay according to its covered benefits.

F. In situations not described in A through E, or when this plan is the first to determine its benefits, it will pay without regard to coverage under any other plan.

G. When this plan is not the first to determine its benefits and there are remaining expenses which are covered by this plan, this plan will pay the difference beween the other plan's benefits and this plan's benefits, or the amount of remaining expenses, whichever is less.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) expands your health insurance rights. If your Research Foundation health coverage ends, your health insurance company will provide you and your dependents with written certification of prior coverage. This can be given to a future employer and used to reduce waiting periods that may apply to preexisting conditions. To avoid a gap in coverage upon termination of your Research Foundation health benefits coverage, consider continuing your coverage under COBRA *(see page 73)*.

Chapter 2

Health Benefits

Chapter 2

Health Benefits

The Research Foundation provides the following plans to help you meet your health care needs:

- the Empire PPO (Preferred Provider Organization) through Empire Blue Cross, or
- an HMO (Health Maintenance Organization), if available in your area.

Empire Blue Cross will provide PPO members with a benefit handbook. HMOs will provide their members with a handbook and a certificate of coverage.

The Empire PPO Plan provides benefits for you and your covered dependents through Empire Blue Cross. The PPO Plan provides a network of participating providers and offers the following features:

- care from in-network providers or out-of-network providers (for some services)
- national recognition of your ID card
- patient responsibility for some precertification requirements

The difference between using an *in-network* or an *out-of-network* provider is as follows:

In-network Participating Providers	Requires a fixed copayment for most provider office visits and there are no claim forms to file.
Out-of-Network Nonparticipating Providers	Requires an annual deductible and 20% coinsurance for most services. You complete a claim form for reimbursement of allowable charges.

Refer to *Chapter 3: Prescription Drugs for Members of the Preferred Provider Organization (PPO) Health Plan* for information on prescription drug benefits for PPO participants.

Empire Blue Cross PPO

Identification card

Once you have enrolled in the PPO plan, you will receive a PPO membership identification card (ID card). It enables you to receive benefits nationally and internationally.

Show your membership card to any Empire Blue Cross participating physician or hospital. The PPO physician or hospital can verify your membership eligibility and coverage with the Research Foundation PPO Plan. When you visit a PPO doctor or hospital, you will have no claim forms to file.

Finding a preferred provider

PPO directories are available by using the following telephone numbers or web sites:

- For Central and Western New York and outside New York State, call 800-810-BLUE (800-810-2583) or refer to the Empire Blue Cross Web site at *www.empireblue.com*. Click on “Find a Doctor or Specialist,” and then click on “Nationwide Provider Search.”
- For Eastern New York, call 800-377-5156 or refer to the Empire Blue Cross Web site at *www.empireblue.com*. Click on “Find a Doctor or Specialist,” and then click on “New York Provider Search.”

You can also obtain information at your local Research Foundation office administering benefits.

In case of emergency, you should obtain immediate care from the nearest medical facility.

PPO Benefits Handbook

If you enroll in the Preferred Provider Organization (PPO) Plan, you will receive a Benefits Handbook from your local Research Foundation office administering benefits. The PPO Benefits Handbook will contain:

- a benefits summary that outlines for you in chart format the specifics of the PPO Plan, including in-network and out-of-network benefit levels.
- general information about the provider network.
- benefits sections that describe in detail the health care services covered under the PPO Plan, including
  - a description of cost-sharing provisions, including premiums, deductibles, coinsurance and copayments for which you may be responsible;
  - any lifetime or annual caps or other limits on benefits;
  - the extent to which preventive services are covered under the plan;
  - whether, and under what circumstances coverage is provided for medical tests, devices and procedures and whether, and under what circumstances coverage is provided for out-of-network services;
  - any conditions or limits in the selection of primary care physicians or providers of specialty medical care;
  - any conditions or limits applicable to obtaining emergency medical care;
  - any provisions requiring preauthorization or utilization review.
- administrative sections that tell you how to claim benefits, contact customer service, make appeals, and deal with changes in your life and employment that will affect your membership in the PPO.
- a glossary that defines health insurance terminology for you.

The PPO Handbook, in conjunction with your Research Foundation *Benefits Handbook*, constitutes the ERISA Summary Plan Description (SPD).

HMOs

You may enroll in a Health Maintenance Organization (HMO) if this type of coverage is offered by the Research Foundation in your geographic area. The HMO will provide you with an HMO handbook and certificate of coverage. These documents, in conjunction with your Research Foundation *Benefits Handbook*, constitute the ERISA Summary Plan Description (SPD). Before enrolling in an HMO, thoroughly review the coverage provisions of the plan. Although HMOs provide hospitalization coverage and a comprehensive plan of medical and surgical care, some provisions differ from those established for the Research Foundation PPO Health Plan. If you are interested in HMO coverage, your local Research Foundation office administering benefits can give you information about HMOs in your area.

Benefits

HMO enrollees must receive health care from physicians or other providers who are part of the HMO, unless the enrollee is referred by the HMO to a physician or provider who is not part of the HMO.

HMOs provide identification cards that you present whenever you receive health care. Only emergency and limited care is available to enrollees who require medical services outside the area served by the HMO, although some HMOs have reciprocal agreements with HMOs outside their service area. HMOs provide prescription drug coverage, but may require that prescriptions be filled at a specific pharmacy. HMOs charge a copayment for office visits and prescription drugs.

Contact your local HMO for answers to specific questions about coverage.

Health Claims Process

Each benefit provider (insurer, HMO or third party claims administrator, as applicable) will follow claims procedures that satisfy the requirements specified in Department of Labor regulations §2560.503-1, published at 65 F.R. 70245 (Nov. 21, 2000) and summarized in this section for claims filed on or after January 1, 2002. For purposes of this procedure, we will refer to the person who is responsible for making a claims decision as the "claims administrator."

Urgent care

An "urgent care claim" is a claim for medical treatment or care that, if not provided quickly, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the case, would subject the claimant to severe pain that cannot be adequately managed without the care or treament requested.

A decision on an urgent care claim will be made within 72 hours after the request is received. If the request is incomplete, the claimant will be notified within 24 hours of the submission (and will be told of the specific information necessary to complete the claim). The claimant then has 48 hours after the notice is received (unless the insurer or claims administrator allows a longer period) to provide the additional information. A decision will be made by the later of (a) 48 hours after the additional information is provided, or (b) the expiration of the deadline to provide additional information.

An appeal of an adverse decision (denial) regarding an urgent care claim will be decided within 72 hours after the appeal request is filed.

Concurrent care

A "concurrent care claim" involves a decision by the Plan or an issuer to reduce or stop a course of treatment that has already begun.

Any reduction or termination of an ongoing course of treatment to be provided over a period of time or a specified number of treatments shall be treated as an "adverse benefit determination" (unless due to an amendment or termination of the Plan). The claimant will be notified of the decision to reduce or terminate the course of treatment in sufficient time to allow an appeal (and a determination on the appeal) to take place before the benefit is reduced or terminated.

Pre-service claims

A "pre-service claim" is any claim for a benefit where the terms of the Plan require approval prior to obtaining medical care.

An initial decision on a pre-service claim must be made in a reasonable time, but no later than 15 days after the submission of the claim. This time period can be extended for an additional 15 days if the claims administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

Post-service claims

A "post-service claim" is any claim that is not a "pre-service claim" (in other words, you do not need approval before obtaining medical care).

The claimant will be notified of any adverse benefit determination of a post-service claim within a reasonable time, but not later than 30 days after receipt of the claim. The period for a decision may be extended for an additional 15 days if the claims administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

Requirements for notification of an adverse benefit determination

The claims administrator will provide the claimant with a written or electronic notification of any adverse benefit decision. The notification will state, in a manner calculated to be understood by the claimant,

- the specific reason(s) for the adverse determination,
- reference to the specific Plan provisions on which the determination is based,
- a description of any additional material or information necessary for the claimant to complete the claim and an explanation as to why such material or information is needed,
- a description of the Plan's review procedures and time limits (including a statement of the claimant's rights to bring a civil suit under Section 502(a) of ERISA following an adverse benefit determination on review), and
- if the claim is an urgent care claim, a description of the expedited review process.

Appeal of an adverse determination

You have 180 days following receipt of an adverse benefit determination to appeal that determination. A review will be conducted by a fiduciary who is neither the individual who made the initial determination nor a subordinate of that person. If the adverse benefit determination was based, in whole or in part, on a medical judgment (including whether a particular treatment, drug, etc., is experimental, investigational or not medically necessary or appropriate) the reviewer will consult with an appropriate health care professional. Any expert whose advice was obtained in connection with the adverse benefit determination will be identified to the claimant.

Women's Health and Cancer Rights Act

Federal law requires group health plans that provide medical and surgical benefits for mastectomies to provide coverage in connection with the mastectomy (in the manner determined by the attending physician and the patient) for:

- reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- protheses and physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. In addition, the law prohibits penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care, or providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with this law.

The above described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similar benefits. If you have any questions about this coverage, please contact the applicable benefits/claims administrator identified on page 5.

Newborns and Mothers Health Protection Act

Under this Federal law, sometimes referred to as the "NMHPA," certain requirements are imposed on group health plans that provide maternity or newborn infant coverage. This includes the fact that the group health plans and health insurance issuers (such as insurance companies and HMOs) may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section.

However, the NMHPA does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours or 96 hours, as applicable.

Qualified Medical Child Support Order

You may obtain a copy of the procedures governing qualified medical child support orders, without charge, by contacting the Research Foundation Central Office of Human Resources.

Chapter 3

Prescription Drugs for Members of Preferred Provider Organization (PPO) Health Plan

Chapter 3

Prescription Drugs for Members of the PPO Health Plan

The Research Foundation provides prescription drug benefits to you and your covered dependents through Medco. Those enrolled in the Research Foundation PPO Health Plan will receive these benefits. If you participate in an HMO, refer to your HMO certificate for prescription drug coverage.

The Prescription Drug Plan is designed to cover most medications that require a physician's written prescription. Prescription drugs may be obtained either through mail order or at a retail pharmacy. All prescriptions, whether purchased through mail order or at a retail pharmacy, are subject to a copayment. You can get up to a 90-day supply (for only a 60-day copayment) through the mail order but only up to a 30-day supply at a retail pharmacy. If your physician prescribes a brand-name drug when a generic equivalent is available, you are responsible for paying the difference between the two prices in addition to the copayment.

Refer to *Where to Get Help*, Prescription Drugs, on page 5 to locate a participating pharmacy near you, to get a list of preferred drugs, to request claim forms, or to obtain assistance in determining medication payment amounts in advance when using the mail order service.

Prescription Drug Programs Brochure

PPO Health Plan members will receive "*Your Prescription Drug Benefit Handbook*" from their local Research Foundation office administering benefits. The handbook explains copayments and other plan details, and along with this *Benefits Handbook* is your Summary Plan Description.

Mail Order (Medco By Mail)

Use Medco By Mail to fill prescriptions through the mail. This program is particularly convenient for long-term prescriptions and offers the advantage of free home delivery. Up to a 90-day supply of medication can be obtained at one time, for only a 60-day copayment.

Retail Pharmacy

Use a Medco participating retail pharmacy when you need short-term or immediate prescriptions. If you need a prescription immediately but will be taking the medication on an ongoing basis, you may ask your physician for two prescriptions: one for a 14-day or 30-day supply that can be filled at a local pharmacy, and one for up to a 90-day supply that can be ordered through the mail.

Identification card

Medco will provide you with a Prescription Drug Identification card (Medco ID card), which you present to the pharmacist at a participating pharmacy when a prescription is filled. This ID card contains your group and member numbers and serves as verification of your enrollment in the plan. Do *not* use your Empire Blue Cross PPO card at the pharmacy. Empire Blue Cross does not cover prescription drugs for members of the PPO plan.

Participating pharmacy

Filling your prescriptions at a participating pharmacy offers the advantage of discounted prescription drug prices. Your Medco ID card can be used at a network of thousands of participating pharmacies that will provide you with prescription drugs at a discounted price. At a participating pharmacy, you present your ID card, pay the copayment and brand-name differential, if applicable, and receive your prescription. You can find a local pharmacy online at www.medco.com.

Nonparticipating pharmacy

If you have prescriptions filled at a nonparticipating pharmacy (not part of the network of pharmacies participating in the plan), the plan will pay only the discounted cost of the drug that a participating pharmacy would charge. You will be responsible for paying the difference between the discounted price and the actual retail price. At a nonparticipating pharmacy, you pay for prescriptions when you receive them and obtain reimbursement from Medco for allowable expenses.

Generic and Brand-Name Drugs

Generic and brand-name drugs (unless they fall under Drugs and Supplies Not Covered below) are covered under both the mail order and retail pharmacy programs, although your out-of-pocket expenses will usually be higher when you use a nonparticipating pharmacy. If a physician prescribes a brand-name drug when a generic equivalent is available, you must pay the difference in cost. Insulin and insulin needles and syringes are covered under prescription drug benefits. Medications used for treating infertility are subject to a 50 percent coinsurance for both mail order and retail prescriptions.

Preferred and Non-Preferred Drugs

Brand-name drugs fall into two categories: Preferred and Non-Preferred. Preferred drugs are typically those that have been in the market for a time and are widely accepted. Medco has arranged a significant discount on these preferred drugs, and therefore the copayment for these drugs is lower. Non-preferred drugs are typically higher-cost and/or newer drugs that have recently come on the market. So-called “designer” drugs also fall into this category. In most cases, an alternative preferred medication is available. Because of the high cost of these drugs, the copayment is also higher than for preferred drugs.

Effective January 1, 2005, there are three categories of covered drugs with three different copayments: generic drugs, preferred brand-name drugs, and nonpreferred brand-name drugs. You will pay the lowest copayment for generic drugs, followed by preferred brand-name drugs. Nonpreferred brand-name drugs have the highest copayment.

Drugs and Supplies Not Covered

The following drugs and supplies are not covered under either the mail order or retail pharmacy programs:

- drugs and medical supplies available over the counter
- vitamins
- food supplements, except those required for treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. *(These require special claim handling – please contact your local Research Foundation office administering benefits.)*
- non-oral contraceptives
- drugs not approved for use under federal or state law
- smoking deterrents (except nicotine patches)
- cosmetic drugs, including drugs for hair growth
- experimental or investigational drugs
- drugs dispensed in a hospital or other medical facility
- drugs covered by Workers’ Compensation or by a drug/medical service which does not charge you a fee

- immunization agents, biological sera, blood, or blood plasma
- refills in excess of the number of refills specified by the physician
- any drug dispensed after 1 year from the original prescription date
- Viagra in excess of 12 tablets per 30-day supply. Viagra is not covered for males under age 18. Limitation also applies to all erectile dysfuncton agents.

Mail Order Process

Refer to *Your Prescription Drug Benefit Handbook*, published by Medco, for instructions.

Retail Network Pharmacy Process

Refer to *Your Prescription Drug Benefit Handbook*, published by Medco, for instructions.

Nonparticipating Pharmacy

You and your pharmacist must complete a Medco Prescription Drug Reimbursement Form and submit it to Medco Prescriptions to be reimbursed for prescriptions purchased at a nonparticipating retail pharmacy. A separate Medco reimbursement form is required for each employee or dependent and for each pharmacy used. Instructions for completing and mailing the form are provided on the form. When your claim is processed, Medco will provide you with a new Medco reimbursement form. You may also obtain forms from either your local Research Foundation office administering benefits or directly from Medco. Refer to *Where to Get Help*, Prescription Drugs, on page 5.

The following table outlines the procedure for filling a prescription, filing a claim, and receiving reimbursement when using a nonparticipating pharmacy:

Step	Action
1	Obtain a Medco Prescription Drug Reimbursement Claim form.
2	Complete and sign Member/Subscriber/Patient Information on the front side of the form.
3	Have prescription filled and pay the full retail price of the generic or brand-name drug; you will receive the prescription and a receipt.
4	Have the pharmacist complete and sign the Pharmacy Information, then tape the original receipt to the claim form. Do not use staples or paper clips.
5	Mail the reimbursement form and receipt to the following address: Medco Prescriptions LLC PO Box 2187 Lee's Summit, MO 64063-2187 *Note: Keep a copy of the form for your records.*
6	After deducting a copayment (and the brand-name difference, if any), Medco will reimburse you for up to a 30-day supply at the discounted price that a participating pharmacy would charge.

Determination of Claims and Appeal

Your prescription drug claim will be treated as a "post-service claim" under the procedures described on page 21. Refer to *Your Rights Under ERISA* on page 82 for full details.

Chapter 4

Dental

Chapter 4

Dental

The Research Foundation Dental Plan provides coverage for you and your covered dependents. The Foundation pays the full cost of coverage for this plan. Under the plan, administered by Delta Dental, you may choose a dentist who participates in the network or a non-participating dentist who is not part of the Delta Dental network.

The Delta Dental network of participating dentists offers the following features and advantages:

- dentist files claims for you
- insurance payment made directly to the dentist
- lower dental fees
- lower out-of-pocket costs
- large network of dentists

Refer to *Where to Get Help* on page 5 for Dental Plan phone numbers.

Delta Dental Booklet

You should receive a Delta Dental Booklet, *Dental Plan Benefits for Employees of The Research Foundation of State University of New York*, from your local Research Foundation office administering benefits. The Delta Dental booklet, in conjunction with your Research Foundation *Benefits Handbook*, constitutes the ERISA Summary Plan Description (SPD). The Delta Dental booklet describes in detail

- the dental services covered under the Dental Plan,
- services not covered, benefit limitations, predetermination and coordination of benefits,
- dental terms used in the plan.

Your dental claim will be treated as a "post-service claim" under the procedures described on page 21. See also *Your Rights Under ERISA* on page 82 for additional information.

If you use a participating dentist, you will not have to complete a claim form. Reimbursement is made directly to your dentist by Delta Dental for covered fees or services according to the terms of the plan.

Participating Network of Dentists

Names of Delta Premier or Delta Preferred participating dentists can be obtained upon request by calling Delta at 800-932-0783 or accessing its Web site at *www.midatlanticdeltadental.com*. You can use the Delta Premier or the Delta Preferred network, but you will have a higher annual maximum benefit if you use the Delta Preferred network. Refer to *Maximum Reimbursements* chart on page 29.

If you do not have Internet access, you can obtain a list of dentists in your area from your local campus office administering benefits or from Delta Dental.

Nonparticipating Dentists

You may use a nonparticipating dentist who is not part of Delta's network of dentists. When you use a nonparticipating dentist, you must complete a claim form for reimbursement of fees according to the terms of the plan. You will be required to pay any dental fees in excess of plan allowances. Claims payments will be sent to you. You may obtain claims forms from your local Research Foundation office administering benefits, or you may use your dentist's claim form. Claims should be submitted to:

Delta Dental, One Delta Drive, Mechanicsburg, PA 17055-6999

Benefits

Dental benefits cover preventive care, treatment of teeth affected by injury or decay, and replacement of missing teeth. Payment is provided according to the usual, customary, and reasonable (UCR) fees for a particular area and according to the plan's percentage of reimbursement for each type of dental service. (See chart below for an explanation of dental services.)

MAXIMUM REIMBURSEMENTS

Type of Service	Percentage of Usual, Customary and Reasonable Charges Paid	Delta Premier Network *Up to a Maximum Benefit of*	Delta Preferred Network *Up to a Maximum Benefit of*
Preventive and Diagnostic	100%	combined maximum of $1,200 per calendar year	combined maximum of $1,500 per calendar year
Basic	75%		
Major and Prosthodontic	50%		
Orthodontic (for dependent children up to and including age 19)	50%	$1,500 lifetime limit per dependent child	$1,500 lifetime limit per dependent child

Waiting periods

There is a 6-month waiting period for most dental benefits, and a 12-month waiting period for major restorative and prosthodontic services.

Annual deductibles

This is the amount you pay for services before payment is made by Delta Dental.

Individual

There is no deductible for preventive and diagnostic services, or for orthodontics. There is a $50 deductible for all other services.

Family

There is no deductible for preventive and diagnostic services, or for orthodontics. There is a maximum $150 family deductible for all other services, except orthodontic services for dependent children. A covered person will become eligible for reimbursement after fulfilling the individual $50 deductible. When more than 3 family members collectively meet the $150 family deductible (for example, 5 family members at $30 each), no additional individual deductibles need to be met for the remainder of the year.

Claims and Appeal Process

Please refer to your Delta Dental booklet and to "post service claims" on page 21 of this handbook.

Extended Dental Benefits After Termination of Employment or Eligibility

If dental work is begun before coverage ends, and is completed within 90 days of termination of eligibility or employment, charges for the following treatments will be paid:

- fixed bridgework, crowns, inlays, onlays, and gold restorations (treatment begins the date the tooth or teeth are first prepared)
- full or partial removable dentures (treatment begins the date the impression is taken)
- root canal work (treatment begins the date the tooth is opened)

Note: Orthodontic payments do not fall within the 90-day extended dental insurance provision. However, you may continue dental coverage by paying for an extension of benefits under COBRA. Refer to Chapter 9: Continuing Benefits on pages 73-77.

Chapter 5

Vision Care

Chapter 5

Vision Care

The Research Foundation Vision Care Plan provides coverage for you and your covered dependents. An examination and corrective lenses are available once every 24 months through participating or nonparticipating providers. If you use a participating provider, you receive maximum plan benefits. The Research Foundation pays the full cost of coverage for this plan; you are required to pay any vision care fees in excess of plan allowances.

An occupational vision benefit is also available through Davis Vision providers. This will cover an additional pair of single vision eyeglasses when a different prescription is needed by an employee for job purposes. The employee must obtain the occupational eyeglasses at the same time as the regular eyeglasses. This is not a benefit for dependents. There are optional frame and lens features available subject to additional fees. Employees and eligible dependents will also have access to Laser Vision Correction Services at discounted rates through a network of participating surgeons.

Definition: participating providers
Participating providers are optometrists, opticians, and vision-care centers throughout the country that have agreed to provide vision care services and supplies and accept payment under the terms of the plan.

Definition: nonparticipating providers
Nonparticipating providers are optometrists, opticians, and vision-care centers that are not part of the Vision Care Plan.

Refer to *Where to Get Help* on page 5 for Vision Care Plan phone numbers.

You should receive a *Davis Vision Care Plan Benefit Description for Employees/ Dependents of the Research Foundation of State University of New York* from your local Research Foundation office administering benefits. This Davis Benefit Description, in conjunction with your Research Foundation *Benefits Handbook*, constitutes the ERISA Summary Plan Description (SPD). This Benefit Description describes in detail:

- how you receive services from a provider in the network
- who the network providers are
- what the plan benefits, frequencies, and costs are
- out-of-network provider benefits
- information about Laser Vision Correction Services
- exclusions
- information about the Davis Vision Web site
- your rights as a patient

Enrollment Packet and Provider Directory

After you have completed a 6-month waiting period, Davis Vision will send you an enrollment packet and a Directory of Vision Care Plan Doctors, which provides a list of participating providers in your area. You can obtain this directory at any time by calling Davis Vision or you can refer to their Web site for a provider in other areas. When using the Vision Care Plan, you can select *either:*

- a participating provider from the directory, *or*
- a nonparticipating provider.

Plan Allowances

Participating providers

If you choose a participating provider from the Directory of Vision Care Plan Doctors, you are entitled to *one* of the following benefits:

- one eye examination and one pair of plan eyeglasses (including lenses and frames) at no cost. This covers plastic and glass lenses, single vision, bifocal or trifocal lenses, post-cataract lenses, lens tinting, and prescription sunglasses, *or*
- one eye examination and up to $45 towards the cost of one pair of contact lenses.

Eye examinations may include dilation of the eye to screen for potentially serious health conditions such as diabetes, hypertension, and nerve damage. Upgraded frame and lens options are available with an additional employee copayment.

Nonparticipating providers

Nonparticipating providers are *not* included in the Directory of Vision Care Plan Doctors. If you choose a nonparticipating provider, you may receive an examination and either one pair of eyeglasses (lenses and frames) or one pair of contact lenses. You will be reimbursed only up to the following amounts:

Reimbursement limitations when using nonparticipating providers

examination	$20
frames	$14
single vision lenses	$14
bifocal lenses	$23
trifocal lenses	$32
cataract lenses	$25
cataract bifocals	$35
contact lenses	$28
cataract contact lenses	$36

Restrictions

The following restrictions apply.

- Coverage is only for routine eye examinations, corrective lenses, and frames. Benefits for medical treatment of eye disease or injury are provided under the Research Foundation Health Insurance Plans.
- All *three* portions of the benefit (exam, lenses, and frames) must be billed at the same time, and by the same provider, to obtain reimbursement for all portions of the benefit.
- Nonprescription lenses are not covered.
- If you want special designer frames or lenses or no-line bifocals from participating providers, you are responsible for all costs that exceed the plan allowance.
- Specialty lenses (progressive, photosensitive) and lens coatings (antireflective, scratch resistant) are available at a discounted rate.

Claims Process

Participating providers

Contact Davis Vision to make sure that 24 months have elapsed since you last used the benefit. Choose a participating provider from the Directory of Vision Care Plan Doctors, contact this provider, give your Social Security number, and schedule an appointment. Date of birth is required for dependents. The provider will contact Davis Vision to confirm your eligibility and enrollment and to obtain approval to proceed with services.

You do *not* need a claim form for covered services when using a participating provider. Davis Vision will pay the provider directly.

Nonparticipating providers

Before scheduling an appointment with a nonparticipating provider, contact Davis Vision to make sure that 24 months have elapsed since you last used the benefit. At the time of the exam you must pay for services and obtain a receipt. Contact Davis Vision by phone or online to obtain a Direct Reimbursement Claim Form. After your prescription has been filled, you must also obtain a receipt for your eyeglasses. Submit the receipts for the exam, lenses, and frames together to Davis Vision for reimbursement at the same time.

Note: You can present the claim form at the time of service or afterward, but the provider must complete the form before reimbursement can be obtained.

Submit the claim form and receipts to Davis Vision at the address shown on the form. You will receive a check for allowable costs after your claim is reviewed.

Dividing services between nonparticipating and participating providers

If you use a nonparticipating provider for an eye exam, you may obtain your eyeglasses from a participating provider under the plan. In this case, you will not receive any reimbursement for the eye exam, but the plan lenses and frames will be covered in full.

Claim status

You may check the status of your claim payment at any time by contacting Davis Vision.

Claims Appeal Process

If you disagree with the amount reimbursed, you may initiate an appeal directly with Davis Vision. Vision care claims are treated as “post service claims” under the claims procedures described on page 21.

First, compare the payment against allowable vision care expenses as outlined in this handbook. If the reimbursement you received is unclear, call Davis Vision for an explanation.

Note: Davis Vision may require you to provide additional information to substantiate your claim.

You may contact your local Research Foundation office administering benefits for assistance in resolving your appeal.

Chapter 6

Life Insurance

Chapter 6

Life Insurance

The Research Foundation provides life insurance benefits for active employees through The Prudential Insurance Company of America.

A Basic Life Insurance and Optional Life Insurance Plan are available to you if you meet eligibility requirements. The plan also provides Accidental Death and Dismemberment (AD&D) coverage.

The Research Foundation pays the entire cost of the Basic Life and AD&D Insurance. You pay the entire cost of Optional Life and AD&D Insurance via payroll deduction on an after-tax basis. There is no cash value resulting from premiums paid for Optional Life Insurance. Refer to *Where to Call for Help* on page 5 for Life Insurance Plan phone numbers.

Enrollment

Enrollment in the Basic Life Insurance Plan is automatic after 6 months of eligible service. Enrollment in Optional Life Insurance is not automatic. You must enroll within 60 days after completing your waiting period, or else you must complete a Statement of Health for the insurance company's review. The insurance company will either approve or deny your request for coverage.

Basic Life Insurance, Optional Life Insurance, and Accidental Death and Dismemberment (AD&D) Insurance

Basic Life Insurance

Basic Life Insurance is paid to your beneficiary upon your death from any cause. If you became eligible before July 1, 1992 and have not had a break-in-service, you are insured for an amount equal to 3 times your basic annual salary, rounded to the next higher $1,000, up to a maximum of $50,000. If you became eligible on or after July 1, 1992, you are insured for $10,000, regardless of salary.

Benefits are reduced by the following percentages, beginning at age 70, as shown below:

- 10 percent reduction at age 70
- 20 percent reduction at age 71
- 30 percent reduction at age 72
- 40 percent reduction at age 73
- 50 percent reduction at age 74

Optional Life Insurance

You can obtain additional coverage through Optional Life Insurance. The combined maximum coverage limit for both Basic and Optional Life Insurance is $300,000 per employee.

Optional Life Insurance is paid to your beneficiary upon your death. You indicate the amount of optional coverage you wish to purchase when you complete the Research Foundation Benefits Enrollment Form.

Your Optional Life Insurance coverage can equal 1, 2, 3, 4, or 5 times your annual salary, rounded to the next higher $1,000, minus the amount of Basic Life Insurance coverage.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) benefits are provided under both Basic and Optional Life Insurance coverage. Benefits apply only if dismemberment or death results from an accident occurring while you are insured under this coverage. The dismemberment or death must occur within 365 days of the accident.

This benefit is provided in addition to your Basic and Optional Life Insurance coverage. In the event of accidental death, you are insured for the same dollar amount as your Basic and Optional Life Insurance coverage. For example, if you have $200,000 in Basic and Optional Life Insurance coverage, that amount (the "principal amount") is also paid for AD&D benefits. Payment will be made to your beneficiary.

If dismemberment results from an accident that occurred within the preceding 365 days:

- *half* the principal amount of the insurance will be paid to you for a total and permanent loss of 1 hand, foot, or sight in 1 eye, *or*
- the *full* principal amount of insurance will be paid for the loss of 2 or more of the above.
- additional amounts (up to $10,000) are paid if accidental death occurs when seat belts or seat belts and airbags were in use at the time of the accident.

Accidental Death and Dismemberment benefits will *not* be paid for any loss caused by:

- a disease or illness of any kind, physical or mental infirmity, or medical or surgical treatment of these.
- ptomaine or bacterial infection, except infection as a result of an accidental cut or wound.
- suicide or attempted suicide.
- an injury or a sickness that is intentionally self-inflicted, or any attempt to inflict such injuries.
- war, declared or undeclared; any act incident to war; service in any military or any country while the country is engaged in war; or police duty as a member of any military organization.
- taking part in, attempting to take part in, or as a result of taking part in, the commission of a felony.
- participation in hazardous sports, such as but not limited to, hang-gliding, skydiving, and bungee jumping.
- drugs or alcohol.

Accelerated Death Benefit

Benefits may also be paid to you prior to your death, if you are terminally ill. If you have a terminal illness in which life expectancy is less than six months, you may receive a one-time, lump-sum payment of

- up to 75 percent of your combined Basic and Optional (if applicable) Life Insurance benefit, not to exceed $50,000.

The minimum amount of life insurance that can be accelerated is the *lesser* of

- 25% of your amount of life insurance, or
- $50,000.

The amount of life insurance coverage that remains in effect will be reduced by the amount paid out under the accelerated death benefit.

Designating Your Beneficiaries

When you complete the RF Benefits Enrollment Form at the beginning of employment or eligibility, you must designate a primary beneficiary (complete Part E) and, if you wish, a contingent beneficiary. You may also name more than one primary and contingent beneficiary. The beneficiaries will receive a benefit payment upon your death. The contingent beneficiary will receive the benefit if your primary beneficiary is deceased.

If you wish to designate a beneficiary for Optional Life Insurance other than the person(s) named for Basic Life Insurance, indicate this on the enrollment form (complete Part F). If you do not designate a beneficiary, it will be assumed that the beneficiary is the same as the one you designated for your Basic Life Insurance coverage.

If you name more than one beneficiary, you must specify in fractions or percentages, rather than dollar amounts, the portion payable to each beneficiary. If you do not specify portions, each beneficiary will share equally in the benefit. Refer to *Payments to Your Beneficiaries* below for information and a schedule of payments to your designated beneficiary(ies).

Changing Your Beneficiaries

You may change your beneficiary designation at any time by completing a new RF Benefits Enrollment Form and submitting it to your local Research Foundation office administering benefits.

Changes will not be effective until the day your local Research Foundation office receives your new enrollment form, but the *effective date* of the change will be the day you signed the form.

Payments to Your Beneficiaries

If you die while covered, your beneficiaries will be notified of the following death benefit payment guidelines:

- Payment will be made to the primary beneficiary(ies) in the manner indicated on the enrollment form.
- If no primary beneficiary is living, benefits are paid to the contingent beneficiaries.
- If the beneficiary is a minor, application for benefits must be made by the court-appointed guardian of the minor's property. Prudential will require a notarized copy of the guardianship appointment prior to payment of the benefit.
- If no beneficiary designation was made, the indemnity for loss of life will be payable in equal shares to the surviving relatives of the highest rank as listed below.
  - Spouse of the employee (legally married).
  - Lawful living children of the employee.
  - Father and mother of the employee.
  - Brothers and sisters of the employee.
  - Estate.

Filing a Claim

Life insurance coverage

In the event of your death, your survivors should contact your local Research Foundation office administering benefits, which will provide assistance in the claims process. Prudential will review and approve claims.

Accidental Death and Dismemberment (AD&D) coverage

If your death is accidental, a police or coroner's report may be required. In the event of accidental injury dismemberment, Prudential may require you or your physician to provide medical documentation.

Accelerated death benefit

There is a separate claims process for an accelerated death benefit payment. Prudential requires satisfactory completion of an employee and employer statement along with proof of terminal illness certified by a physician. Spousal consent is also required.

Claims Appeal

If a claim for life insurance benefits is denied, Prudential will, within 90 days after receipt of the claim, notify the claimant of the denial of the claim. The notice of denial:

- shall be in writing;
- shall be written in a manner calculated to be understood by the claimant; and
- shall contain
  - the specific reasons for denial of the claim,
  - a specific reference to the pertinent insurance contract provisions upon which the denial is based,
  - a description of any additional material or information necessary to complete the claim, along with an explanation of why such material or information is necessary, and
  - a description of the claims review and appeal procedure, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse claim determination.

The period for making the determination may be extended for up to an additional 90 days, if necessary, provided Prudential notifies the claimant of the extension within the initial 90-day period.

If a written notice of denial of a claim is received, the claimant may file a written request with the claims administrator that it conduct a full and fair review of the denial of the claim for benefits. A written request for a review of a denied claim must be made within 60 days after the receipt of the written notice of denial of the claim. The written request for review should state why the claimant believes the claim should not have been denied, and should describe any documents, data, or other information that may have a bearing on the claim. A claimant shall have the right to review pertinent documents affecting his/her claim and to submit additional information or comments. A claimant shall also have the right to be represented. Prudential shall deliver to the claimant a written decision on the claim within 60 days after the receipt of the request for review. The period for delivering this decision may be extended for up to an additional 60 days, if necessary, provided Prudential notifies the claimant of the extension within the initial 60-day period. The decision shall:

- be written in a manner calculated to be understood;
- include the specific reason(s) for the decision; and
- contain a specific reference to the pertinent insurance contract provisions upon which the decision is based.

The decision upon review shall be final. The claimant then has the right to bring a civil action under Section 502(a) of ERISA.

Policy Conversion at Employment Termination

You may convert your Basic and Optional Life Insurance coverage to an individual policy when your employment terminates or you are no longer eligible. You may *not* exceed the amount for which you were insured under the Research Foundation's group policy. In addition, the amount you may convert is reduced by any other group life insurance for which you are eligible, or for which you become eligible within 31 days after your Research Foundation insurance ends. This individual policy will be issued at the insurance company's regular rates and will not require proof of good health. You must submit an application and pay the first premium within 31 days after your coverage ends. Call Prudential to request an application.

Portability of Optional Life Coverage at Employment Termination

Instead of converting your Optional Life Insurance coverage to a whole life policy, you may instead select a lower-cost term life policy. Premiums, however, will increase as you age and coverage will end at age 70. Portability is not offered when employment termination is due to retirement.

Policy Conversion – Reduction Due to Age

If you are still employed at or after age 70, when your life insurance amount reduces as shown on page 35, you may purchase an individual policy equal to the amount by which your Foundation coverage was reduced. This individual policy will be issued at the insurance company's regular rates and will not require proof of good health. You must submit an application and pay the first premium within 31 days after your birthday, which coincides with the reduction in coverage.

Certificate of Insurance

Contact your local Research Foundation office administering benefits to request a copy of Prudential's Certificate of Insurance, which provides details about the Research Foundation's Group Life and AD&D Insurance Plan.

Chapter 7

Disability Plans

Chapter 7

Disability Plans

The Research Foundation provides the following programs to assist you with income protection when you are disabled and unable to work.

- **Workers' Compensation** through Chubb Insurance Company provides partial income replacement, as well as payments for medical expenses, for an on-the-job injury or illness. It also provides for death benefits for your surviving spouse and eligible dependents.
- **New York State Disability** insurance through Zurich Insurance Company provides partial income replacement for *up to 26 weeks* for an off-the-job illness or injury.

  Note: Since this plan does not provide payment for medical expenses, you should submit medical claims to your health insurance carrier.
- **Long-Term Disability** insurance through the The Standard Insurance Company provides partial income replacement for a certified total disability that prevents you from working for more than 6 months.

  Note: Since this plan does not provide payment for medical expenses, you should submit medical claims to your health insurance carrier.

Definition: total disability

During the period before benefits begin under long-term disability (see chart below), and for the following 24 months, total disability is defined as a complete inability to perform the material and substantial duties of your normal occupation. After that period, you are considered disabled only if you are unable to perform the material and substantial duties of any occupation for which you are reasonably qualified by education, training, or experience.

You will also be considered disabled for insurance purposes if, after being totally disabled, you are able to work but you are unable to earn more than 80 percent of your prior wages.

Refer to *Where to Call for Help* on page 5 for Disability Plan phone numbers.

Coverage

Plan	When Benefits Begin	When Benefits End
Workers' Compensation	If your work-related injury or illness results in more than a 7 consecutive, calendar-day-absence from work, you are eligible for income benefits on day 8. However, if the disability exceeds 14 consecutive days, the 7-day waiting period will be waived and income benefits will be paid retroactive to the first day you were unable to work.	When you are no longer disabled.
New York State Disability	There is a 7-day waiting period before these benefits begin from the first day you are unable to work because of your disability.	When you are no longer disabled, or a maximum of 26 weeks from the time you exhaust your sick leave credits. See page 43.
Long-Term Disability	Benefits begin on the first day of the month following 6 consecutive months of a certified total disability, or when full sick leave payments end, if later. See page 44.	The length of time benefits are paid while you are disabled depends on your age when the disability began. Refer to the chart on page 42 for when benefits end.

The following chart shows the period during which long-term disability benefits will be paid or the age at which benefits end. Benefits will not be paid for more than 24 months if disability is due to alcoholism and/or drug abuse.

Age When Disability Began	Maximum Benefit Period/ Age When Benefits End
59 or younger	to age 65
60 through 64	5 years
65 through 68	to age 70
69 or older	1 year

Workers' Compensation

Benefits

If you are unable to work because of an injury or illness directly caused by your job, you have the following options regarding the use of leave accruals and Workers' Compensation benefits:

- You may use sick leave accruals and remain on the Foundation payroll from the first day of disability through your current appointment period, or until your sick leave accruals are exhausted, whichever comes first. Refer to *Sick leave credit* on page 43.
- You may elect to receive Workers' Compensation payments from the first day they are due.
- You may receive Workers' Compensation payments *and* charge partial leave accruals through your current appointment period in order to maintain your income level prior to disability.

Chubb Insurance Company will make Workers' Compensation payments for medical treatment expenses for an injury or illness directly caused by your job.

If you are eligible for income replacement benefits, you will receive up to two-thirds of your average weekly wages, but no more than the maximum benefit set by the New York State Workers' Compensation Board. The average weekly wage is based on payroll records for the year prior to the date of disability or accident. Workers' Compensation benefits will continue until your physician approves your return to work.

Health, Dental, Vision Care and Life Insurance coverage continuation

The health, dental, vision care and life insurance benefits will continue in effect when you become disabled while you are receiving income replacement benefits for a total disability, subject to the terms of those plans. Refer to *Chapter 9: Continuing Benefits*, under *Disability: New York State Disability or Workers' Compensation* on page 69 for more information on health, dental, and vision care coverage continuation and to *Disability: Life Insurance Continuation* on page 72 for more information on life insurance coverage continuation.

Filing a claim

If you are accidentally injured at work or experience a work-related illness, immediately report the incident to your supervisor, who should notify your Research Foundation campus office administering Workers' Compensation claims.

Reporting claims

Your Research Foundation campus office administering Workers' Compensation claims will report claims to the insurance company.

Sick leave credit

Once a claim is approved, the Research Foundation will request reimbursement from the insurance carrier for the period, if any, during which you used your sick leave accruals instead of receiving Workers' Compensation income replacement benefits. After the reimbursement is received, your sick leave credits will be restored, based on the value of the reimbursement.

New York State Disability Insurance

Benefits

Benefits are available to employees who are disabled and unable to work because of an off-the-job illness or injury. Under the plan, you must remain on the Foundation payroll until all sick leave credits are exhausted or through your current appointment period, whichever comes first.

New York State Disability benefits will then be paid, up to an additional maximum of 26 weeks. You may receive a New York State Disability weekly benefit *and* charge partial vacation leave accruals through your current appointment period in order to maintain your income level prior to disability, provided you remain actively appointed.

Benefits are currently 50 percent of your average weekly salary, up to the maximum benefit allowance established under the New York State Disability Benefits Law. These benefits will continue until your physician approves your return to work, up to a maximum of 26 weeks. Medical care claims should be submitted to your health insurance carrier.

Under Section 205.3 of the Disability Benefits Law, no benefits are paid for any disability that is the result of injury or sickness sustained by the employee in the performance of an illegal act (for example, driving while intoxicated) or any act of war.

Health, Dental, Vision Care and Life Insurance coverage continuation

The health, dental, vision care and life insurance benefits in effect when you became disabled will be continued for the period of time during which partial income replacement is received through New York State Disability insurance, subject to the terms of those plans. Refer to *Chapter 9: Continuing Benefits,* under *Disability: New York State Disability or Workers' Compensation* on page 69 for more information on health, dental, and vision care coverage continuation and to *Disability: Life Insurance Continuation* on page 72 for more information on life insurance coverage continuation.

Filing a claim

If your disability absence will exceed 7 calendar days, contact your local Research Foundation office administering benefits to get the documents and information necessary to obtain disability income. You and your physician should complete a New York State Disability Claim Form (DB-450) and file it with your local Research Foundation office administering benefits.

Workers' Compensation and New York State Disability Insurance

Claims appeal

If the insurance carrier denies your claim for disability benefits, they are required to send you a Notice of Rejection within 45 days of receiving your claim, telling you the reasons benefits are not being paid. If you disagree with their action, you have a legal right to request a review of the rejection by the Workers' Compensation Board.

Note: If within 45 days of filing of your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact any office of the Workers' Compensation Board.

Long-Term Disability Insurance

Benefits

Long-term disability insurance through The Standard Life of New York (The Standard) is designed to replace a substantial part of a totally disabled eligible employee's income. The benefit is 60 percent of your regular monthly salary, up to a maximum of $5,000 per month.

Note: Monthly salary is one-twelfth of your projected annual salary at the time you become unable to work because of the disability, prior to any voluntary deductions or deferrals, such as for retirement or health insurance plans. Overtime and other forms of compensation are not included in regular monthly salary.

You must be continuously disabled for 6 months, or if longer, the period you are receiving sick leave or salary continuation from the Research Foundation before benefits start.

You must be under the regular care of a physician, other than yourself or a member of your family. Benefits will *not* be paid if the total disability is due to participation in a felony or riot, to war, or to an intentionally self-inflicted injury. Benefits will *not* be paid while you are in prison, or if you do not participate in rehabilitation. Benefits will be limited to 24 months unless hospital confined, if disability is due to alcoholism and/or drug abuse.

Your long-term disability benefits are reduced by any income benefits you receive from New York State Disability insurance, Workers' Compensation, pension, sick leave, and actual or estimated Social Security. In addition to these offsets, coverage will be reduced if, at any time, your long-term disability benefits, in combination with any other group disability benefits for which you are eligible, exceed 70 percent of your regular monthly salary.

You must apply for Social Security disability benefits and file all available appeals. The Standard can provide you with assistance. The Standard will estimate Social Security benefits and reduce your long-term disability benefits by this amount, until it receives a final written decision from the Social Security Administration. The Standard will make adjustments, if needed, when it receives the final written decision.

The length of time benefits are paid while you are totally disabled depends on your age when the disability began. Refer to the Long-Term Disability Benefits chart on page 42.

The Standard provides rehabilitation services that prepare you to work to the fullest extent of your ability. If you are a candidate for these services and refuse them, your benefits will be discontinued.

Contact your local Research Foundation office administering benefits to request a copy of The Standard Life of New York Certificate of Insurance, which provides details about the Research Foundation's Group Total Disability Insurance Plan.

Note: Employees disabled prior to November 1, 2004 will continue to be covered by the TIAA total disability insurance policy provisions.

Work Transition Benefit

If you are able to return to work on a part-time basis, the first 12 months after your return to work is considered a work transition period. During this time, The Standard will pay the full long-term disability benefit with no offset for your part-time earnings. However, the sum of the benefits from other sources such as Social Security, your part-time earnings and long-term disability benefit payment from The Standard can never exceed 100 percent of your increasing monthly wage base (your pre-disability wage base adjusted annually for inflation).

After one year, if your functionality increases, and you are able to work and earn more, benefits will continue to be recalculated. If your earnings capacity ever exceeds 80 percent of the increasing monthly wage base, no further benefits are due in accordance with the terms of the policy.

Health, Dental, Vision Care and Life Insurance coverage continuation

Benefits in effect at the time you became disabled will be continued based on your date of employment. Refer to *Chapter 9, Continuing Benefits, Long-Term Disability* on pages 70-71 for more information.

Filing a claim

If your disability is expected to last more than 6 months, you will receive information and an application from the Research Foundation Central Office of Human Resources to apply for The Standard Life of New York Long-Term Disability. If you do not receive this information by the fourth month of your disability and you expect to be disabled for more than 6 months, contact your local Research Foundation office administering benefits.

You must complete the application and send it to The Standard Life of New York. The Standard will make a decision within 90 days of receiving your application.

Claims appeal

If your request is denied or you are not satisfied with the response, you may ask for a review. Write directly to The Standard Life of New York within 60 days of receiving your answer. You or your duly authorized representative may examine any documents pertaining to your question or request. You are encouraged to submit issues and comments to The Standard. You will receive a decision in writing on the review within 45 days.

If special circumstances require a delay on a request or question, The Standard will notify you before the end of the initial 45-day determination period. The maximum extension period for the determination is an additional 45 days, for a maximum of 90 days. The notice will explain reasons for the delay and when you can expect a decision.

Retirement contributions

If you are vested in the Basic Retirement Plan at the time you become disabled, The Standard Life of New York will make contributions to your annuity contract while you are receiving long-term disability payments. The contribution will be allocated to TIAA-CREF in the same proportion as when your disability began. You may change your allocation at any time by calling TIAA-CREF.

For more information, refer to *Chapter 8: Pension Benefits, If You Are Not Vested and Leave Research Foundation Employment* on page 51 and *If You Are Vested and Leave Research Foundation Employment* on page 52 and *If You Leave the Research Foundation* on page 62, and *Chapter 9: Continuing Benefits, Disability: New York State Disability or Workers' Compensation* on page 69 and *Long-Term Disability, Retirement contributions continuation* on page 71.

Chapter 8

Pension Benefits

Chapter 8

Pension Benefits

The Research Foundation retirement plans are designed to provide you with income during your retirement. The Research Foundation of State University of New York Retirement Plan ("Basic Retirement Plan") is a defined contribution plan designed to satisfy the requirements of Section 401(a) of the Internal Revenue Code ("Code"). It is funded by the Research Foundation through biweekly contributions to eligible employees' retirement annuity contracts with Teachers Insurance and Annuity Association (TIAA) and the College Retirement Equities Fund (CREF) during your active employment years. The Research Foundation also provides the Optional Retirement Plan to assist you in saving additional funds for your retirement years.

The Research Foundation of State University of New York Optional Retirement Plan ("Optional Retirement Plan") is a voluntary program under Code Section 403(b) designed to provide you with additional retirement savings. All contributions toward the Optional Retirement Plan are made by employees under voluntary salary reduction agreements. The tax-deferred funding vehicles available to you are:

- TIAA-CREF Tax-Deferred Annuity (TDA)
- TIAA-CREF Group Supplemental Retirement Annuity (GSRA)
- Fidelity mutual funds

Definitions

anniversary year
An anniversary year is any consecutive 12-month period, beginning with your date of hire or initial date of qualified service.

defined contribution plan
A plan that provides an individual account for each participant, and in which benefits are based on the amount contributed, plus net earnings which are credited to those contributions.

qualified service
Qualified service is Research Foundation employment in a nonstudent title and nonstudent employment with an eligible prior employer. A year of qualified service is an anniversary year of eligible employment of at least 975 hours for employees working 37.5 hours per week or at least 1,000 hours for employees working 40 hours per week.

service credit
Service credit is time counted towards the service requirements for participation and vesting in the Research Foundation Basic Retirement Plan.

rollover
A rollover is a tax-free transfer of assets from one eligible retirement plan to another.

- An indirect rollover is a payment by the plan made directly to the participant for the purpose of transferring the payment to another eligible retirement plan.
- A direct rollover is a payment by the plan to another eligible retirement plan.

The IRC Section 415 limit takes into account contributions to the Optional Retirement Plan as well as those to the Basic Retirement Plan. Finally, the IRC requires that contributions do not discriminate in favor of highly-compensated employees. If your contributions are affected by the nondiscrimination rules, you will be notified.

Special rules affecting contributions

- For employees hired before July 1, 1992, your initial date of employment will determine your contribution tier unless your Research Foundation service is interrupted for 12 or more consecutive months, in which case your most recent hire date after the interruption in service will govern your contributions following reemployment.
- For employees hired on or after July 1, 1992, the initial date of employment will determine your contribution tier unless your Research Foundation service is interrupted for 15 or more consecutive months, in which case your most recent hire date after the interruption in service will govern your contribution tier following reemployment.
- If you are rehired on or after April 1, 2000, service with SUNY after termination and prior to rehire shall not be considered an interruption in Research Foundation service for purposes of determining your contribution tier.
- If you are hired as a student, your contribution rate will be determined by the date you become a regular (nonstudent) employee. In addition, any student employment following employment as a regular employee will be treated as an interruption in service for the purpose of determining your contribution tier.

Basic Retirement Plan

Eligibility and participation

All nonstudent Research Foundation employees working the required hours of service (975 hours of service for a 37.5 hour week or 1,000 hours for a 40-hour week) shall participate in the Basic Retirement Plan upon completing one year of qualified service. The following individuals are ineligible to participate in the Plan:

- full-time SUNY students employed in a specific student title; however, student service will be considered toward the waiting and vesting periods if the student is subsequently appointed as a regular RF employee;
- members of a collective bargaining unit, unless participation is agreed to pursuant to good faith bargaining;
- leased employees; and
- persons engaged as independent contractors.

Research Foundation contributions

After you complete the one-year waiting period, the RF will contribute to your retirement plan. Your initial date of employment determines your retirement *tier* and the contribution to your account, unless your employment with the Research Foundation is not continuous (see *Special rules affecting contributions,* above). The contribution is a percentage of your annual earnings, to an earnings maximum of $205,000 in 2004 (this maximum is determined by the IRS and subject to change). Internal Revenue Code (IRC) Section 415 limits annual contributions to the *lesser* of $41,000 (2004 amount) or 100% of your compensation.

- **Tier 1**
  Hired before January 1, 1981. 12 percent of the first $16,500 of annual earnings and 15 percent of annual earnings exceeding $16,500.
- **Tier 2**
  Hired on or after January 1, 1981 and before July 1, 1992. 12 percent of annual earnings.

- **Tier 3**
  Hired on or after July 1, 1992 and before July 1, 1994. 9 percent of the first $16,500 of annual earnings and 12 percent of annual earnings exceeding $16,500.
- **Tier 4**
  Hired on or after July 1, 1994. 8 percent of earnings until you complete 7 years of Research Foundation eligible service, and 10 percent of earnings thereafter. The first year of eligible service must include 975/1,000 hours of nonstudent employment. (See *Eligibility and participation* on page 49.) Each subsequent anniversary year in which you are appointed for 1 hour or more of eligible nonstudent service will count as 1 year of service. An anniversary year in which you do not work at least 1 hour of service will result in elimination of previously credited service. When you have completed 7 years of service according to these rules, contributions will increase to 10 percent. Contributions will continue at 10 percent as long as you remain active in Tier 4.

For information about continuing health benefits when you retire, refer to *Chapter 8: Continuing Benefits* on pages 68-69.

Refer to *Where to Call for Help* on page 5 for TIAA-CREF and Fidelity Investments phone numbers.

Pension contribution on sick leave (made at retirement)

If you terminate employment on or after age 55 and are eligible for retiree health insurance *(see page 68)*, you will be provided with an additional pension contribution on your unused sick leave accrual. This contribution is calculated by multiplying the value of your accrued sick leave, up to a maximum of 200 days, by your contribution rate at the time you retire. This benefit is subject to the contribution limits described on page 49. Refer to *Chapter 9: Continuing Benefits* on page 68 for age and service requirements, which are the same as for retiree health insurance.

Vesting rules

Period of nonvested participation

After you complete the 1-year waiting period, described under *Eligibility and participation* on page 49, you become a nonvested participant in the plan. Contributions are set aside for you based on your retirement tier, until you have completed 4 additional years of qualified service.

All Basic Retirement Plan contributions made during this period are applied to the TIAA Traditional Annuity account *(see page 52)* and remain there for the entire period of nonvested participation, provided eligibility status and required hours are maintained.

Vesting

You become a vested participant at the end of 5 full years of qualified service. By *vesting* you gain ownership of contributions made before you became vested and to all future contributions made to your retirement accounts while you are employed by the Research Foundation.

You will be notified when you become vested and you must complete a TIAA-CREF application for annuity contracts. Refer to *Obtaining an annuity contract* on page 52 for more information on the application process.

Employment service credit

Under certain circumstances, the Research Foundation recognizes employment with other organizations in meeting service requirements for participation and vesting in its retirement plan. Continuous, non-student employment with an eligible employer *immediately preceding* your Research Foundation appointment will be considered for qualified service credit. In order to be qualified service, your employment must have terminated no more than 1 year before your Research Foundation appointment and must have been with:

- an accredited college or university in the United States, including State University of New York, or
- a private, nonprofit *research* organization incorporated in the United States under section 501(c)(3) of the Internal Revenue Code. The *primary* function of this organization must be research.

For dates of hire on or after 4/01/00, SUNY service immediately preceding employment with the Foundation will be disregarded if it disadvantages an employee with a longer period of qualified service from another institution. Service with the other institution must have ended within 12 months prior to Foundation employment.

Non-student employment with SUNY which is concurrent with Research Foundation employment will also be counted toward participation and vesting. Concurrent service with other employers will not be counted.

Request for retirement credit based on other employment service

To have your prior qualified service considered toward your retirement waiting and vesting periods, complete and sign Part I of a Request for Retirement Service Credit form and have it certified by your former employer. The form is available from your local Research Foundation office administering benefits. If your request is approved by the Research Foundation, you will receive a year of service credit toward the retirement waiting and vesting periods for each anniversary year you worked at least 1,000 hours (for a 40-hour workweek) of qualified service (975 hours for a 37.5-hour workweek). A completed form must be approved by the Research Foundation before contributions are made based on other employment service. No investment earnings will be credited for periods prior to the date contributions are made.

If you are not vested and leave Research Foundation employment

If you are not vested and leave Research Foundation employment, the funds in your account will be forfeited.

You will have a "break in service" if you are credited with less than 500 hours of service in an anniversary year. If you have 5 consecutive one-year breaks in service, you will lose all past service credit toward vesting and past contributions. You will begin new waiting and vesting periods if you return to eligible employment. If you return to employment before incurring 5 consecutive one-year breaks in service, you will :

- retain all past service credit,
- have contributions and earnings on prior eligible service restored, and
- continue to receive contributions as long as your employment results in your working 1,000 hours each anniversary year.

Note: The hours of service referenced above assume that your appointment is based on a 40-hour week. If your appointment is based on a 37.5-hour week, 500 hours changes to 487.5 hours, and 1,000 hours changes to 975 hours.

If you are vested and leave Research Foundation employment

Once you are vested, your benefits cannot be taken away. The funds in your contracts continue to share TIAA-CREF earnings/losses, even if no further contributions are made. If you return to eligible Research Foundation employment at some future date, you will immediately return to plan participation without a waiting period or new vesting period, although a new retirement application may be required and you may be in a new retirement tier.
(Refer to pages 49-50.)

Directing your investment

Once you have completed 5 years of qualified service you must complete an application to obtain an annuity contract and direct the investment of all the contributions allocated to the Plan on your behalf. You may divide your contributions among the TIAA and/or CREF funds in any whole percentage.

The Plan is intended to be a plan described in Section 404(c) of ERISA, with the result that the fiduciaries of the plan may be relieved of liability for any losses that are the direct and necessary result of your investment decisions and instructions.

Obtaining an annuity contract

To obtain your annuity contracts, complete the application you receive from your local Research Foundation office administering benefits, including your designation of how you want your contributions invested. Return the completed application to your local Research Foundation office administering benefits. ***You must return the application in order for your pension benefits to be allocated to the TIAA-CREF investment funds described below.***
The application will be reviewed and forwarded to the Research Foundation Central Office of Human Resources for processing. Annuity contracts are then sent to you by TIAA-CREF.

Investment funds

The following sections provide brief descriptions of TIAA and CREF funds.

TIAA
Teachers Insurance and Annuity Association (TIAA) is a nonprofit legal reserve life insurance company that provides annuities for employees of educational and research institutions.

TIAA offers two allocation choices, as follows:

- The **TIAA Traditional Annuity** is a fixed annuity in which TIAA guarantees principal plus a specified rate of interest and provides the opportunity for additional dividends. Investments are made in long-term mortgages and bonds.
- The **TIAA Real Estate Account** seeks a return through rental income and capital appreciation. Because it is a variable annuity, its accumulation and returns will fluctuate with the performance of its underlying investments. This account offers no guarantees of principal or earnings.

CREF
College Retirement Equities Fund (CREF), a separate nonprofit companion organization to TIAA, is an investment company that offers 8 annuity investment accounts, as follows:

- The **CREF Stock Account** invests in a diversified portfolio of domestic and foreign stock, with primary emphasis on the US market.
- The **CREF Money Market Account** invests primarily in low-risk, short-

term debt instruments.

- The **CREF Bond Market Account** invests primarily in investment-grade, fixed-income securities.
- The **CREF Social Choice Account** invests in a balanced portfolio of stocks, bonds, and money market instruments of companies that pass certain social criteria screens.
- The **CREF Global Equities Account** invests primarily in foreign stocks, with some domestic stock exposure.
- The **CREF Growth Account** invests in a diversified portfolio of stocks issued by companies of all sizes, with special emphasis given to small- and medium-sized companies in emerging areas of the economy.
- The **CREF Equity Index Account** invests in a diversified portfolio of domestic stocks encompassing almost the entire range of domestic stock investments.
- The **CREF Inflation-Linked Bond Account** invests primarily in U.S. government bonds and other inflation-indexed securities whose rates of return are designated to outpace inflation.

All CREF accounts are variable annuities, so their accumulation and returns will fluctuate with the performance of the underlying investments. CREF accounts offer no guarantees of principal or earnings. For a more complete description of the funds, call, or view publications on their Web site at *www.tiaa-cref.org*. Historical investment returns are available online or by phone request. You should also obtain a fund prospectus from TIAA-CREF before investing.

Changing your distribution of funds

After you have vested, you may change how your future premiums are allocated. Contact TIAA-CREF for information and to process your request (*see page 5*).

Transferring funds

You may also transfer CREF accumulations in amounts of at least $1,000 to any other TIAA-CREF account at any time. Accumulation in the TIAA Real Estate Account may be transferred once a month. Funds in a TIAA Traditional Annuity may be transferred to the TIAA Real Estate Account and to CREF accounts in annual installments over a 10-year period using the Transfer Payout Annuity (TPA) Option. The minimum transfer amount is $10,000 (or the entire accumulation if less than $10,000). Contact TIAA-CREF for information and to process your request.

Changing your name, address, or beneficiary

You may change your name, address, or beneficiary on your contracts by contacting TIAA-CREF. Refer to *Selecting your beneficiary* on page 58 for restrictions on naming a beneficiary if you are married. See page 5 for contact information.

Quarterly accumulation statements and annual illustration

After you have vested, TIAA-CREF will send you statements indicating premiums remitted during the previous quarter and the total accumulation of your contract(s). In addition, TIAA-CREF will send you an annual illustration that provides an estimate of single-life annuity income based on certain assumptions, such as future premiums, retirement age, and future earnings.

You may request a customized illustration by contacting TIAA-CREF.

YOUR W-2 TAX STATEMENT

Under IRS regulations, during any calendar year when contributions are set aside for you as a vested or nonvested member of the Basic Retirement Plan, the Pension Plan Box on your W-2 will indicate **Yes.** This may limit your and your spouse's options for contributing to a personal Individual Retirement Account (IRA).

Certified disability

If you are unable to work because of a medically certified disability and are no longer on the Research Foundation payroll, you will continue to be credited with hours of service based on the percent of effort you were working at the time you became disabled for the rest of your current anniversary year. These hours will be counted, if needed, to ensure that you are credited with a maximum of 1,000 hours (or 975 hours for a 37.5-hour workweek) in that year. If you were credited with 1,000 hours in the current anniversary year prior to incurring a medically certified disability, you would not need to count these additional hours in order to receive a year of service in that anniversary year. In that case, service credit during your disability will continue until you have received a maximum of 1 additional year of service that you would not otherwise have earned as a result of your disability. If you return to work and become disabled again, you will receive up to 501 hours of service credit for each subsequent disability.

Military leave

If you are a non-vested participant, all time during which you were on military leave will be counted toward your retirement waiting/vesting period. For vested employees, contributions cease when you go off the payroll while on military leave. If you return to active employment following military leave, military service qualifying under the Uniformed Services Employment and Re-employment Act (USERRA) of up to 5 years will be credited towards eligibility and vesting service. Retroactive contributions will be made to the Basic Retirement Plan for the period of military service based on your salary in effect at the start of the military leave.

Family and Medical Leave (FMLA)

If you are on an approved leave of absence because of pregnancy, childbirth, infant care, or adoption, you will be credited with up to 501 hours of service in one anniversary year, if needed, to prevent a break-in-service. If you are on an approved leave under the Family and Medical Leave Act for any other reason, you will be credited with 480 hours of service in one anniversary year.

Benefit payments from vested TIAA-CREF contracts

TIAA will provide you with assistance in selecting an annuity option(s) in settlement of annuity contracts.

The normal retirement age is 65; however, you can receive a distribution at any age from your TIAA-CREF contracts following termination from employment with the Research Foundation. Retirement funds can be collected in one of the forms specified below provided you meet the criteria shown in the following payment options. Income from *each* TIAA and CREF contract may begin on multiple dates using any combination of payout options, provided at least $10,000 of accumulation is specified for each starting date and option you choose. The time period selected for a fixed-period option cannot exceed your life expectancy based on TIAA-CREF tables.

Normal form of payment

If you are married on the date you commence to receive payments under the Basic Pension Plan, the payment will be in the form of a Two-Life Annuity with your spouse as the second annuitant, unless your spouse consents to another payment form in writing during the 90 days preceding the date annuity benefits begin. This consent can be revoked only during the same 90-day period. It cannot be revoked after benefits begin.

Annuity payment options

An annual illustration from TIAA-CREF provides an estimate of the single-life annuity income you will receive, based on certain factors and assumptions, such as future earnings and retirement age. Upon request, TIAA-CREF will prepare a personal estimate of annuity income based on your specifications (for example, age at retirement and projected salary increases).

Descriptions of available annuity options are provided below. Options are limited for married participants subject to spousal consent. Please note that once you begin receiving benefits in the form of an annuity, the option may not be changed.

- A **Single-life Annuity** pays you an income for as long as you live. All payments stop at your death. Payments will not be made to a beneficiary unless you select a guaranteed period. With a guaranteed period feature, if you die before the end of the guaranteed period you selected (10, 15, or 20 years), payments will continue to your beneficiary for the remainder of the guaranteed period. The guaranteed period may not exceed your life expectancy.
- A **Two-life Annuity** pays you and your annuity partner income for as long as either of you live. Payments may be continued to a different beneficiary by electing a guaranteed period feature. With a guaranteed period feature, if you and/or your annuity partner die before the end of the guaranteed period you selected (10, 15, or 20 years), payments will continue to your beneficiary for the remainder of the guaranteed period. The guaranteed period may not exceed your joint life expectancy. The payment amount continuing after your death or the death of your annuity partner depends on which of the following benefit payment options is chosen:
  - **Full benefit to survivor.** The benefit payment does not change at the death of the first person.
  - **Two-thirds benefit to survivor.** The benefit payment is reduced to two-thirds of the original amount at either your death or the death of your annuity partner.
  - **Half-benefit to second annuitant.** The benefit payment to you (the former employee) is never reduced. The benefit payment to your annuity partner is reduced to one-half the original amount at your death.

Other payment options

Refer to *Making a cash withdrawal and tax implications* on page 57.

- A **Cash option** allows you to receive your TIAA Real Estate and CREF accumulations in one or more lump sum payments, if you are terminated from Research Foundation employment. This may include systematic withdrawals where you design your own periodic payment plan.
- The **TIAA Transfer Payout Annuity (TPA) Option** allows you to receive your TIAA Traditional Annuity accumulation in annual installments over a 10-year period, if you are terminated from Research Foundation employment. After your death, any remaining balance will be paid to your beneficiary.

- The **Installment Refund Option** is available to you if your TIAA Traditional Annuity contract was issued *before* January 1, 1985 and pays you an income for life. If you die before receiving total contractual payments equal to the full TIAA Traditional Annuity accumulation in your account when annuity payments began, the income will be continued to your beneficiary until the sum of all contractual payments equals that accumulation amount. If you live longer than it takes to pay the original accumulation, payments still continue for the rest of your life, but there are no payments to your beneficiary when you die.
- The **Retirement Transition Benefit** allows you to receive a cash payment of up to 10 percent of your TIAA or CREF accumulations at the time you start annuity income.
- The **TIAA Interest Payment Retirement Option (IPRO)** allows you to receive interest income payments from your TIAA Traditional Annuity, while leaving the principal amount intact, if you are terminated from Research Foundation employment. This option may be discontinued only by converting to another annuity option or to the Minimum Distribution Option (MDO). Refer to *When distribution must begin* below.
- The **Minimum Distribution Option** (MDO) is available to participants who are at least 70½, and allows them to collect the minimum amount required under IRS regulations, while delaying selection of a lifetime annuity income. They must begin receiving income by April 1 following the calendar year in which they turn age 70½. Refer to *When distribution must begin* below.

Full and partial cash withdrawals, systematic withdrawls and the TIAA Transfer Payout Annuity (TPA) Option require authorization by your local campus office administering benefits in order to confirm that your employment has ended.

For a more complete description of payment options, call TIAA-CREF or access the publications section of their Web site. Contact TIAA-CREF for the necessary forms to select an income option.

When distribution must begin

Federal tax law requires that retirement income begin by April 1 of the calendar year following the *later* of

- the calendar year in which you reach age 70½, *or*
- the calendar year in which you terminate employment.

The required IRS minimum income can be collected using the MDO described above.

If the required minimum amount is not distributed, the IRS applies a tax penalty equal to 50 percent of the difference between the amount that should have been distributed and the amount actually distributed.

Minimum distribution requirements

You must begin to receive distributions the April 1 following the year you turn age 70½ , or the April 1 following the year of your retirement, if later. If you are planning to receive periodic distributions to satisfy the minimum distribution requirement, you may wish to consider beginning required distributions by the December 31 of the year you attain age 70½ , to avoid receiving two taxable distributions in the calendar year following attainment of age 70½.

Both TIAA-CREF and Fidelity can assist you in determining your minimum required distribution amount.

Benefits if you die

If you are vested in the Basic Retirement Plan and you die *before* you have annuitized all funds in your TIAA-CREF contracts, any unannuitized balance is available to your beneficiary in a lump sum, unless you have chosen another payment option for your beneficiary, as described in your annuity contract. Your beneficiary may also contact TIAA-CREF for additional options.

Your entire balance must normally be distributed to your beneficiary by December 31 of the 5th calendar year after your death. If elected, death benefits may be payable over the life expectancy of the beneficiary, if the distribution of benefits begins no later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 70½, had you lived.

If you die *after* all funds have been annuitized, any additional payments will be determined by the annuity option you selected at retirement.

There is no death benefit if you are not vested.

Making a cash withdrawal and tax implications

When your Foundation employment ends, you may surrender your Basic Retirement Plan vested TIAA-CREF contracts for the cash value, subject to IRS regulations, if your TIAA Traditional Annuity retirement annuity accumulation is less than $2,000, and your total TIAA-CREF retirement annuity accumulation from employer-paid premiums is not over $4,000 and annuity payments have not begun, including a TIAA Transfer Payout Annuity.

Cash distributions are subject to ordinary income taxes and may be subject to an additional early withdrawal tax penalty. TIAA-CREF must withhold 20 percent from any single sum benefit paid to you, and send it to the IRS. The IRS will apply the amount toward income taxes due. A 10 percent tax penalty will generally apply to cash withdrawals made before age 59½, unless you have medical expenses exceeding the tax-deductible limit or you become disabled, die, or end employment after age 55. There is no tax penalty applied to payments made to children or to a divorced spouse in accordance with a qualified domestic relations order.

If you are married, your spouse must consent in writing to the cash withdrawal. For more information, refer to *Selecting your beneficiary: spousal rights* on page 58. TIAA-CREF will provide additional tax reporting information when a distribution is made. Neither this handbook nor the information provided by TIAA-CREF is intended to be relied upon solely for tax advice. You are encouraged to consult a tax advisor.

Rollover to another qualified retirement plan or traditional IRA

Since 2002, the IRS has allowed the rollover of distributions between different types of retirement plans (e.g., to or from 401(a), 403(a), 403(b), 457(b), and IRA plans). The plan sponsor's rules must also permit this, however. The Research Foundation's plans do not permit distributions before termination of employment.

A qualified rollover will not be taxed. If, however, you take a distribution, and then do not roll the funds over into another qualified retirement plan or to a traditional Individual Retirement Annuity (IRA) account within 60 days of receipt, the IRS will consider the distribution a lump-sum withdrawal and will tax the amount you received.

A mandatory 20 percent federal withholding tax applies to an indirect rollover (that is, one that is made to you, not directly sent to a recipient plan or IRA), which will be refunded by the IRS if the rollover is completed. If you use a direct rollover, the distribution is not received by you, therefore, taxes are not withheld.

You cannot roll over to a Roth IRA. However, you may be able to convert the assets to a Roth IRA based on IRA guidelines. Contact TIAA-CREF for information.

Selecting your beneficiary; spousal rights

Under federal law, if you are married and die before annuity benefit payments begin, your spouse is automatically designated as your beneficiary and must receive a benefit that is at least 50 percent of your retirement plan accumulations. No other beneficiary may receive more than 50 percent of your accumulations, unless your spouse waives this benefit in writing, as required on the form provided by TIAA-CREF.

Note: Your spouse can waive his or her rights to this pre-retirement death benefit once you have reached age 35, or at any age after your employment ends.

Your retirement benefits if you become divorced or separated

In the event that a judgment, decree, or court order establishes the rights of another person to your benefits under the plan, and where there is a qualified domestic relations order, payments will be made by TIAA in accordance with that order. A court order may preempt the usual requirement that your spouse be considered your primary beneficiary for a portion of the accumulation. A copy of the Plan's procedures for determining whether a judgment, decree or order is a "qualified domestic relations order" is available free of charge upon request to the Research Foundation Central Office of Human Resources.

Federal insurance not applicable

Since the Basic Retirement Plan is a defined contribution plan, it is not eligible for federal insurance under the Pension Benefit Guarantee Corporation (PBGC). The PBGC is the government agency that guarantees benefits under defined benefit pension plans.

Claims procedure

You or your beneficiary (or an authorized representative) ("claimant") may submit a written request for benefits under the Plan to the Plan Administrator. The Plan Administrator shall, within 90 days from its receipt, notify the claimant (the person making the claim) of its acceptance or denial. This 90-day period may be extended (up to a maximum of an additional 90 days) if the Plan Administrator determines that special circumstances require an extension of the time for processing the claim. In such case, written notice of the extension shall be furnished before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring the extension and the date by which the Plan Administrator expects to make its decision.

If a claim is wholly or partially denied, the Plan Administrator shall furnish the claimant in writing:

(a) specific reasons for denial;

(b) specific reference to Plan provisions on which the denial is based;

(c) a description (and reason for the needing) of any additional material or information needed to consider the claim; and

(d) an explanation of the review procedure, the time limits applicable, and a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following a denial of a claim following a review.

If, within 90 days of submitting a claim, a notification of acceptance, denial or extension has not been received, the claimant may request a review as if his or her claim had been denied.

If an adverse decision is made on a claim, the claimant is entitled to:

(a) request, in writing, a review of his or her claim by the Plan Administrator – if the adverse decision was by written notification, the request must be made within 60 days following receipt of notification;

(b) review and receive copies of all documents, records, and other information relevant to the denial (no charge will be made for the copies requested); and

(c) submit written comments, documents, records and other information relating to the claim.

The review will take into account all comments, documents, records and other information submitted, whether or not such information was submitted or considered in the initial benefit determination.

The Plan Administrator shall make a final written decision on a claim review, within 60 days, giving specific reasons and making specific references to Plan provisions on which the decision is based. The 60 days may be extended for another 60 days if the Plan Administrator finds that special circumstances require an extension of time for processing, and notifies you of that need before the end of the initial 60-day period for review. As before, you have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits.

Optional Retirement Plan

The Optional Retirement Plan is a defined contribution plan operating under section 403(b) of the IRC, under which employees of tax-exempt organizations can enter into salary reduction agreements with their employers. Under the agreement, a portion of your compensation is deducted from your pay on a before-tax basis and contributed to an annuity contract or mutual fund custodial account, rather than being paid directly to you. These amounts, together with any earnings, are not subject to state or federal income tax until you or your beneficiary starts receiving benefits.

Eligibility

If you are an active employee of the Research Foundation (including students and employees who are paid hourly), you are eligible to participate in the Optional Retirement Plan, regardless of hours worked. There is no waiting period, and you do not have to be a vested or nonvested participant in the Basic Retirement Plan. The money you tax-defer is invested in the way you designate.

All contributions to the Optional Retirement Plan are immediately vested; however, funds can be withdrawn only under limited circumstances. Refer to *Making cash withdrawals* on page 64.

If you would like to participate in the Optional Retirement Plan, contact your local Research Foundation office administering benefits.

Acceptance of eligible rollover distributions

You may make a rollover contribution to the Optional Retirement Plan of an eligible rollover distribution from another employer's eligible retirement plan or your individual retirement account (other than a Roth IRA) or individual retirement annuity. You must request a direct rollover from the distributing plan or make an indirect rollover within 60 days of receipt of the eligible rollover distribution. Contact TIAA-CREF or Fidelity for more information.

IRS maximum salary reduction allowance

The IRS places limitations on the amount of your salary that may be placed in a tax-deferred annuity or mutual fund custodial account. The first limitation, under section 402(g) of the IRC, is a dollar limit. This limit is $13,000 for 2004, $14,000 for 2005 and $15,000 for 2006. After 2006, the 402(g) limit will be adjusted by the IRS for changes in the cost of living.

If you participate in more than one employer's plan, it is your responsibility to make certain that the total contribution from all employers does not exceed the IRC 402(g) limitation. If the limit has been exceeded, you should request a distribution of the excess by notifying the Research Foundation by March 1 of the year following the excess contribution. The excess will then be distributed to you by April 15.

Catch-up contributions

If you are at least age 50 by the end of the Plan year (December 31) and otherwise make the full salary reduction contribution available to you under the Optional Retirement Plan, you may make an additional salary reduction contribution to the plan of up to $3,000 in 2004, $4,000 in 2005 and $5,000 in 2006.

Enrollment

To participate in the Optional Retirement Plan, complete the following forms:

- The **Salary Reduction Agreement** indicates the percentage or dollar amount of salary you would like to contribute and lets you stipulate when the contributions should begin.
- The **Designation of Investment** indicates the TIAA-CREF or Fidelity tax-deferred program(s) – TDA, GSRA, or Fidelity – to which you wish to contribute and the allocation of funds to be applied to one or more of the programs.
- The **application for the program(s)** you select provide information TIAA-CREF or Fidelity will need to open your account and/or establish contracts in your name:
  - TIAA-CREF Retirement Annuity Contract (TDA)
  - TIAA-CREF Group Supplemental Retirement Annuity Certificate (GSRA)
  - Fidelity Investments 403(b) Custodial Account(s) (Mutual Funds)

TIAA-CREF Investment funds

For information on TIAA-CREF funds, refer to *Investment funds* on pages 52-53 for information on TIAA or CREF, and *Where to Get Help* on page 5.

Fidelity Investments

Fidelity Investments is a mutual fund company and financial services brokerage firm that provides investment opportunities in mutual funds. There is a $12 annual maintenance fee per participant, regardless of the number of funds in which you participate; this fee is deducted from the first account listed on your statement each year. Sales charges (commonly known as "loads") are waived for employees who invest in Fidelity accounts through the Research Foundation's Optional Retirement Plan, however, you should familiarize yourself with the investment management fee charged by each of the Fidelity investment options.

For a more complete description, contact your local Research Foundation office administering benefits for an enrollment kit, or view the Fidelity Web site at *www.fidelity.com/atwork*. You should obtain a prospectus from Fidelity before investing. Refer to *Where to Get Help* on page 5.

Changing your distribution of funds

For information on changing your distribution of funds for your TDA contracts, contact TIAA-CREF. For GSRA contracts, you may transfer accumulations among any TIAA or CREF accounts at any time, or from TIAA and CREF accounts to Fidelity, in amounts of at least $1,000. You may also transfer accumulations among Fidelity accounts, or from Fidelity to TIAA and CREF accounts, and change how your future premiums are allocated among your Fidelity or TIAA-CREF accounts. Contact TIAA-CREF or Fidelity to process your request.

Note: Certain investment options may have restrictions on transfers. Please review the TIAA-CREF and Fidelity investment descriptions for more information.

Changing your name, address, or beneficiary

You may change your name, address, or beneficiary on your accounts by contacting TIAA-CREF or Fidelity. If you are married, see *Selecting your beneficiary; spousal rights* on page 58.

Quarterly accumulation statements

TIAA-CREF sends you statements indicating premiums remitted during the previous quarter and the total accumulation of your contract(s). In addition, TIAA-CREF sends you an annual illustration that provides an estimate of single-life annuity income based on certain assumptions, such as future premiums, retirement age, and future earnings. You can request an illustration with alternative assumptions by contacting TIAA-CREF.

Fidelity Investments sends you statements indicating salary reduction contributions remitted during the previous quarter and the total accumulation of your account(s).

Differences Between Group Supplemental Retirement Annuities (GSRAs) and Tax-Deferred Retirement Annuities (TDAs)

Optional Retirement Plan GSRA and TDA contracts are offered through TIAA-CREF and can provide the same investment options. However, there are some differences in investment features, as follows:

Feature	GSRA	TDA
Contract used for funding	Group Supplemental Retirement Annuity Contract	Retirement Annuity Contract
TIAA interest rate for new contributions	.50 percent lower than rate for TDAs	.50 percent higher than rate for GSRAs
TIAA Traditional Annuity transfers to TIAA Real Estate or to CREF	Transfers are completed no later than the next business day	Transfers are completed in 11 installments over a 10-year period
Cash withdrawals after employment ends and at other times subject to IRS restrictions	Full and partial cash withdrawals from TIAA and CREF	Full and partial cash withdrawals from TIAA Real Estate Account and CREF. Cash withdrawals from a TIAA Traditional Annuity are completed in 11 installments over 10 years.
Retirement income payments consisting of TIAA Traditional Annuity interest only	Not available since contracts are fully cashable	Available
Loans	Available up to the lesser of 45 percent of GSRA balance or $50,000	Not available

Changing your Salary Reduction Agreement

The Salary Reduction Agreement will remain in effect for the entire calendar year unless you terminate or change the agreement. If you are

- on the payroll at the end of the calendar year, the agreement will remain in effect through the end of the following calendar year.
- *not* on the payroll at the end of the calendar year, the agreement will end.

Note: A new salary reduction agreement is required if you return to employment in a subsequent calendar year.

Contributions during leave of absence

During a paid leave of absence, plan contributions will continue to be remitted in accordance with your Salary Reduction Agreement. No contributions will be remitted during an unpaid leave of absence.

Stopping your contributions

You may stop your contributions at any time by providing your local Research Foundation office administering benefits a written request to cancel your Salary Reduction Agreement. To start contributions again in the same calendar year, a new Salary Reduction Agreement is necessary.

Changing your investment designations

You may change your investment designations among the tax-deferred programs – TDA, GSRA, or Fidelity mutual funds – for future premiums at any time, and as frequently as you choose, by completing a new Designation of Investment form which is available from the local Research Foundation office administering benefits.

YOUR W-2 TAX STATEMENT

For the calendar year in which you set aside personal contributions in the Optional Retirement Plan, the Pension Plan Box on your W-2 will indicate **Yes.** This may limit your and your spouse's options for contributing to a personal Individual Retirement Account (IRA).

Group Supplemental Retirement Annuity (GSRA) loan option

If you own a GSRA contract, TIAA-CREF offers a loan provision that allows you to use your accumulations as collateral for a loan without making a withdrawal from your contract. If you are married, your spouse must consent to the loan.

You may borrow up to 45 percent of the funds remitted through the Research Foundation to your TIAA-CREF GSRA contract. The minimum loan is $1,000, and the maximum is $50,000. The loan amount you request may be reduced by any outstanding loans under this option. Repayments are made quarterly over a 5-year period, except when the loan is used to purchase a principal residence. In that case, the repayment period may be up to 10 years. The term of the loan cannot extend past April 1 of the year in which you attain age $70^{1}/_{2}$. Your TIAA Traditional Annuity accumulation is used as collateral to secure the loan and must be at least 110 percent of the loan amount. You may transfer TIAA Real Estate and CREF funds to a TIAA Traditional Annuity to increase the collateral. Since the TIAA Traditional Annuity accumulation securing the loan remains in your account, it continues to earn interest and dividends. After the loan is paid, you can transfer the TIAA Traditional Annuity accumulation back to TIAA Real Estate and CREF accounts.

The interest rate on the loan is a variable rate based on Moody's corporate bond yield average. The rate is determined quarterly and will not change unless the new rate differs from the current rate by at least .5 percent. Other than interest on the loan, there are no fees for using this service, and no credit review will be done. If you fail to make a loan payment, the outstanding loan balance, plus the interest on that payment, will be subject to ordinary income taxes and may be subject to the tax penalties applied to early withdrawals.

The above rules apply to funds remitted through the Research Foundation. To obtain more information about the GSRA loan option, or about rules governing funds remitted by other plans, contact TIAA-CREF.

If you leave the Research Foundation

The funds in your TIAA-CREF contracts and Fidelity accounts continue to share in earnings/losses if you leave the Research Foundation, even if no additional contributions are made. The same options you have available to you for changing your distribution of funds as an active employee remain unchanged.

GSRA

Funds contributed to a GSRA during your employment with the Foundation will continue to be available to you for loans, subject to IRS regulations. No future contributions may be made to your GSRA unless you are employed by a TIAA-CREF participating institution.

TDA

You may make contributions on an aftertax basis to a TDA during a full calendar year in which no employer makes contributions on your behalf.

Fidelity

You may make aftertax contributions to Fidelity mutual funds, but since you will no longer be investing through the Research Foundation, your account will be subject to sales charges.

Benefit payments from TIAA-CREF contracts

All options explained under payment options on pages 55-56 are available.

GSRA fixed-period option

In addition to the payment options shown on pages 55-56, the fixed-period option allows you to receive income from your GSRA contract over a fixed number of years – from 2 to 30. If you die during that period, payments will continue to your beneficiary.

Note: The TIAA Interest Payment Retirement Option (IPRO) is not available for GSRA contracts.

Benefit payments from Fidelity accounts

Fidelity does not offer options for collecting a guaranteed lifetime annuity. However, it can provide you with life expectancy tables to help you decide on a periodic payment schedule or assist you in transferring your funds to a company that does offer a guaranteed lifetime annuity option. You may also elect to make periodic withdrawals, to withdraw all funds at one time, or to take a rollover distribution.

Minimum distribution requirements

The minimum distribution requirements for retirement funds from TIAA-CREF or Fidelity are the same for the Basic and Optional Retirement Plans. Refer to *Minimum distribution requirements* on page 56.

Benefits if you die

TIAA-CREF
If you die *before* you have annuitized all funds in your TIAA-CREF contracts, any unannuitized balance is available to your beneficiary in a lump sum, unless you have chosen another payment option for your beneficiary, as described in your annuity contract. Your beneficiary may also contact TIAA-CREF for additional options.

Your entire balance must normally be distributed to your beneficiary by December 31 of the 5th calendar year after your death. If elected, death benefits may be payable over the life expectancy of a designated beneficiary if the distribution of benefits begins no later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 70$^{1}/_{2}$, had you lived.

If you die *after* all funds have been annuitized, any additional payments will be determined by the annuity option you selected at retirement.

Fidelity
The balance in your Fidelity account is available to your beneficiary in a lump sum and must be distributed by December 31 of the 5th calendar year after your death, or in accordance with the special rule described above under TIAA-CREF. Your beneficiary should contact Fidelity for additional information.

Making cash withdrawals

GSRA contracts and Fidelity accounts
Cash withdrawals from annuity accumulations credited before January 1, 1989 are not subject to any restrictions and are available at any time. Cash withdrawals from contributions made to an annuity contract and any earnings credited to an annuity contract *on or after January 1, 1989,* as well as contributions to a Fidelity account credited on any date, are permitted only if you satisfy at least *one* of the following criteria:

- you are employed by the Foundation and have attained age 59$^{1}/_{2}$,
- you have terminated Foundation employment at any age,
- you encounter financial hardship, as defined by the IRS,

  Note: Only the principal may be withdrawn.
- you become disabled as defined by the IRS, or
- you die.

  Note: Your beneficiary may make withdrawals.

TDA contracts
Refer to *Making a cash withdrawal and tax implications* on page 57.

Hardship withdrawals

You may request a hardship withdrawal if you have an immediate and heavy financial need and a distribution is necessary to satisfy that need, under the standards described below. A hardship distribution is includable in income for tax purposes, subject to a 10 percent early distribution tax if you are not yet age 591/2 , and may not be rolled over. You may increase the amount of your hardship distribution request by an amount necessary to pay taxes or penalties reasonably anticipated to result from the distribution. You may not repay a hardship distribution to your account.

The following are the only situations considered to cause an immediate or heavy financial need:

- unreimbursed medical expenses incurred by you, your spouse or dependents;
- purchase (excluding mortgage payments) of your principal residence;
- payment of tuition and related fees and room and board expenses for the next 12 months of post-secondary education for yourself, your spouse, or dependents;
- payment of amounts necessary to prevent eviction from your principal residence, or foreclosure of your principal residence; or
- such other situation that the IRS identifies in regulations.

A distribution will be treated as necessary to satisfy the immediate and heavy financial need if:

- the distribution does not exceed the financial need plus anticipated taxes and penalties;
- you have obtained all distributions and nontaxable loans available from the Optional Retirement Plan; and
- your salary reduction contributions are immediately suspended for six months.

Taxes

Retirement distributions from TIAA-CREF contracts and Fidelity accounts are normally subject to ordinary income taxes. Refer to *Making a cash withdrawal and tax implications* on page 57. A 10 percent tax penalty will generally apply to cash withdrawals made before age 59$^{1}/_{2}$, unless you have medical expenses exceeding the tax-deductible limit, become disabled, die, or end employment at age 55 or older.

Spousal rights

Refer to *Selecting your beneficiary; spousal rights* on page 58. In addition, your spouse must consent in writing to any TIAA-CREF GSRA loan, as described on page 63.

Your retirement benefits if you become divorced or separated

Refer to *Your retirement benefits if you become divorced or separated*, on page 58.

Chapter 9

Continuing Benefits

Chapter 9

Continuing Benefits

There are several situations when you are no longer on the payroll but could still be receiving benefits. This chapter provides current rules on continuing certain benefits following or during one of these events:

- ending your employment
- disability
- leave of absence

Ending Your Employment: Death of an Active or Disabled Employee

Surviving dependent coverage continuation – Health, Dental, Vision Care

Health, Dental, and Vision Care coverage will continue for your covered dependents for 6 months following your death. If you had met all eligibility requirements for retiree health insurance, health coverage may be continued beyond 6 months. The first 6 months of coverage is provided without charge, after which the dependent must pay the full premium.

If you had not met the eligibility requirements for retiree health insurance, coverage beyond the first 6 months is available to your dependents under COBRA. Refer to *COBRA* on page 73 for more information.

Ending Your Employment: Termination

Health, Dental, Vision Care coverage continuation

If you terminate employment, voluntarily or involuntarily, you are eligible to continue Health, Dental, and Vision Care coverage under COBRA. Refer to *COBRA* on pages 73-77 and *Chapter 4: Dental, Extended Dental Benefits After Termination of Employment or Eligibility* on page 29.

Health insurance can also be continued on a direct-payment basis with the carrier. If you are interested, contact Empire Blue Cross or your HMO.

Certification of prior group health plan coverage

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health insurance carrier will provide you and your dependents with certification of prior health insurance coverage. The certificate can be given to a future employer and be used to reduce waiting periods that may apply to pre-existing conditions.

Basic Life (Accidental Death and Dismemberment), Optional Life (AD&D) coverage continuation

You may convert your Basic Life (AD&D), and Optional Life (AD&D) coverage to an individual whole-life policy by contacting Prudential within 31 days from the date your employment ends. You may also be eligible to continue your Optional Life coverage with a lower cost term policy. Refer to *Chapter 6: Life Insurance, Policy Conversion at Employment Termination* on page 38 and *Portability of Optional Life Coverage* and *Policy Conversion – Reduction Due to Age* on page 39.

New York State Unemployment Insurance

The Research Foundation through the New York State Department of Labor (DOL) provides unemployment insurance compensation for up to 26 weeks.

Eligibility

New York State unemployment insurance benefits are available to employees who involuntarily terminate employment with the Research Foundation. You may apply for benefits immediately following termination through your local DOL office.

When benefits begin and end
There is a 7-day waiting period following application for unemployment insurance benefits. Benefits eligibility begins on the eighth day. Benefits end when you are no longer unemployed or 26 weeks have elapsed since the day you began receiving benefit payments, whichever occurs first.

Compensation
The benefit amount paid to you is based on your wages and a DOL formula, up to the maximum weekly benefit in effect under DOL rules at that time. The maximum period during which you may receive benefit payments is 26 weeks; however, the DOL may extend benefits up to 13 additional weeks during periods of high unemployment. Your maximum weekly benefit may be reduced by any pension benefit or other compensation you receive.

Filing a claim
When you terminate employment, you will receive a DOL Record of Employment form which includes your exact date of termination. You should provide the form to your local DOL office when you file a claim (application for benefits). The DOL will review your claim and make a determination on your benefit eligibility based on the New York State Unemployment Insurance Benefits Law. If you meet the Department of Labor's eligibility rules, benefits will begin as described above. You will be notified by the DOL if you are not eligible for benefits. You have the right to appeal a claim in accordance with the DOL's guidelines. Refer to *Where to Call for Help* on page 5 for phone number and Web site.

Health insurance coverage continuation at retirement

This section describes retiree health insurance rules now in effect. The Research Foundation reserves the right to change these rules in the future.

The Research Foundation will continue your health insurance coverage *after you retire*, if you meet the following eligibility requirements. You must:

- be enrolled in either the Research Foundation Health Plan *or* a Health Maintenance Organization (HMO) when you retire.
- have completed a minimum of 10 years of continuous, full-time service (or the equivalent in part-time service, at 50 percent or more of full-time effort) with the Research Foundation immediately before you retire. (For example, a person working 50 percent of time for 20 years would qualify.)

  Note: A break-in-service of one year or more will disqualify your previous service toward retiree health insurance. Time spent working as a SUNY employee will not count as a break-in-service for those retiring on or after November 1, 1999, nor will it count as eligible service.
- be at least age 55.
- be continuously employed by the Research Foundation during the one-year period immediately prior to retirement dates on or after November 1, 1999.
- enroll in Original Medicare Parts A and B when you reach age 65, but not part D.

If you do not choose to continue your health insurance with the Research Foundation at the time you retire, there is no option for enrollment at a later date.

The Research Foundation will continue health insurance coverage for your eligible dependents if they have been covered under your plan for at least 1 year before you retire. No new dependents can be added to your coverage after you retire. If you die, health insurance for your covered dependents will continue for the remainder of their lifetime, provided you retired *after* January 1, 1986 and your dependents remain in an eligible status.

Payment of health insurance premiums
After you retire, your Research Foundation health insurance premiums will be paid as follows:

If you were	then
hired *before* January 1, 1986	The Research Foundation will pay the full premium for your coverage. You must enroll in Original Medicare Parts A and B when you reach age 65, and pay the Part B premium.
hired *on or after* January 1, 1986	Until you become covered by Medicare, you are responsible for the same share of the premium as an active employee. Payment details will be provided at the time of retirement. The Research Foundation will pay the full premium for your coverage once you become covered by Original Medicare Parts A and B, which currently occurs at age 65. You must pay the Part B premium

How Medicare affects your health insurance benefits

You must enroll in Medicare Part A (hospital) and Part B (medical/surgical), if:

- you are age 65 or older and are retired from Research Foundation active employment, *or*
- you have received Social Security disability benefits for 2 years or longer.

If you delay enrollment in Original Medicare Parts A and B, benefits that would otherwise be paid under the Research Foundation plan will be reduced by the amount that would have been paid by Medicare. If you enroll in a Medicare plan other than Original Medicare, your secondary benefits through the Research Foundation may be reduced or eliminated. Please contact the Research Foundation Central Office of Human Resources before enrolling in a Medicare Plan that is not Original Medicare.

You should not enroll in Medicare Part D (prescription drug coverage) which begins in 2006. This is because the Research Foundation will have an agreement with the federal government to continue providing your prescription drug benefits.

Dental, Vision Care, Basic Life (AD&D), Optional Life (AD&D) coverage continuation

Refer to *Ending Your Employment: Termination*, under *Health, Dental, Vision Care coverage continuation* and *Basic Life (AD&D), Optional Life (AD&D) coverage continuation* on page 67.

Disability: New York State Disability or Workers' Compensation

Health, Dental, Vision Care coverage continuation

For the period of time you receive income replacement through New York State Disability insurance for a nonwork-related illness or injury, the Research Foundation will continue the benefits in effect at the time of your disability.

If you currently receive income replacement through Workers' Compensation for a *total disability* caused by a work-related illness or injury sustained during Research Foundation employment, the Foundation will continue the benefits in effect at the time of your disability, either for the period of the total disability, or up to age 65, whichever comes first. At age 65, you will be eligible to continue your health insurance coverage as a retiree if you meet the eligibility criteria. Refer to *Health insurance coverage continuation at retirement* on page 68.

Retirement contributions continuation

If you are participating in the Research Foundation Basic Retirement Plan, the Research Foundation will continue to make retirement contributions but only as long as you remain on the payroll receiving a paycheck. Refer to *Chapter 7: Disability Plans* on page 40, and *Chapter 8: Pension Benefits* on page 46 for additional information.

Disability: Long-Term Disability

Health, Dental, Vision Care coverage continuation

Full-time employees

If your disability extends beyond 6 months and you qualified for Long-Term Disability benefits before you became disabled, you are eligible to apply for benefits under the Long-Term Disability Insurance Plan, insured by The Standard Life of New York.

If you are receiving Long-Term Disability payments, the benefits in effect at the time you became disabled will continue under the same terms and conditions that apply to active employees. Based on your date of employment, coverage continues as follows:

Hired before January 1, 1986

For those employees hired before 1986, the Health, Dental, and Vision Care coverage you had prior to your disability will continue *for the length of your disability*.

In addition:

If you	then
had met 10 consecutive years of full-time equivalent service before your disability began and you continue to be disabled at age 65,	you will continue receiving health insurance coverage for the length of the disability, or until age 65, whichever comes first, and your health insurance will be continued as a retiree. Refer to page 68.
do not meet the 10-year full-time equivalent service requirement, but had 5 consecutive years years of full-time equivalent service before you became disabled,	while you are receiving Long-Term Disability payments, you will be credited with service toward eligibility for retiree health insurance at age 65.
are no longer receiving Long-Term Disability payments, and your disablility ended after you met the age and service requirements for retiree health insurance.	your health insurance will continue as a retiree. Refer to page 68.

Hired on or after January 1, 1986

For those employees hired on or after January 1, 1986, the Health, Dental, and Vision Care coverage you had at the time of your disability will continue *for one year* from the date your Long-Term Disability benefits begin.

In addition:

If you	then
had met 10 consecutive years of full-time equivalent service before your disability began and and continue to be disabled at age 65,	you will continue receiving health insurance coverage for the length of the disability, or until age 65, whichever comes first, and your health insurance will continue as a retiree. Refer to page 68.
do not meet the 10-year full-time equivalent service requirement, but had at least 5 consecutive years of full-time equivalent service before you became disabled,	while you are receiving Long-Term Disability payments, you will be credited with service toward eligibility for retiree health insurance at age 65, *provided you continue coverage by paying the total premium (employer and employee share) until age 65.*
are no longer receiving Long-Term Disability payments, and your disability ended after you met the age and service requirements for retiree health insurance .	your health insurance will continue as a retiree. Refer to page 68.

Retirement contributions continuation

Vested employees

If you are vested in the Research Foundation Basic Retirement Plan when you become totally disabled, The Standard Life of New York will continue contributions to your annuity contract at the same rate as before the disability based on your annual salary at the time of your disability. Contributions continue for as long as you receive Long-Term Disability benefits. The contributions credited toward your retirement account are divided between TIAA and CREF in the same proportion as when your disability began. You may change your allocation at any time by calling TIAA-CREF directly.

Nonvested employees

If you are not yet a vested member of the Basic Retirement Plan at the time your disability begins, contributions to your retirement account will not continue while you are receiving Long-Term Disability benefits.

Disability: Employees Not Eligible for Long-Term Disability Benefits

Health, Dental, Vision Care coverage continuation

If you are a totally disabled employee not eligible for Long-Term Disability, Health, Dental, and Vision Care benefits effective at the time of your disability will continue if you are receiving Social Security disability payments under the following circumstances:

If you have	then
at least 1 year, but less than 10 years of full-time service (or the equivalent in part-time service, at 50 percent or more of full-time effort) at the time of disability,	benefits will continue for 1 year beyond the time New York State Disability benefits cease. *Note: After 1 year, benefits may be continued for a limited period under COBRA, if you pay the full premium. Refer to* COBRA *on pages 73-77.*
10 or more consecutive years of full-time service (or the equivalent in part-time service, at 50 percent or more of full-time effort) at the time of disability,	health insurance benefits will continue for the duration of the total disability while you remain covered by Original Medicare Parts A and B until you reach age 65. At age 65, health insurance will continue as a retiree. Refer to page 68.
If you are no longer receiving a Social Security disability benefit,	health insurance benefits will continue as a retiree if you meet the age and service requirements outlined on page 68.

Disability: Life Insurance Continuation

Basic Life (AD&D) coverage continuation

Basic Life and AD&D Insurance coverage in effect at the time of your disability will continue as long as you remain totally disabled and are collecting New York State Disability, Workers' Compensation, Long-Term Disability, or Social Security Disability benefits. You must continue to submit proof of disability to the life insurance carrier. Coverage is subject to the following limits. If you become disabled:

- before age 60, coverage ends at age 65.
- at or after age 60, but before age 65, coverage ends after 5 years.
- between (and including) ages 65 and 68, coverage ends at age 70.
- age 69 or older, coverage ends after one year.

Optional Life (AD&D) coverage continuation

If you are eligible, you may continue Optional Life and AD&D Insurance coverage in effect at the time of your disability for the remainder of the disability provided you pay the full premium to the Research Foundation. The age limitations shown under Basic Life Insurance coverage continuation above, also apply to Optional Life Insurance.

Leave of Absence: Without Pay

Health, Dental, Vision Care, Basic Life (AD&D), Optional Life (AD&D) coverage continuation

While on an approved leave of absence for up to 1 year, you may continue Health, Dental, Vision Care, and Life Insurance benefits by paying the full premium (employee plus employer share) directly to the Research Foundation.

Leave of Absence: Family and Medical Leave

Health, Dental, Vision Care coverage continuation

During periods of approved leave under the federal Family and Medical Leave Act (FMLA), you may continue Health, Dental, and Vision Care coverage if you pay the same share of the premium as an active employee. Please contact your local RF office administering benefits to obtain the forms you must complete for this continuation.

Basic Life (AD&D), Optional Life (AD&D) coverage continuation

You may continue Basic Life (AD&D) and Optional Life (AD&D) Insurance during Family and Medical Leave by paying the full premium.

After your Family and Medical Leave period ends

Upon your return to employment following FMLA leave, all benefits for which you were eligible before the leave will be reinstated without a waiting period, even if benefits were not continued during the leave.

If you remain on leave without pay beyond the maximum 12-week FMLA period, you may be required to meet a waiting period when you return to work, unless you continued your benefits by paying the entire premium for the time out beyond 12 weeks.

If you choose not to return to work after FMLA leave expires, the Research Foundation can recover its share of the premium from you.

If you have questions about continuing your benefits while on FMLA leave, contact your local Research Foundation office administering benefits. Refer to *COBRA* on page 73 for additional information on continuing your benefits.

Leave of Absence: Military Leave

Health, Dental, Vision Care coverage continuation

During periods of approved military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), your Health, Dental, and Vision Care coverage in effect at the time of the leave may be continued for up to 18 months. You will be required to pay the same share of the premium as an active employee for the first 12 weeks of leave, the full premium after 12 weeks and up to 1 year from the beginning date of military service, and the COBRA premium rate (100 percent premium and 2 percent administrative fee) for the next 6 months. Refer to *COBRA* on pages 73 for additional information regarding your coverage.

Basic Life (AD&D), Optional Life (AD&D) coverage continuation

Your Life Insurance coverage in effect at the time of leave will continue for *up to 1 year,* provided you pay the full premium.

Reinstatement of your benefits upon return from Military Leave

All benefits for which you were eligible prior to qualifying military leave under USERRA will be reinstated without a waiting period upon your return. Any benefit for which you are eligible that became effective during the military leave will become effective upon your return to Research Foundation employment. You will be credited with time toward the 10-year retiree health insurance service requirement and toward retirement plan vesting during the period of qualifying military service. You must return to Research Foundation employment and document your service and discharge as required under the law.

COBRA

Health, Dental, Vision Care, Health Care Flexible Spending Account coverage continuation

COBRA continuation coverage is available to “qualified beneficiaries” on account of “qualifying events.” COBRA continuation coverage is a continuation of health plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” If you, or a member of your family, have coverage under the Health, Dental, Vision Care, and/or Health Care Flexible Spending Account at the time of the qualifying event, you each have an opportunity to continue coverage under any of these plans.

Qualified Beneficiary

COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under a health plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. In order to be a qualified beneficiary, an individual must generally be covered under the group health plan on the day before the qualifying event that causes a loss of coverage (such as termination of employment, or a divorce from, or death of, the covered employee). However, a dependent child born to you, or placed for adoption with you, while you have COBRA continuation coverage has the same right to elect COBRA continuation coverage as the dependents who were covered by the Plan on the day before the event that created your COBRA rights. Electing COBRA continuation coverage for newborn or adopted children is important if, during the first 18 months of COBRA coverage following a termination of employment or reduction in hours, a second qualifying event occurs involving your death, divorce or legal separation, or entitlement to Medicare, or the dependent child ceases to meet the definition of "dependent" under the terms of the Plan. Under such circumstances, a dependent child who has elected COBRA continuation coverage has the right to continue COBRA coverage for an additional period of time, up to 36 months from the date of the first qualifying event. *You should notify the Plan Administrator within 30 days of the child's birth or placement for adoption, so that this valuable right is not lost.*

If a proceeding in bankruptcy is filed with respect to the Research Foundation, and that bankruptcy results in the loss of coverage of any retired employee covered under the health benefit plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the health plan.

Qualifying Events

Termination or Reduction in Hours

If you lose group health plan coverage because of a termination of employment (for reasons other than gross misconduct) or a reduction in hours, you and other qualified beneficiaries who have coverage through you under Research Foundation health plans may elect to continue existing coverage for a period of time.

Death, Divorce, Medicare Entitlement

If your spouse's or dependent's coverage would otherwise terminate because of your death, your entitlement to Medicare, or divorce or legal separation, the affected individuals may elect COBRA continuation coverage.

Loss of Dependent Status

If dependent children lose coverage because they are no longer considered "dependents" under the terms of the Plan, they also may elect COBRA continuation coverage.

Note: Dependent children over the age of 19 covered under full-time student status are no longer eligible for coverage once they leave school for any reason, unless they apply for COBRA continuation.

Duration of Continuation Coverage

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months. This 18-month period may be extended under two circumstances: due to a disability or a second qualifying event.

Disability Extension

If an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan is generally required to make COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to COBRA continuation coverage in the covered employee's family is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for up to 29 months, rather than 18 months, to any qualified beneficiary in the family that elects this extended coverage. The COBRA premium will increase to 150% of the full premium after the initial 18 months of continuation coverage. In order to qualify for the extension, the individual must be disabled at the time of termination of employment or reduction in hours of employment, or become disabled during the first 60 days of COBRA continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. The affected individual must notify the Research Foundation Central Office of Human Resources within 60 days of any final determination that the individual is no longer disabled.

Second qualifying event extension

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualifying beneficiary eligible to elect coverage, except for bankruptcy.

Bankruptcy

If qualified beneficiaries lose coverage due to a bankruptcy proceeding, affected retirees and surviving spouses of deceased retirees are entitled to elect lifetime coverage. Spouses and dependent children of retirees are eligible to continue coverage until the retiree dies, and then are entitled to up to 36 months of continuation coverage from the date of the retiree's death. However, the events that can cause early termination of COBRA coverage still apply.

Your responsibilities

Under the law, you and your family member(s) have the responsibility to inform the Research Foundation as Plan Administrator of a divorce, legal separation, or child losing dependent status within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. If the disability extension is elected, you must notify the Research Foundation Central Office of Personnel Services within 60 days of any final determination that the qualified beneficiary is no longer disabled.

You must elect COBRA continuation within 60 days of the date you receive the Election Form, or coverage will be lost.

Paying for Continuation Coverage

You and other qualified beneficiaries who elect COBRA continuation must pay for the coverage elected. Qualified beneficiaries must pay the full premium (employee and employer share) plus an administrative fee of two percent to the Research Foundation. When coverage is continued for longer than 18 months on the basis of disability, the COBRA premium will increase to 150% of the full premium after the initial 18 months of continuation coverage. You will be notified of the cost of coverage at the time you are given notice of your right to elect COBRA following a qualifying event. The cost may change during the period of COBRA continuation coverage.

The initial payment (including premiums for all periods since the qualifying event) is due no later than 45 days following election of continuation coverage. After the initial payment, payment for each month of continuation coverage is due on the first of the month. There is a grace period of 30 days for payment of the regularly scheduled premium.

If you do not pay for continuation coverage, coverage will be retroactively terminated.

Termination of Continuation Coverage

The law also provides that your continuation coverage may be terminated prior to the end of its maximum coverage period for any of the following reasons:

- The Research Foundation no longer provides group health coverage to any of its employees;
- The premium for your continuation coverage is not paid on time;
- After electing continuation coverage under the Research Foundation health plan, the qualified beneficiary becomes covered by another group plan, unless that plan contains any preexisting condition exclusions or limitations that apply to the qualified beneficiary;
- You become entitled to Medicare;
- Coverage is extended for up to 29 months because of disability, and there has been a final determination that the qualified beneficiary on whom the extension is based is no longer disabled.

Health Care Flexible Spending Account

COBRA continuation coverage under the Health Care Flexible Spending Account (“Health FSA”) is subject to the following rules:

If, as of the date of the Qualifying Event, the Qualified Beneficiary can receive a higher benefit from the Health FSA than the maximum amount the Plan may charge for COBRA premiums under the Health FSA for the remainder of the Plan Year, then continuation coverage must be made available for the remainder of the Plan Year (but not for any subsequent year). This would likely be the case where a Qualified Beneficiary has had more money contributed to the Health FSA for the year than he or she has submitted reimbursable expenses as of the date of the qualifying event. For example, if a Qualified Beneficiary could receive benefits for $2,400 in unreimbursed medical expenses and the maximum COBRA premium for the remainder of the plan year is $1,002, the qualified beneficiary may elect continuation coverage under the Health FSA.

If, as of the date of the Qualifying Event, the maximum amount the plan may charge for COBRA premiums under the Health FSA for the remainder of the plan year equals or exceeds the maximum benefit that the Qualified Beneficiary can receive from the Health FSA for the remainder of the year, continuation coverage is not available. This would be the case where the Qualified Beneficiary already received reimbursement for expenses equal to or greater than his or her Health FSA account balance as of the date of the Qualifying Event.

Effect of Not Electing COBRA

If you do not choose continuation coverage, your Health, Dental, Vision Care, and Health Care Flexible Spending Account coverage will end on the date specified by the plan. If you have a 63-day break in Health Benefit coverage, you could lose the ability to join another health plan without the imposition of an exclusion or waiting period with respect to any preexisting condition you or your spouse or dependents may have.

Chapter 10

Optional Programs

Chapter 10

College Savings Program

The Research Foundation offers participaton through direct deposit in New York's College Savings Program (NYCSP). The savings plan allows an employee state and federal tax benefits while saving for qualified higher education expenses.

This program is authorized under Section 529 of the Internal Revenue Code and is jointly administered through the Office of the State Comptroller and the Higher Education Service Corporation. The program is managed by UPromise Investments, Inc., and the funds are managed by the Vanguard Group, Inc.

Any employee eligible for payroll direct deposit is eligible for the College Savings Program. Participation is only through payroll direct deposit to a NYCSP account managed by UPromise.

Program overview

Parents, grandparents, other relatives or friends (the account owner) can set up a Tuition Savings Account for a future college student (a specific beneficiary). Contributions to the account are invested according to the investment options selected by the account owner. After the account has been open for 36 months, the account owner can withdraw money without penalty to pay for the qualified higher education expenses of the beneficiary.

The first $5,000 which is invested each year for a future college student will be deductible from New York State gross income when the employee files his or her state income tax return. A married couple filing a joint return may deduct up to $10,000 per year. Investment earnings will not be taxed by the state or federal government as long as the money withdrawn is used for qualified higher education expenses and the funds remain on deposit for 36 months before they are withdrawn.

Withdrawals used by the beneficiary for qualified higher education expenses are not subject to federal or New York State income taxes. Federal tax advantages will expire in 2010 unless extended by Congress.

UPromise rewards

UPromise offers a unique opportuity to add additional credits to your account simply by registering for the rewards program and by making qualifying purchases from any of the Plan's numerous nationwide partners. Refer to *Program information* on page 80 to learn how to get additional details.

New York's College Savings Program brochure

You should receive a New York's College Savings Program brochure from your local Research Foundation office administering benefits. If you want to enroll, you can request an Enrollment Kit, which includes detailed information about the program, a payroll deduction authorization form, and an enrollment form. You can complete the electronic form on the New York College Savings Program Web site at *http://www.nysaves.org*. Enrollment forms are also available on the same Web site.

In Order to Enroll You Must

- Be qualified for and enroll in your Campus Direct Deposit Program.
- Ask for and complete a College Savings Program "Enrollment Form and Tuition Savings Agreement."
- Ask for and complete a College Savings Program "Authorization for Automatic Payroll Deduction."
- Submit signed and completed forms to the Research Foundation Payroll Office.

Payroll Deductions

The effective date of the direct deposit for the College Savings Program will be the start date of the second payroll period following the date the forms are received by the Research Foundation Payroll Office. Ten (10) business days are required from their receipt of the forms before payroll deduction funds can be accepted.

Overpayments

Direct deposits to the NYCSP account are made before direct deposits to your local bank. If you are overpaid and also have directed funds to college savings, you will be required to reimburse the RF for the entire overpayment. Funds already deposited to the NYCSP will remain in the college savings account.

You are responsible for the maintenance of your college savings account. You may retrieve funds from NYCSP by filling out the appropriate NYCSP forms and taking any penalties that may apply to nonqualified withdrawal.

Program Information

Program information can be obtained by calling 1-877-NYSAVES (1-877-697-2837) or by using the Program Web site at *http://www.nysaves.org*.

Group Long-Term Care

The Research Foundation, in partnership with C N A Insurance, offers regular, salaried employees working at least half-time, the opportunity to purchase a voluntary Group Long-Term Care Plan. This plan is made available to employees after six (6) months of employment. You or your spouse/domestic partner pay the full cost of the program participation through payroll deduction on an after-tax basis. Also eligible are your parents, parents-in-law, grandparents and grandparents-in-law who will be billed directly by the carrier for premiums. Premiums are per person and based on the individual's age on the effective date of coverage.

Group Long-Term Care from C N A offers comprehensive, flexible benefits at an affordable price. Long-term care protection is a variety of services available to individuals who are unable to care for themselves due to an illness, accident or disability. The services are provided in a setting other than the acute care portion of a hospital. Services can be provided on a temporary or permanent basis, in a nursing home, or in a person's home. Long-term care services can range from simple help with meal preparation to assistance with bathing and dressing or to complete 24-hour monitored care.

With Group Long-Term Care from C N A, you choose a plan that's right for your needs. Because not everyone needs the same amount of coverage, you determine the amount of daily benefit and the lifetime maximum. The daily benefit amount is the maximum daily amount a person can receive in benefits.

If you are an eligible employee and enroll during your initial eligibility period, you are guaranteed acceptance. Spouses, domestic partners, and other eligible family members may enroll at this time but their coverage is subject to C N A medical underwriting approval and is not guaranteed.

C N A Brochure

You should receive a C N A Long-Term Care Brochure from your local campus office responsible for administering benefits. There are several ways to obtain more information about the Group Long-Term Care Plan from C N A and to enroll:

- Visit their web site at *www.ltcbenefits.com* (password trfsunyltc).
- Call C N A Group Long-Term Care Customer Service toll-free at 1-877-777-9072.

The enrollment kit contains the various applications and brochures that outline the plan design, rates, exclusions and limitations. The completed application should be mailed to: C N A Insurance, P.O. Box 946760, Maitland, FL 32794-9776.

ERISA

Your Rights Under ERISA

The following statement is required by federal law and regulation and applies to those benefit plans identified in the "Summary of Plans" that have a "Plan Number," indicating that the plan is subject to the Employee Retirement Income Security Act (ERISA). The Research Foundation of State University of New York is the Plan Administrator.

As a Participant in the Plans, you are entitled to certain rights and protections under ERISA of 1974, which provides that all Plan Participants shall be entitled to the following protections.

Right to receive information about your plan and benefits

You are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) 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 Administrator is required by law to furnish each Participant with a copy of this summary annual report; and
- With respect to the Retirement Plans, obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to earn the right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.
- With respect to the group health plans, including the health, vision and dental plans, continue coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- With respect to group health plans (other than dental and vision), reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage form another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to election COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent actions by Plan fiduciaries

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

Enforcement of your rights

If your claim for a pension 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 at 1-866-444-EBSA (3272) or accessing the Web site at *http://www.dol.gov/ebsa*.

HIPAA

Your Privacy Rights Under HIPAA

The Research Foundation is the sponsor of group health plans that are subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA privacy rules, although Research Foundation is not itself generally a "covered entity," the group health plans sponsored by the Research Foundation are covered entities. The Research Foundation and its group health plans are committed to maintaining the privacy of health information pertaining to individuals enrolled in the Plan.

"Protected health information" (PHI) is all individually identifiable information that relates to the past, present, or future physical or mental health or condition of an individual, or the past, present, or future payment for health care for an individual, regardless of the form (oral, written or electronic) in which the information is held.

Each of the plans may disclose PHI to the Research Foundation to carry out the following administration functions for the plan:

- to determine if an individual is participating in the plan;
- to modify, amend or terminate the plan;
- to obtain premium bids to provide insurance coverage for the plan, including reinsurance;
- to carry out other administrative functions of the plan such as:
  - Claims Assistance: Designated personnel may assist Covered Persons (i.e., employees of the Research Foundation who are plan participants and their covered dependents) in attaining a resolution of any issues related to obtaining payment for claims, including coverage and eligibility issues.
  - Appeal of Benefit Denials: Designated personnel may assist Covered Persons in appealing benefit denials of the insurer or third party claims administrator.
  - Individual Rights Requests: Refer to *Your rights regarding your PHI* on page 86 for more information.
  - Audit Functions: Designated Personnel may review PHI such as Check Registers to confirm payment and perform other audit functions.

Designated Personnel are Research Foundation employees who administer the group health plans.

Designated Personnel will provide the services on behalf of the Plan as part of the payment and/or health care operations of the plan. As a result, it is intended and understood that any and all disclosures of PHI of plan participants by and insurer or third party administrator to the Designated Personnel shall be permitted by 45 CFR 164.506(c)(1) and shall be exempt from the authorization requirement of 45 CFR 164.508.

These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information may not be disclosed or used by the Research Foundation for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Company.

With respect to the health plans identified as being self-insured in the Summary of Plans contained on page 6, the Research Foundation may receive PHI in connection with its role as the final arbiter of claims that have been appealed as provided under the administrative services agreements.

With respect to PHI that Research Foundation receives from the Plan, Research Foundation shall:

- Not further use or disclose the PHI other than as permitted or required by the Plan Documents or as required by law;
- Ensure that any agents, including an insurance broker or a subcontractor, to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to Research Foundation with respect to such information;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Research Foundation;
- Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for herein, of which it becomes aware;
- Make available PHI as required by 45 C.F.R.§164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526;
- Make available the PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for purposes of determining compliance by the Plan;
- If feasible, return or destroy all PHI received from the Plan that the Research Foundation still maintains in any form, and not retain copies when the PHI is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;
- Ensure that adequate separation between the Plan and the Research Foundation is established.
- The plans will disclose PHI to the Research Foundation only upon receipt of a written certification by Research Foundation that the plan documents have been amended to incorporate the foregoing provisions of this paragraph.

The Plan will disclose, as permitted or required by the Plan, PHI to only the following classes of employees or other persons under the control of Research Foundation: Employees who administer the group health plans.

These employees and the Designated Personnel shall use and disclose only the minimum amount of PHI necessary to perform the administration functions identified in this Section.

Participants can report complaints concerning Research Foundation's use or disclosure of PHI to: Privacy Officer, Vice President for Human Resources, The Research Foundation of State University of New York, P.O. Box 9, Albany, NY 12201-0009.

Please refer to the Notice of Privacy Practices issued by each of the plans for more information. Those Notices are incorporated into and considered a part of your summary plan description (member handbook) for each of the health plans.

Your rights regarding your PHI:

- Right to Inspect and Copy. You have the right to inspect and receive a copy of your protected health information, except under a few unusual circumstances. If you request a copy of your protected health information, the Plan may charge a fee for the costs of copying.
- Right to Amend. If you feel that protected health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. To request an amendment, your request must be made in writing and should include the reasons(s) why you believe the Plan should amend your information. The Plan will respond to your request for amendment no later than 60 days after the receipt of your request. If the Plan denies your request for an amendment, the Plan will provide you with a written notice that explains its reasons. You will have the right to submit a written statement disagreeing with the denial. You will also be informed of how to file a complaint with the Plan or with the Secretary of the Department of Health and Human Services.
- Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain disclosures the Plan has made of your protected health information. Disclosures that were made to carry out payment and health care operations, disclosures to persons involved in your care or payment for your care, disclosures that were made to you or made in accordance with your written authorization, and certain other disclosures need not be included in an accounting of disclosures.

  To request an accounting of disclosures, you must submit your request in writing and must state the time period for which you are requesting an accounting of disclosures, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request will be free. If you request additional lists within 12 months, the Plan will charge you for the costs of providing the list. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before costs are incurred. The Plan will respond to your request for an accounting of disclosures within 60 days.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information the Plan uses or discloses about you for treatment, payment or health care operations. The Plan is not required to agree to your request. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care, like a family member or friend. If the Plan agrees to your request for restriction, the Plan will limit the disclosure of your protected health information, unless the information is needed to provide you with emergency treatment or to comply with law. To request restrictions on disclosures, you must make your request in writing, and you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- Right to Request Confidential Communications. You have the right to request that the Plan communicate with you in a certain way or at a certain location. For example, you have the right to request that messages not be left on an answering machine. To request confidential communications, you must make your request in writing. The Plan will not ask you the reason for your request, and the Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and how payment for your health care will be handled if the Plan communicates with you through this alternative method or location.
- Right to Receive a Notice of Privacy Practices. You have the right to receive a Notice of Privacy Practices from a plan. To obtain a copy of this Notice, please contact the Privacy Official at the Benefits/Claims Administrator identified on page 5.

Key Terms

Understanding Important Terms

This section provides brief definitions of important terms used in this handbook.

For health plan terms, refer to your PPO or HMO handbook.

Terms that primarily relate to a specific benefit plan are indicated as such. If no specific plan is indicated, the definition may apply to several plans.

Annuitant – A person receiving retirement annuity payments.

Annuity – A contract that provides a retirement income for a lifetime or for a specified number of years.

Beneficiary – Person(s) you designate to receive benefits at the time of your death (Life Insurance or Retirement).

Break-in-service – A specified period of time during which you no longer meet the eligibility requirements for a particular benefit.

Claims administrator – The insurance carrier (or company) that contracts with the Research Foundation to administer claim payments for a benefit plan.

Compensation – Salary and wages paid to an employee (including amounts contributed pursuant to a valid salary reduction agreement under Section 125, 403(b), or 457(b) of the Internal Revenue Code), as reported on federal income tax form W-2, or its equivalent. Salary and wages in excess of IRS limits ($205,000 in 2004) shall be disregarded for retirement contributions, as shall imputed taxable income resulting from group health plan coverage for individuals other than dependents recognized by the IRS.

Copayment – The amount you pay a provider on each visit.

Deductible – The amount you pay for services each calendar year before payment is made by the plan.

ERISA – The Employee Retirement Income Security Act (ERISA) of 1974 entitling employees to benefits rights and protections.

GSRA – A TIAA-CREF Group Supplemental Retirement Annuity contract for employee tax-deferred funds.

HIPAA – Health Insurance Portability and Accountability Act *(see page 84)*.

HMOs – Health Maintenance Organizations. Certified health care organizations that provide hospitalization coverage, a comprehensive plan of medical and surgical care, and prescription drugs. HMOs operate within designated regions.

Leave of absence – A period of up to 1 year of approved time away from your job.

Medicare – The health care programs for the aged and disabled established by the Social Security Act of 1965, as amended.

Military service – Performance of voluntary or involuntary U.S. military duty including active and inactive duty for training, full-time National Guard duty, and time away from employment for physical exams to determine fitness to serve.

Nonforfeitable – A benefit that cannot be taken away from you (e.g., vested Pension Benefits).

Nonparticipating providers – Providers who are not part of a plan's authorized network (e.g., Dental, Health, or Vision Care).

Participant – A person eligible to receive benefits and enrolled under any benefit plan or an eligible employee for whom retirement contributions are being remitted.

Participating pharmacy – A pharmacy that has agreed to fill prescriptions and accept payment under the terms of the plan (Prescription Drugs).

Participating providers – Providers who are part of a plan's authorized network (Health, Dental, or Vision Care).

Primary plan – The benefit plan responsible for paying for any covered services before the other plan(s), when you are covered under two or more plans.

Qualified domestic relations order – A court order providing for child support or other marital property payments that may affect benefits.

Qualifying event – A change in an employee's personal or employment status that permits a change to be made in pretax health insurance deductions outside of the annual open enrollment period.

Secondary plan – The benefit plan responsible for paying for any covered services after the primary plan, when you are covered by two or more plans.

TDA – A TIAA-CREF Tax-Deferred Annuity contract for employee tax-deferred funds.

Total disability – A condition resulting from disease or injury which, as certified by a physician, causes your inability to perform any occupation for which you are reasonably suited by education, training, or experience.

Usual, Customary and Reasonable – The fee calculated and payable by Delta Dental for services as follows:

Usual Fee – the amount regularly charged or received by a dentist for the service performed.

Customary Fee – an amount within the accepted range of all usual fees charged or received by dentists for the same service in the same area.

Reasonable Fee – the usual and customary fee for the service performed, unless there are exceptional circumstances which warrant a higher fee.

Vesting period – A specified period of time before you gain a nonforfeitable right to a retirement benefit and during which contributions are set aside on your behalf (Pension Benefits).

Waiting period – A specified period of time that must elapse before you become eligible to participate in a benefit plan.

Index

Using the Index: Facts at Your Fingertips

When you want benefits information quickly, use this alphabetical index to look up the main word of the item you need.

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