

**RESEARCH FOUNDATION FOR MENTAL HYGIENE
WELFARE PLAN AND SUMMARY PLAN DESCRIPTION
BASE DOCUMENT, FOR USE WITH ADOPTION AGREEMENT**

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ARTICLE I

INTRODUCTION

This document, together with the Adoption Agreement and the Supporting Documents, describes the terms of the Plan identified in the Adoption Agreement ("Plan"). The Supporting Documents are the separate benefit documents (including, without limitation, plan documents, trust agreements, group insurance policies and certificates of coverage, to the extent applicable) providing for the terms and conditions of coverage and benefits available. Participants and beneficiaries may request copies of these Supporting Documents from the Plan Administrator. Except as specifically provided herein, the provisions of this Plan shall apply to all of the Supporting Documents. In the event of a conflict between the Plan and the specific terms of any insurance contract, the insurance contract shall control. In the event of a conflict between the Plan and Supporting Documents (other than the specific terms of an insurance contract), the provisions of this Plan document shall control; in the event of a conflict between the Plan (taking into consideration the Supporting Documents) and any other document or communication regarding welfare benefits, the provisions of this Plan document (together with the Supporting Documents incorporated herein) shall control.

With respect to any group health plans and disability benefits provided under the Plan, the Plan is intended to be an "accident and health plan" under Sections 105 and 106 of the Code, and with respect to the life insurance benefits, the Plan is intended to qualify as "group term life insurance" under Section 79 of the Code. The Plan is to be interpreted in a manner consistent with the requirements of such Sections. The Plan is established and shall be maintained with the intention of meeting the requirements of ERISA and the Code (including the COBRA Rules, to the extent applicable) and the corresponding provisions of any subsequent laws, and the provisions of the Plan shall be construed to effectuate this intention.

THE EMPLOYER RESERVES THE RIGHT, IN ITS SOLE DISCRETION, TO CHANGE OR TERMINATE THE PLAN AND/OR THE COMPONENT BENEFITS AT ANY TIME WITHOUT PRIOR NOTICE TO OR CONSENT OF THE PARTICIPANTS OR BENEFICIARIES.

ARTICLE II

DEFINITIONS

As used in the Plan:

2.01 Adoption Agreement means the Adoption Agreement signed by the Employer, that describes certain terms and conditions for participating in the Plan, and identifies Component Benefits. The Adoption Agreement is incorporated into and is a part of the Plan.

2.02 Board means the Board of Directors or Board of Trustees or other appropriate governing entity of the Employer.

2.03 CHIPRA Enrollment Period means the 60-day period following the date of a notice that a premium assistance subsidy is available under a State Child Health Insurance Program (CHIP) with respect to a Dependent.

2.04 Claims Administrator means the person(s) or entity/entities appointed by the Plan Administrator and responsible for the administration and/or adjudication of claims under one or more Component Benefits, including an insurer. The Claims Administrator for each of the Component Benefits is identified in Article II of the Adoption Agreement.

2.05 COBRA or COBRA Rules means the rules set forth in Code Section 4980B and implementing Treasury Regulations, in accordance with which the Employer must allow Qualified Beneficiaries to elect to continue Group Health Plan coverage upon the occurrence of certain events, known as "qualifying events."

2.06 Code means the Internal Revenue Code of 1986, as amended from time to time, any Treasury Regulations thereunder, and any rulings issued by the Internal Revenue Service. References to any Section of the Code shall include any successor provision.

2.07 Component Agencies means (a) a member of a controlled group of corporations or group of trades or businesses under common control (as defined in Code Section 414(b) and (c)) of which the Employer is a member, or (b) a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer, (c) any other entity that must be aggregated with the Employer pursuant to Section 414(o) of the Code, or (d) such other entity that, with the consent of the Employer, elects to be treated as an Related Employer, any of which adopts the Plan with the permission of the Employer. The term "controlled group of corporations" has the meaning given in Code Section 1563(a), but determined without regard to Code Sections 1563(a)(4) and (e)(3)(C). The list of Component Agencies for purposes of this Plan is set forth in Section 1.07 of the Adoption Agreement.

2.08 Component Benefit(s) means any welfare benefit coverage offered by the Employer under the Plan that is identified as a Component Benefit in the Adoption Agreement. The Component Benefits are part of this Plan and the terms of the Component Benefits are specifically incorporated into this Plan. In the event that any of the Group Health Plans is a self-insured medical expense reimbursement plan within the meaning of Section 105(h) of the Code, the Group Health Plans are hereby designated as constituting a single plan that is intended to satisfy the requirements of Section 105(h)(2) of the Code.

2.09 Creditable Coverage means coverage of an individual under any of the following: a group health plan, health insurance coverage, Part A or B of Title XVIII of the Social Security Act (Medicare), Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services (armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service)), a medical care program of the Indian Health Service or of a tribal organization, a State Health benefits risk pool, a health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program), a public health plan (domestic or foreign), a health benefit plan under Section 5(e) of the Peace Corps Act, and Title XXI of the Social Security Act (State Children's Health Insurance Program).

2.10 Dependent means (except as otherwise provided in the applicable Supporting Documents) the person(s) (if any) identified in the Adoption Agreement as Dependent(s), depending on the Component Benefit. "Dependent" also includes (a) a Disabled Dependent Child, with respect to any Component Benefit in the Adoption Agreement that provides the a Disabled Dependent Child is eligible for coverage, and (b) any child an Eligible Employee is required to treat as a "dependent" pursuant to a "qualified medical child support order" (as defined in Section 609(a) of ERISA).

Effective for Plan Years beginning on or after September 26, 2010, for a Group Health Plan that is not an Excepted Benefit (other than a Health Flexible Spending Account), an adult child shall be a Dependent until the child attains age 26. The terms of the Supporting Document shall control when coverage ceases as a result of attaining this limiting age. If the Supporting Document is silent, coverage ends at midnight on the day prior to the child's 26th birthday.

2.11 Disabled Dependent Child is a Dependent Child, regardless of age, who is mentally or physically disabled prior to the attainment of disqualifying age specified in the Adoption Agreement for the applicable Component Benefit, if the child is covered under the Plan and classified as disabled by the Plan Administrator prior to attainment of that disqualifying age.

2.12 DOMA Spouse means the female spouse of a male Participant, or the male Spouse of a female Participant.

2.13 Domestic Partner means the person satisfying criteria established by the Plan Administrator as the domestic partner of an Eligible Employee, if the Adoption Agreement identifies Domestic Partners as eligible for coverage under one or more Component Benefits.

2.14 Effective Date means the effective date of this Plan, as identified in the Adoption Agreement.

2.15 Election Form means the form(s) provided by the Plan Administrator to an Eligible Employee to elect coverage under the Plan, to specify one or more Component Benefit(s) and to provide such additional information as may be required by the Plan Administrator.

2.16 Eligible Employee means a common-law employee of the Employer or a Related Employer that has adopted the Plan, who meets the requirements set forth under each Component Benefit in Adoption Agreement, and who is not identified as "Ineligible" in the same provisions.

2.17 Enrollment Period means the open enrollment period(s) established by the Plan Administrator during which an Eligible Employee must file an Election Form to participate in the Plan and elect coverage under one or more Component Benefits. "Enrollment Period" for the Plan shall include any Special Enrollment Period and any CHIPRA Enrollment Period.

2.18 Employer means the entity identified in the Adoption Agreement.

2.19 Excepted Benefit means a separately-offered, limited-scope dental or vision benefit, a separately-offered benefit for long-term care, home care, community-based care, or such other similar, limited benefit as are specified in regulations, coverage for a specified disease or illness and hospital indemnity or other fixed indemnity insurance offered as independent, noncoordinated benefit, Medicare supplemental health insurance, coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the U.S. Code, and similar supplemental coverage.

2.20 ERISA means the Employee Retirement Income Security Act of 1974, as amended.

2.21 FMLA means the Family and Medical Leave Act of 1993, as amended.

2.22 FMLA Leave means the unpaid leave of up to 12 work weeks in any 12-month period for any of the following reasons, as required under the FMLA:

- a. the birth and or care of the employees newborn child,
- b. the placement and/or care of a child with the employee for adoption or foster care,
- c. to care for a spouse, son, daughter, or parent with a serious health condition, or

d. because of the employee's own serious health condition which renders the employee unable to perform the essential functions of his/her position.

2.23 Group Health Plan means a Component Benefit that provides health care (directly or otherwise) to Participants and their Dependents, as identified in Section 2.01 of the Adoption Agreement; except that, for the purposes of the Special Enrollment Period, the term "Group Health Plan" does not include any Excepted Benefits.

2.24 Participant means an Eligible Employee who participates in the Plan as provided in Section 4.03.

2.25 Period of Coverage means the Plan Year or such other period as the Plan Administrator shall specify. As an exception, the Period of Coverage for an individual who first becomes an Eligible Employee during a Plan Year shall commence only after he or she has satisfied the eligibility requirements under any specific Component Benefit.

2.26 Plan means this welfare benefit plan, the name of which is identified in the Adoption Agreement, as amended from time to time.

2.27 Plan Administrator means the person(s) or entity described in Section 1.10 of the Adoption Agreement, or the delegate of such person(s) or entity

2.28 Plan Year means the Plan Year identified in Section 1.08 of the Adoption Agreement.

2.29 Pre-Tax Contribution means the amount contributed on behalf of the Participant pursuant to a compensation reduction agreement under a Section 125 Plan.

2.30 Qualified Medical Child Support Order, or OMCSO is defined in Section 8.04.

2.31 Special Enrollment Period means the 30 day period following an event that provides special enrollment rights described in Section 6.04(c).

2.32 Spouse has the meaning determined by the laws of the state in which the Participant lives, except as otherwise provided in the Supporting Documents, and includes a DOMA Spouse.

2.33 Supporting Documents means the separate Component Benefit(s) documents including, without limitation, plan documents(s), certificates of coverage, booklet(s), handbook(s), summary plan description(s), trust agreement(s), group insurance policies and administrative service contract(s), to the extent applicable, that describe the principal terms and conditions of coverage and benefits of the Component Benefits, as amended or replaced from time to time. The Supporting Documents are incorporated herein by reference and made a part of this Plan.

2.34 USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III

COST OF COVERAGE

The cost of coverage is described in the separate schedules provided by the Plan Administrator.

ARTICLE IV

ENROLLMENT

4.01 Nondiscrimination on the Basis of a Health Factor

Eligibility for enrollment and re-enrollment in a medical coverage option is not based on health status, medical condition (including both physical and mental illness), claims experience, receipt of health care services, medical history, genetic information, or evidence of insurability or disability.

4.02 Preexisting Condition Exclusions. Certain medical coverage options available under the Plan may contain preexisting condition exclusions or limitations of benefits. A preexisting condition exclusion or limitation of benefits may be imposed for any condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the first day of coverage under the Plan, or the first day of any waiting period for coverage under the Plan. Preexisting condition exclusions do not apply to pregnancy or to newborns, adopted children, or children placed for adoption, as long as the child is covered under some form of Creditable Coverage within 30 days after birth, adoption or placement for adoption.

The maximum limitation period for a preexisting condition exclusion is 12 months, or 18 months if you do not enroll when first eligible or during a special enrollment period. The preexisting condition exclusion period is reduced for each day that you had "creditable coverage" under another health plan, as long as you have not had a 63-day break in coverage. To take advantage of this reduction of the limitation period, request a certificate of coverage from your prior coverage, and provide it to the Administrator.

Effective for Plan Years beginning on or after September 23, 2010, preexisting condition exclusions do not apply to a child under the age of 19 with respect to a Group Health Plan that is not an Excepted Benefit.

If any coverage option contains a preexisting condition exclusion, you will be notified of this by the Claims Administrator.

4.03 Enrollment Periods

There are several opportunities to enroll and participate in the Plan:

a. Initial Eligibility: When you first become eligible to participate, you may enroll during the time period established by the Plan Administrator immediately before the date your participation begins.

b. Open Enrollment: The Plan Administrator usually holds an annual enrollment period at the end of each Plan Year, for coverage commencing on the first day of the next Plan Year.

c. Special Enrollment Periods. (See Section 4.06 below).

4.04 Commencement of Participation

Participation in any Component Benefit shall commence when all of the eligibility requirements specified in Article II of the Adoption Agreement are satisfied, at the time specified in Article IV of the Adoption Agreement.

4.05 Participation Upon Reemployment

If you are reemployed following a termination of employment you must again satisfy the eligibility requirements described in the Adoption Agreement for the applicable Component Benefit.

4.06 Special Enrollment Periods

a. HIPAA Special Enrollment. An Eligible Employee (and his or her Spouse and/or Dependent(s)) may enroll for Group Health Plan coverage (other than an Excepted Benefit) during the 30-day period corresponding with a special enrollment period provided in accordance with the Health Insurance Portability and Accountability Act. Special enrollment rights occur under the following circumstances:

- i. Loss of Other Coverage. If, during open enrollment, the Eligible Employee waived medical coverage because the employee and/or the employee's Spouse and/or Dependent(s) were covered under another health plan at that time, and that coverage ends because
 - A. it was COBRA coverage and its maximum time limit expired,
 - B. where the other coverage was not under COBRA, coverage terminated due to loss of eligibility (for example, as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or termination of employer contributions. There is no special enrollment right if coverage is cancelled voluntarily.

The Eligible Employee has 30 days after the other coverage ends to enroll in a Group Health Plan coverage option. Enrollment will be effective on the day after the other coverage is lost.

- ii. New Dependent. An eligible Employee may enroll a new Spouse or Dependent (through marriage, birth, adoption, or placement for adoption) (and the Eligible Employee, if not previously enrolled) for Group Health Plan coverage within 30 days of the marriage, birth, adoption or placement for adoption. Coverage will become effective
 - A. in the case of marriage, as of the date of the marriage;
 - B. in the case of a Dependent's birth, as of the date of such birth; or
 - C. in the case of a Dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

b. CHIPRA Enrollment. During a CHIPRA Enrollment Period, the Dependent (and, if not otherwise enrolled, the Eligible Employee) may be enrolled in a Group Health Plan that is not an Excepted Benefit as a Dependent of the Eligible Employee. The Eligible Employee must provide evidence of the CHIP premium assistance subsidy to the Plan Administrator. See Appendix C for more information about CHIPRA enrollment.

Contact the Plan Administrator if you wish to take advantage of a special enrollment right.

4.07 When Coverage Ends

Your participation in the Plan or a Component Benefit offered under the Plan will terminate on the earlier of the date on which (i) the Plan or the applicable Component Benefit terminates, (ii) your eligibility to participate ceases, (iii) the Participant refuses a request for information by the Plan Administrator or the Claims Administrator, (iv) with respect to elected benefits, you revoke your most recent Election Form and notify the Administrator that you no longer want to be covered by one or more of those benefits, (v) you terminate employment, or (vi) coverage is terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact).

Spouse and Dependent coverage ends if (i) the Plan terminates, (ii) the Plan Sponsor terminates all coverage to Spouses and/or Dependents under the Plan, (iii) the Spouse or Dependent becomes covered as an Eligible Employee (iv) the Spouse or Dependent is no longer eligible for benefits, (v) you fail to make any required contributions, or (vi) the Participant's coverage terminates.

If you lose eligibility during the Plan Year, participation in the Component Benefit for which you are no longer eligible will end on the date described in Article IV of the Adoption Agreement. This does not effect eligibility for COBRA continuation of Group Health Plans. See Article V.

ARTICLE V

CONTINUATION OF COVERAGE (COBRA)

5.01 In General. 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 an Eligible Employee or Dependent has coverage under a Group Health Plan at the time of the qualifying event, each person has an opportunity to continue coverage under COBRA.

5.02 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 Group 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 child born to a Group Health Plan Participant or who is placed for adoption with a Group Health Plan Participant during the period of COBRA continuation coverage is also a qualified beneficiary.

A Domestic Partner is not a qualified beneficiary. See Appendix C, Domestic Partner Benefits, for further information.

A Spouse who is not a DOMA Spouse is a qualified beneficiary with respect to Group Health Plans insured in New York. For self-funded plans, and insurance issued outside the State of New York, see the Supporting Documents for more information.

A dependent child born to a covered Participant, or placed for adoption with a covered Participant, while COBRA continuation coverage is in effect 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 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.

5.03 Qualifying Events:

a. **Termination, Reduction in Hours or Loss of Eligibility:** If Group Health Plan coverage is lost because of a termination of employment (for reasons other than gross misconduct) or a reduction in hours or, with respect to an insured coverage option issued in the State of New York, a loss of eligibility, the covered Participant and other qualified beneficiaries who have coverage through the employee under the Group Health Plan(s) may elect to continue existing coverage for a period of time.

b. **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.

c. **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.

5.04 Duration of COBRA Continuation Coverage. The law requires that a qualified beneficiary be afforded the opportunity to maintain COBRA continuation coverage for up to 36 months unless Group Health Plan coverage was lost because of a termination of employment or a reduction in hours (or, in insured coverage, loss of eligibility). In that case, the required continuation coverage period is 18 months. For insured Group Health Plan coverage, an additional 18 months of continuation coverage is available after the initial 18-month of COBRA

continuation, for a total of 36 months of continuation coverage, regardless of the qualifying event. If the initial COBRA period is 18 months (for example, for Dental), this 18-month period may be extended under two circumstances: due to a disability or a second qualifying event).

5.05 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 any individual entitled to the COBRA continuation coverage in the covered Participant'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 Participant's family that elects this extended coverage. The COBRA premium may 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. In addition, the Plan Administrator must be 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. If the Social Security determination of disability predates the qualifying event, the Plan Administrator must be notified of the determination within the first 60 days of COBRA continuation. The affected individual must notify the Employer within 60 days of any final determination that the individual is no longer disabled.

5.06 Second Qualifying Event Extension. If a qualified beneficiary experiences another qualifying event covered while receiving COBRA continuation coverage, the qualified beneficiary 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 Group Health Plan as a Dependent child. In all of these cases, the Plan Administrator must be 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.

5.07 Responsibilities of the Participant. Under the law, the Participant and the Participant's family member(s) have the responsibility to inform the 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 Group Health Plan because of the event, whichever is later. If the disability extension is elected, you must notify the Employer within 60 days of any final determination that the qualified beneficiary is no longer disabled.

COBRA continuation must be elected within 60 days of the date the Election Form is received, or coverage will be lost.

Each Eligible Employee has an obligation to the Plan Administrator informed of any changes in the addresses of the Participant and Dependents.

5.08 Paying for Continuation Coverage. A qualified beneficiary who elects COBRA continuation must pay for the coverage elected. Qualified beneficiaries must pay the full premium (employee and employer share) and may also be charged an administrative fee of two percent to the Employer. 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 date specified in Section 1.15 of the Adoption Agreement. There is a grace period of 30 days for payment of the regularly scheduled premium.

If the premium for continuation coverage is not timely paid, coverage will be retroactively terminated to the first day of the month for which coverage is not paid.

5.09 Termination of Continuation Coverage. The law also provides that continuation coverage may be terminated prior to the end of its maximum coverage period for any of the following reasons:

- The Employer (and any employers aggregated and treated as a single employer with Employer under Code Section 414(b), (c), (m), or (o)) no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- After electing continuation coverage, the qualified beneficiary becomes covered by another group health plan, unless that plan contains any preexisting condition exclusions or limitations that apply to the qualified beneficiary;
- After electing continuation coverage for health insurance, the qualified beneficiary becomes entitled to Medicare;
- Where coverage is extended for up to 29 months because of disability, there has been a final determination that the qualified beneficiary on whom the extension is based is no longer disabled; or
- Your employment is terminated for gross misconduct.

5.10 Effect of Not Electing COBRA. If COBRA continuation coverage is not elected, Group Health Plan coverage will end on the date specified in the Adoption Agreement. If there is a 63-day break in Creditable Coverage, another health plan may impose an exclusion or waiting period with respect to any preexisting condition you or your spouse or dependents may have.

5.11 NYS Young Adult Coverage or COBRA Continuation Coverage. Young adult coverage is available under insured medical coverage options if a Dependent would lose coverage under the insured medical coverage option because the young adult ceases to be a Dependent under the terms of that plan, and meets the following conditions:

- Age 29 or younger;
- Unmarried;
- Live, reside or work in New York State;
- Not eligible for medical coverage under another employer's health plan (note that this requirement is about eligibility not enrollment – if you are eligible for the other coverage, you lose your eligibility to continue under the Employer's medical coverage);
- Not covered by Medicare.

Young adult coverage is different from COBRA continuation coverage. You should consider the following when you make your decision:

- COBRA coverage lasts for 36 months from the date coverage would be lost as a result of “aging out” or loss of full-time student status. NYS young adult continuation coverage lasts until the child reaches age 30 if the eligibility conditions are met.
- COBRA coverage can continue if you move out of New York, get married, or if you get a job that offers medical insurance coverage (but you do not enroll for the other employer's coverage). NYS young adult coverage ends if one of these situations arise.
- If you do not elect COBRA coverage within 60 days of receiving your COBRA notice, you lose the right to COBRA coverage. If you do not elect NYS young adult coverage within 60 days of the date you would lose coverage as a young adult under the medical insurance policy, you can elect coverage on a prospective basis during an open enrollment period. If you otherwise qualify for NYS young adult coverage, you could make an election during the open enrollment period when you anticipate that your COBRA will expire – but if you wait until COBRA actually expires, you might have a period of time in which you are not covered.
- The Employer can charge 102% of the premium cost for COBRA coverage, but only 100% of the premium cost for NYS young adult coverage. In addition, you must pay the premium for NYS young adult coverage when you elect the coverage. You have 45 days after your election to pay your first premium payment for COBRA.
- NYS young adult coverage ends if the Employer switches to self-insured medical coverage; COBRA coverage ends only if the Employer offers no medical coverage, insured or self-insured (assuming no other early termination event applies).

ARTICLE VI

COMPONENT BENEFITS

6.01 Terms of Component Benefits

The Adoption Agreement provides a summary of the coverage options available as Component Benefits. For more information regarding a specific Component Agreement, you can contact the Plan Administrator or the Claims Administrator at the address or phone number listed in the Adoption Agreement.

The terms of the Component Benefits under the Plan, eligibility requirements, effective dates of coverage, termination and coordination of benefits, and related provisions shall be determined by the terms of the Supporting Documents, which are hereby incorporated by reference. Supporting Documents may be amended at any time by agreement between the Employer and the Claims Administrator or insurer (if any). The Component Benefits may be terminated by the Employer or may be terminated by the Claims Administrator or insurance carrier as described in the applicable contract or certificate. If you need a copy of these documents, please contact the Plan Administrator.

6.02 Breast Reconstruction Benefits

The health coverage options available under the Plan provide benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This Federal law requires group health plans that provide medical and surgical benefits for mastectomy to also provide certain additional benefits related to breast reconstruction.

If the Participant (or a covered Dependent) is receiving mastectomy benefits and elects breast reconstruction in connection with the mastectomy, the health coverage options will provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

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. Further, the law prohibits: (i) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (ii) providing any incentive (monetary or otherwise) to induce the attending physician to provide care that would be inconsistent with the law.

The above described coverage required by the law may only be subject to the annual deductibles and coinsurance that apply to similar benefits.

Benefits will be provided as they would for any other surgical expense.

6.03 Benefits Under the Newborns' and Mothers' Health Protection Act

A Group Health Plan or group health insurance insurer may not, under federal law, 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 cesarean section. However, the mother's or the newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, no pre-authorization from your health plan or the group health insurance insurer is needed for a stay of up to 48 hours (or 96 hours).

6.04 Qualified Medical Child Support Order

A Qualified Medical Child Support Order is an order or judgment from a court or administrative body that directs the Plan to cover a child as a Participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a Qualified Medical Child Support Order. When an order is received, each affected Participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a Qualified Medical Child Support Order will not become effective until

the Administrator determines that the order is a Qualified Medical Child Support Order. A copy of the written procedure for determining whether a Qualified Medical Child Support Order is valid is attached as Appendix A.

6.05 Patient Protections/Primary Care Physician

If a medical Component Benefit requires or allows for the designation of primary care providers by participants or beneficiaries, you have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For Component Benefits that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, you do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our health plan network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For information on how to select a primary care provider, and for a list of the participating primary care providers, see the Supporting Documents for the Component Benefit.

6.06 Coordination of Benefits

Coordination of benefits is a method of paying benefits when more than one medical plan covers you or a family member. It determines how much each plan pays toward expenses. The contract or certificate provided by the insurer or HMO that you have selected describes the terms and conditions regarding Coordination of Benefits and subrogation (collecting from third parties who may be liable for paying some of the health expenses).

6.07 Subrogation, Reimbursement and Third Party Recovery

You may incur medical care services due to injuries that may be caused by a third party or a third party may be responsible for payment. In such circumstances, you may have a claim against the liable third party, including but not limited to any third party's liability insurance and uninsured or underinsured motorist. The benefits advanced, or to be advanced by this Plan will be paid only if you fully cooperate with the terms and conditions of the Plan. When the Plan advances benefits for accidental injury or illness or other loss for the benefit of a person covered by this Plan, the Plan shall be subrogated to all rights of recovery that the person, his heirs, guardians, executors, agents or other representatives may have as a result of the loss.

Any person who claims and receives medical care services on account of an injury caused by a third party may be required by the Plan Administrator or a Claims Administrator to execute a reimbursement agreement. The signed reimbursement agreement indicates that the person who receives benefits from the Plan agrees to promptly reimburse the Plan for benefits advanced, out of any monies recovered against the person causing the injury or any other source as the result of judgment, award, settlement or otherwise.

Regardless of whether a reimbursement agreement is required or signed, accepting advanced benefits under this Plan for incurred medical expenses automatically assigns to the Plan any rights the participant may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim, which the participant has against any third party, or insurer, whether or not the participant chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the participant whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

Each person covered by the Plan agrees to recognize the Plan's right to subrogation and reimbursement from the first dollars recovered. The Plan specifically states that it has priority over any and all funds paid by any party relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, other costs or expenses, whether or not the participant is made whole. If the Participant fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the participant will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant. The Plan may not pay for any additional care or treatment for the Participant, whether anticipated or unanticipated, until the Plan is reimbursed in accordance with the Plan terms.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds. If the injury or condition giving rise to subrogation involves wrongful death of a participant, this provision applies to the parent, guardian or the executor, agent or other personal representative of the estate.

When a right of recovery exists, the Participant will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan advance benefits. Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. In addition, the participant will do nothing to prejudice the right of the Plan to subrogate. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan.

The Plan shall have no obligation to share the costs of, or pay any part of, the Participant's attorney's fees and costs incurred in obtaining any recovery.

ARTICLE VII

CLAIMS AND APPEALS PROCESS

7.01 Application For Benefits

A claim for benefits under the Plan can be filed by a Plan Participant or beneficiary (a “claimant”), or by an authorized representative acting on behalf of the claimant, by contacting the insurer, HMO or Claims Administrator identified in the Adoption Agreement in the manner specified in its booklets and contracts describing the coverage provided. .

7.02 Procedures for Health Claims

Each insurer, health maintenance organization and Claims Administrator for a Group Health Plan will follow claims procedures that satisfy the requirements specified in this Section. For purposes of this procedure, the person who is responsible for making a claims decision is referred to as the “Claims Administrator.”

a. 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 treatment 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.

b. 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.

c. 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.

d. 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.

e. Appeal of an Adverse Determination: A claimant has 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.

f. External Review Available: The Patient Protection and Affordable Care Act and New York State Insurance Law allows health care consumers to file an external appeal when a medical plan denies care or coverage on the basis that these services are not medically necessary, experimental or investigational. External appeals are conducted by an independent review organization consisting of health professionals who have no connection to the Plan, the health care provider or the health care facility involved in your care. You will be notified about how to pursue an external appeal in the final adverse determination. Remember, an external appeal is only available following a final adverse determination, i.e. after you or your provider have lost at least one internal appeal within the medical coverage option.

7.03 Procedures for Disability Claims

A decision on a claim for benefits will be made no later than 45 days after receipt of the claim. This time period can be extended for two additional 30-day periods if, prior to the expiration of the determination period, the Claims Administrator determines that, due to matters beyond its control, a decision cannot be rendered within that determination period. If an extension of the initial 45-day claim period is necessary, the Claims Administrator will notify the claimant of the date it expects to render a decision. If a second 30-day extension becomes necessary, the Claims Administrator will inform the claimant of the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

In any case where the Claims Administrator requests additional information, the claimant will have at least 45 days to provide the information.

If a disability claim is denied, a written request for review of the denial must be made within 180 days after receiving notice of the denial. A decision on appeal will be rendered within 45 days after the request for review. If an extension of time is required to process the claim, the Claims Administrator will notify the claimant in writing before the end of the initial 45-day period of the special circumstances requiring the extension and the date by which a decision is expected. The maximum extension period is 45 days. The claimant has at least 45 days to provide any additional information requested by the Claims Administrator.

7.04 Procedures for Life Insurance and AD&D Claims

A decision on a claim for life insurance or AD&D benefits shall be made no later than 90 days after receipt of the claim. If the Claims Administrator determines that an extension of time for processing the claim is required, the claimant will receive written notice of the extension prior to the end of the initial 90-day period. The maximum extension period is an additional 90 days. The extension notice will describe the special circumstances requiring the extension and the date by which a decision is expected.

If a claim is denied, the claimant has 60 days to make a written appeal to the adverse decision. Written comments, documents, records and any other information related to the claim may be submitted. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

7.05 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 Plans 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.

ARTICLE VIII

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts, 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 copies of the latest annual report (Form 5500 series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health 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.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to 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 month (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 the 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 the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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 materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the 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 Area 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, DC 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.

ARTICLE IX

PRIVACY RIGHTS

9.01 Privacy of Protected Health Information

The Employer 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, the Group Health Plans sponsored by the Employer are covered entities even if the Employer is not. The Employer 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.

a. Permitted Disclosures. Each of the Group Health Plans may disclose PHI to the Employer 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:
 - o Claims Assistance: Designated personnel may assist Covered Persons (i.e., employees of the Employer 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.
 - o Appeal of Benefit Denials: Designated personnel may assist Covered Persons in appealing benefit denials of the insurer or third party Claims Administrator.
 - o Individual Rights Requests (more information on individual rights is contained later in this section.)
 - o Audit Functions: Designated Personnel may review PHI such as Check Registers to confirm payment and perform other audit functions.

b. With respect to PHI that the Employer receives from the Plan, the Employer 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 the Employer 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 the Employer;
- 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, policies and procedures and documentation required by the Security regulation (as of the effective date of such regulation), relating to such safeguards, 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 Employer 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 Employer is established and supported by reasonable and appropriate security measures; or
- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

c. The Plan will disclose PHI to the Employer only upon receipt of a written certification by the Employer that the Plan documents have been amended to incorporate the provisions of the preceding paragraph.

The Designated Personnel identified in the Plan's Notice of Privacy Practices 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.

The Designated Personnel will protect the privacy of your health information and ensure it is used only as described in this Article or as permitted by law. Unless authorized by you in writing, protected health information may not be disclosed or used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

9.02 COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.

Pursuant to the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"),

a. The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

b. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

c. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Section 9.01.

ARTICLE X

PLAN ADMINISTRATION

10.01 Method of Funding. The Plan will be funded by Employer contributions and Participant contributions (either pre-tax or after-tax) as indicated in Article II of the Adoption Agreement.

a. The Employer shall have no obligation, but shall have the right, to insure any benefits under this Plan or to establish any fund or trust for the payment of benefits under this Plan, except as otherwise mandated by law. Any benefits insured through an insurance company or health maintenance organization shall be paid solely by such insurance company or health maintenance organization, and the Employer shall have no responsibility, other than payment of premiums, for the payment of such benefits.

b. The Employer shall have no obligation to pay interest on any contributions made by or on behalf of any Participant or the Employer.

10.02 Administration of the Plan. The Plan Administrator (or its designee) shall be responsible for the management, operation, and administration of the Plan, and shall have all powers necessary to fulfill these responsibilities. The Board may appoint or remove a Plan Administrator, which can be a single person or a committee, and any appointed Plan Administrator may resign upon 10 days prior written notice to the Board. In the absence of an appointed Plan Administrator, the Board shall be the Administrator.

a. Except as otherwise expressly provided in the Plan, in addition to all other powers provided by this Plan, the Plan Administrator's powers shall include, but shall not be limited to the following:

- i. To make and enforce such rules and regulations, and to establish such procedures and requirements, as it deems necessary or proper for the administration of the Plan;
- ii. To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan and, to the extent such persons as so appointed, to rely in good faith on the opinions, reports and valuations of such persons;
- iii. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan;
- iv. To prepare and distribute or to cause to be prepared and distributed information explaining the Plan and the Component Benefits to eligible Employees and Participants;
- v. To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan and the Component Benefits;
- vi. To comply with ERISA's reporting and disclosure requirements;
- vii. To accept, modify or reject elections under the Plan;
- viii. To prepare, distribute and collect Election Forms to be used by Participants;
- ix. To act as the Plan's agent for the service of legal process;
- x. To take all other actions deemed necessary to properly administer the Plan in accordance with its terms and the requirements of applicable law.

b. In exercising its responsibilities, the Plan Administrator (or its designee(s)) shall have, to the full extent permitted by law, the exclusive authority and discretion, to the extent not inconsistent with the terms of the Supporting Documents, to construe any uncertain or disputed term or provision in the Plan and any related document (e.g., the summary plan description) and to decide all questions concerning the Plan, including (but not limited to) the following:

- i. determining any questions of fact and/or law;
- ii. determining whether any individual is eligible for benefits under this Plan;
- iii. determining the amount of benefits, if any, an individual is entitled to under this Plan;
- iv. interpreting all of the provisions of this Plan; and
- v. interpreting all of the terms used in this Plan.

Such exercise of discretionary authority shall:

- A. be binding upon any individual claiming benefits under this Plan, including, but not limited to, the Participant, his or her Spouse, the Participant's estate, and any beneficiary of such claimant;
- B. be entitled to deference upon review by any court, agency or other entity empowered to review the Plan Administrator's decisions, to the fullest extent permitted by law; and
- C. not be overturned or set aside on such review, unless an abuse of discretion has been found because the actions were arbitrary and capricious or made in bad faith.

In the event the Plan Administrator exercises any authority under the Plan with respect to a Participant who is a Plan Administrator, the authority shall be exercised solely and exclusively by the other Plan Administrators. If the affected Participant is the sole appointed Plan Administrator, the authority shall be exercised solely and exclusively by the Board.

c. The Plan Administrator and its assistants and representatives shall be free from all liability for their acts and conduct in the administration of the Plan except for acts of willful misconduct. However, the preceding sentence shall not relieve any person from any responsibility, obligation, or duty that person may have under applicable law. In the event and to the extent not insured against by any insurance company pursuant to provisions of any applicable insurance policy, the Employer shall indemnify and hold harmless the Plan Administrator and its assistants and representatives from any and all claims, demands, suits, or proceedings in connection with the Plan that may be brought by any employees, Participants, or their beneficiaries or legal representatives, or by any other person, corporation, entity, government, or agency. However, indemnification shall not apply to any person for such person's acts of willful or grossly negligent misconduct in connection with the Plan, or for breaches of fiduciary obligations or duties under applicable law.

d. To the extent approved by the Employer, all expenses of administration may be paid by the Plan. Such expenses may include any expenses incident to the performance of a fiduciary's responsibilities, including, but not limited to, claims administration fees and costs, fees for accountants, legal counsel and other specialists, bonding expenses, and other costs of administering this Plan. Until paid, such approved expenses shall constitute a liability of the Plan. However, the Employer may pay directly, or may reimburse the Plan, for any administration expense incurred.

e. Every fiduciary and other person who handles funds or other property of this Plan shall be bonded to the extent required by Section 412 of ERISA.

f. The named fiduciary of this Plan shall be the Plan Administrator. The Plan Administrator may designate other named fiduciaries to have complete authority to determine whether and to what extent Participants and beneficiaries are entitled to benefits under the Plan and to review all denied claims for benefits under the Plan. To the extent any Claims Administrator, insurance company, or health maintenance organization exercises discretionary authority or discretionary responsibility over the benefit claims procedure pursuant to Article VII, it shall be a fiduciary for purposes of the Plan and shall have the authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets and certificates pursuant to Section 10.02(b).

ARTICLE XI

EMPLOYER

11.01 Amendment of Plan. The Employer reserves the right to amend this Plan and the Component Benefits at any time and from time to time. This right to amend or modify altogether any benefit or benefits under the Plan is unqualified. The types of amendments or modifications that may be made include, but are not limited to:

- a. revising the eligibility requirements of the Plan;
- b. reducing or eliminating any benefit offered under the Plan;
- c. curtailing or eliminating Employer contributions to the Plan; and/or
- d. increasing any cost-sharing feature of the Plan (e.g., Participant contributions, deductibles, coinsurance payments, out-of-pocket limits, and lifetime maximums, to the extent applicable).

Any amendments shall be binding upon each Participant, each Participant's estate, and any Dependent or beneficiary of a Participant.

Notwithstanding the foregoing, the Plan Administrator may amend the Component Benefits available under the Plan (and amend the Adoption Agreement accordingly) or any cost-sharing feature (and revise the cost-sharing schedules accordingly) without the need for a formal Plan amendment.

11.02 Termination of Plan. In recognition of the fact that future conditions and circumstances cannot be foreseen, the Employer expressly reserves the unqualified right to terminate the Plan with respect to all Participants at any time and for any reason without liability.

11.03 No Contractual Rights to Benefits. Notwithstanding any other provision in the Plan to the contrary, a Participant (or his Spouse and Dependents) and/or other claimant shall not have any contractual right to benefits under the Plan which interferes with the right to amend the Plan pursuant to Section 11.01 or terminate the Plan pursuant to Section 11.02. This Plan is not a contract. **THE EMPLOYER MAKES NO PROMISE TO CONTINUE PLAN BENEFITS IN THE FUTURE AND RIGHTS TO FUTURE BENEFITS WILL NEVER VEST.** In particular, retirement does not in any manner confer upon any Participant, Dependent or interested party any right to continued benefits under this Plan or any other welfare benefit plan maintained by the Employer. Nothing in this Section shall be construed as interfering with an individual's continuation rights as described in Article VII.

ARTICLE XII

MISCELLANEOUS PROVISIONS

12.01 Status of Employment Relations. The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and its employees or to be consideration for, or an inducement or condition of, the employment of any person. Nothing herein contained shall be deemed (a) to give to any employee the right to be retained in the employ of the Employer; (b) to affect the right of the Employer or any Related Employer to discipline or discharge any employee at any time; (c) to give the Employer the right to require any employee to remain in its employ; or (d) to affect any employee's right to terminate employment at any time.

12.02 Nonassignability of Rights. Any right a Participant may have to receive a benefit under the Plan shall not be alienable by the Participant (or other individual) by assignment or any other method, and will not be subject to being taken by the Participant's creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law. This Section shall not, however, preclude direct payment to providers to the extent permissible under the Supporting Documents.

12.03 Medicaid Benefits. Payment for Group Health Plan benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Participant (or a beneficiary of the Participant) as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

12.04 No Guarantee of Tax Consequences. Although the Plan intends to provide for the payment of Component Benefit premiums on a pre-tax basis, neither the Administrator nor the Employer guarantees that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes.

12.05 Information to be Furnished. Participants shall provide the Employer and Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the administration of the Plan.

12.06 Applicable Law. The Plan shall be construed, regulated, interpreted, and administered under and in accordance with the laws of the State of New York without regard to its conflicts of law provisions, unless preempted by Federal law.

12.07 Invalidity. The invalidity or unenforceability of any term or provision of this Plan shall not affect the other terms and provisions, and such invalid or unenforceable term or provision shall, in all events, be construed and enforced to the fullest extent permissible under law.

12.08 Headings. The headings and sub-headings of this Plan have been inserted for convenience of reference and are to be ignored in any construction of the provisions hereof.

12.09 Gender and Number. Wherever any words are used herein in the masculine, feminine or neuter, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

12.10 Protective Clause. The Employer shall not be responsible for the validity of any insurance company, HMO or third party administrator document issued in connection with the Plan or for the failure on the part of an insurance company, HMO, or third party administrator to make payments provided by such documents, or for the action of any person which may delay such payment(s) or render such document(s) null and void or unenforceable in whole or in part.

12.11 Adoption of Plan by Component Agency.

a. Any Component Agency, whether or not presently existing, may, with the approval of the Employer, adopt this Plan by executing such documents as may be necessary to make such Component Agency a party to the Plan as an Employer.

b. Any Component agency adopting the Plan shall delegate authority to the Board to operate, manage and administer the Plan and to modify, amend or terminate the Plan, without the consent of any Component Agency.

12.12 Captions. The titles of the Articles and Sections for convenience of reference only. In the case of any conflicts, the text of this instrument, rather than the titles or headings, shall control.

APPENDIX A

Qualified Medical Child Support Order Procedures

I. Introduction.

The Employer identified in the Adoption Agreement sponsors the various Group Health Plans that, for the purposes of this procedure, are referred to as the "Plan."

The following describes the rules and procedures ("Procedures") that will be followed when the Plan Administrator receives a written medical child support order that is intended to be a qualified medical child support order ("QMCSO") as defined in Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") or Section 1908 of Title XIX of the Social Security Act, 42 U.S.C. Section 1396g-1 ("Section 1908 of the Social Security Act"). If the Plan Administrator receives a National Medical Support Notice, the additional provisions and procedures set forth in Section V of this Appendix A shall apply. A National Medical Support Notice is a standardized medical child support order that is used by a state child support enforcement agency to enforce a medical child support obligation to provide health care coverage for a child. If properly completed, a National Medical Support Notice will be deemed to be a QMCSO (see Section V below).

These Procedures may be amended or modified from time to time, and at any time without notice to any party. Any amendment or modification of these Procedures shall be effective as of the date of adoption unless either retroactive or prospective effective dates are specified.

The Plan will comply with a medical child support order only if the Plan Administrator determines that it meets all legal requirements for a QMCSO, as established by law and explained in these Procedures.

In dealing with parties regarding QMCSO issues, the Plan Administrator and its representatives may provide general factual guidance regarding the QMCSO requirements and the terms of the Plan. All guidance shall be directed toward this end, and shall not involve the Plan in the merits of the issues between the parties. At all times, the parties retain the responsibility for resolving substantive issues, and for preparing an order that both accurately incorporates their intentions and satisfies the QMCSO requirements, unless otherwise specified in Section V. The parties may not rely upon the Plan Administrator, its representatives, or any employees or agents of the Employer, for legal advice or for advice on what the QMCSO should provide under any particular factual situation. If the parties are unclear as to the legal requirements for a QMCSO, they should consult with their legal advisors.

II. Definitions.

- A. Qualified Medical Child Support Order. A "QMCSO" is any medical child support order determined by the Plan Administrator (or its designee) to satisfy the requirements of Section 609(a) of ERISA. As provided in Section V(B) below, an "appropriately completed" National Medical Support Notice shall be deemed to be a QMCSO.
- B. Medical Child Support Order. A "medical child support order" (or for purposes of these Procedures an "order") is any judgment, decree or order (including the approval of a domestic relations settlement agreement) which:
1. provides for child support with respect to the child of a group health plan participant or provides for health benefit coverage to such child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan; or
 2. is made pursuant to a state law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan.
- Such judgment, decree or order must be issued: (a) by a court of competent jurisdiction; or (b) effective August 22, 1996, by a state administrative agency with authority to issue legally binding orders (including administration agency notices that have the effect of court orders under applicable state law).
- C. Alternate Recipient. The term "Alternate Recipient" means any child of a Participant who is recognized under a medical child support order as having a right to enrollment under the Plan with respect to the Participant.

- D. Child. The term "child" includes any child adopted by, or placed for adoption with, the Participant.
- E. Participant. The term "Participant" means the affected participant or former participant required under the QMCSO to provide coverage for an Alternate Recipient and includes an employee who is eligible to participate in the Plan but who has not enrolled in the Plan (for example, the employee has waived coverage).
- F. Plan Administrator. The term "Plan Administrator" means the entity or individual named as "Plan Administrator" under a specific Group Health Plan, or as otherwise identified in the Adoption Agreement.
- G. Issuing Agency. The term "Issuing Agency" means a State agency that administers the child support enforcement program under Part D of Title IV of the Social Security Act and that has issued the National Medical Support Notice.
- H. Interested Parties. The term "Interested Parties" means the individuals affected by the issuance of the QMCSO or National Medical Support Notice.

III. **Qualification of a Medical Child Support Order.**

- A. To be a QMCSO, the copy of the medical child support order provided to the Plan Administrator must be certified (either by a court of competent jurisdiction or by an attorney of record) as to its authenticity and must clearly contain the following:
 - 1. Language which creates or recognizes the existence of an Alternate Recipient's right to medical coverage.
 - 2. Each group health plan to which the order applies.
 - a. For orders issued after August 5, 1997, if the group health plan is not identified in the order, the order will be deemed to apply to each group health plan from which the Participant is eligible to receive benefits.
 - 3. The name, social security number, and last known mailing address of the Participant (if any) and of each Alternate Recipient covered by the order. The order should also provide the date of birth and the relationship of each Alternate Recipient to the Participant.
 - a. To the extent provided in the order, the name and mailing address of a state or local governmental official may be substituted for the mailing address of an Alternate Recipient.
 - b. An order that lacks sufficient addresses will not fail to be a QMCSO for this reason alone if the Plan Administrator otherwise knows the necessary addresses.
 - 4. A reasonable description of the type or level of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined. The Plan provides those Group Health Plan benefits identified in the Adoption Agreement.
 - a. Unless otherwise specified in the order, each Alternate Recipient will generally be enrolled in the coverage option in which the Participant is currently enrolled. In the event that the Participant is not currently enrolled in the Plan, but is otherwise eligible to participate in the Plan (i.e., has waived coverage), the Participant and each Alternate Recipient shall be enrolled in the coverage option specified in the order. In the event that the order does not specify a particular coverage option, the Participant and each Alternate Recipient shall be enrolled in the coverage option elected by the Participant. If the Participant fails to make such an election, the Alternate Recipient shall be automatically enrolled in the applicable group health benefit(s) offered by the Plan; where there is more than one coverage option that requires the least employee contribution towards coverage shall be elected. The Employer may require the Participant to enroll in "2-person" or "family coverage" to provide the necessary coverage for the Alternate Recipient.

- b. Unless otherwise specified in the order, an order will be deemed to apply to all group health plans for which the Participant (or the Alternate Recipients) is eligible.
5. The coverage period to which the order applies (i.e., a description of when coverage for each Alternate Recipient is to start and stop):
- a. If the order provides that coverage for the Alternate Recipient is to be immediate (and provided the Alternate Recipient is otherwise eligible for coverage), upon a determination by the Plan Administrator that the order constitutes a QMCSO, coverage will commence as soon as administratively feasible after the commencement date specified in the order. Unless otherwise specified in the order, coverage for the Alternate Recipient will be effective as soon as administratively feasible after the date that the order was issued. Retroactive coverage, prior to the date of an order, will not be provided.
 - b. Coverage for each Alternate Recipient under the Plan will end (subject to any available COBRA continuation coverage rights) on the earlier of:
 - 1. the date set forth in the order as of which coverage is to end;
 - 2. the date as of which the Alternate Recipient ceases to be eligible for coverage under the terms of the Plan;
 - 3. the date as of which the Participant ceases to be eligible for coverage under the terms of the Plan (e.g., the Participant leaves employment with the Employer); or
 - 4. the date coverage terminates due to the non-payment of any required contributions or premiums.
 - c. If an employee has not yet satisfied the Plan's generally applicable waiting period for coverage under the Plan, the Alternate Recipient will commence coverage upon the employee's satisfaction of the applicable waiting period.
 - d. An order will not be a QMCSO if it requires coverage that is not permitted under the terms of the Plan.
6. Who will be responsible for the payment of any required contributions or premiums for coverage of each Alternate Recipient under the Plan (e.g., by withholding from the Participant's pay the required employee contributions or by direct contributions to the Plan).
- a. Unless otherwise stated in the order, the Participant will be solely responsible for the payment of any required employee contributions or premiums.
7. A statement that the order does not require the Plan to provide any form or type of benefit or any option, or to make any reimbursements in excess of those required under the terms of the Plan, not otherwise available under the Plan, except to the extent necessary to meet the requirements of certain state laws made pursuant to Section 1908 of the Social Security Act.

IV. **Procedures for Qualified Medical Child Support Orders.**

The procedures for determining whether a medical child support order is a QMCSO are as follows:

- A. **Notice of Receipt of Order.** Upon receiving a medical child support order, the Plan Administrator (or such other individual designated for such purpose), will promptly notify the Participant and each Alternate Recipient (or designated representative) (collectively the "Interested Parties") of the receipt of the medical child support order and of these Procedures. Such notice will be given to the address of the party providing the medical child support order, and to the last known address of the Participant and the address of each Alternate Recipient specified in the order. If no address is specified in the order, notice shall be given to the last known address of the Participant and the address of each Alternate Recipient. An Alternate Recipient and Participant each may, in a writing submitted to the Plan Administrator, designate a representative to receive all

communications from the Plan Administrator. The designation must include the name, address and telephone number of the representative. Notice to a designated representative shall be deemed notice to the Alternate Recipient or Participant, as the case may be.

While the Plan Administrator is determining whether the medical child support order is a QMCSO, the Alternate Recipient is not entitled to coverage under the Plan.

Upon request, the Plan Administrator shall also provide these Procedures to a Participant, potential Alternate Recipient (with a copy of the response provided to the Participant), or designated representative at any time, whether or not a medical child support order has been received by the Plan.

- B. Determination of Status of Order. The Plan Administrator will review the medical child support order within 60 days to determine whether the order is a QMCSO. The Plan Administrator may utilize the services of such counsel or other representatives as it deems advisable to complete this process and provide the determination to the parties.

The Plan Administrator may qualify a medical child support order on the condition that the Interested Parties agree with its interpretation of certain terms and provisions provided under the order. Interested Parties will have 15 days from the date such notice is given to dispute the Plan Administrator's interpretation of the order. If no written response is received within the 15 days, the Plan Administrator will presume that the Interested Parties agree with its interpretation and the order will be implemented on such terms and provisions.

- C. Notice of Determination. After determining whether a medical child support order is a QMCSO, the Plan Administrator shall notify the Participant and each Alternate Recipient (or any designated representative) in writing of such determination. The Plan Administrator will take whatever actions are appropriate for the Plan in either implementing the QMCSO or in rejecting the order, as the case may be.

The notice of determination shall state:

1. whether the medical child support order has been determined to be a QMCSO; or
2. the reasons why the medical child support order does not satisfy the requirements for a QMCSO, if the order is determined not to be a QMCSO.

If, after making a determination that a medical child support order is not a QMCSO, the Plan Administrator receives an amended medical child support order, such order shall be treated as the receipt of a new medical child support order under these Procedures. The Plan Administrator (and its representatives) may assist the Interested Parties to structure a modified order which meets the QMCSO requirements.

The Alternate Recipient (or designated representative) has the right to appeal any administrative determination regarding the medical child support order made by the Plan Administrator. A copy of the procedures for administrative appeal may be obtained by contacting the Plan in writing.

- D. Orders That Are Not Medical Child Support Orders.

If the Plan Administrator initially determines that the instrument received by the Plan does not appear on its face to be a "medical child support order" within the meaning of Section 609(a) of ERISA, the Plan Administrator shall advise each Interested Party:

1. of its receipt;
2. that the Plan has adopted these Procedures for determining whether a medical child support order constitutes a QMCSO;
3. that the instrument received does not appear to be a medical child support order; and

4. that the Plan Administrator will take no further action pursuant to these Procedures unless it should receive information, satisfactory to it, that the instrument is a medical child support order.

V. **Additional Procedures for National Medical Support Notices.**

- A. **Employer Procedure Upon Receipt.** Within 20 business days of receipt of a National Medical Support Notice, the Employer shall review and complete Part A, "Employer Response" of the Notice by returning it to the Issuing Agency if health care coverage is not available for the Alternate Recipient pursuant to one (or more) of the items listed on Part A. If health care coverage is available for which the Alternate Recipient may be eligible, the Employer shall forward Part B, the "Medical Support Notice to Plan Administrator," to the Plan Administrator.
- B. **Determination of Status of Notice.** If the Plan Administrator receives an "appropriately completed" National Medical Support Notice ("Notice") issued pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998, with respect to the Child of the Participant who is a non-custodial parent of the Child, the Notice shall be deemed to be a QMCSO, provided it meets the requirements of Sections 609(a)(3) and (a)(4) of ERISA.

While the Plan Administrator is determining whether the Notice is a QMCSO, the Alternate Recipient is not entitled to coverage under the Plan.

An "appropriately completed" Notice, within the meaning of Section 609(a)(5)(C) of ERISA, satisfies the informational requirements of the QMCSO provisions by:

1. naming the Issuing Agency;
 2. providing the name and last known mailing address (if any) of the Participant and the name and mailing address of each Child covered by the Notice (or the name and address of a substituted official or agency);
 3. having the Issuing Agency identify either the specific type of coverage or all available group health coverage (if a Notice does not designate either specific type(s) of coverage or all available coverage, it will be assumed that all are designated);
 4. instructing the Plan Administrator that if a group health plan has multiple options and the Participant is not enrolled, the Issuing Agency will make a selection after the Notice is qualified and, if the Issuing Agency does not respond within 20 business days, the Child will be enrolled under the Plan's default option (if any); and
 5. specifying that the period of coverage may end for the Child only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of events specified in the Notice.
- C. **Determination of Coverage to be Provided.** Within 40 business days after the date of a Notice that is deemed to be a QMCSO, the Plan Administrator shall:
 1. notify the Issuing Agency whether coverage of the Child is available under the terms of the Plan and, if so, whether the Child is already covered under the terms of the Plan and either the effective date of such coverage, or, if necessary, any steps to be taken by the custodial parent (or by an official of a state or political subdivision substituted for the name of such Child) to effectuate the coverage;
 2. notify the Issuing Agency of the options for coverage where the Participant is not currently enrolled in a Plan, or where the Child resides outside of the coverage area under the Participant's Plan, and provide to the Issuing Agency a description of the coverage available under the Plan, and enroll the Child (and Participant) in the Plan selected by the Issuing Agency; or
 3. notify the Issuing Agency when enrollment in the Participant's Plan will require the Employer to withhold amounts in excess of the withholding limitations

identified in the Notice, and, provide to the Issuing Agency a description, including the cost, of the coverage available under the Plan, and enroll the Child in the Plan selected by the Issuing Agency.

- D. **Notice of Determination.** Upon a determination of the coverage to be provided to the Alternate Recipient, the Employer (or such individual designated for such purpose), shall notify the Participant, the Alternate Recipient (collectively, "Interested Parties") and the Issuing Agency of the determination with respect to coverage, and shall provide to the custodial parent (or substituted official) a description of the coverage available under the Plan and any forms or documents necessary to effectuate such coverage.

The Employer and Plan Administrator are required by federal law to comply with an appropriately completed Notice. Interested Parties must contact the Issuing Agency to appeal any non-administrative determinations with respect to a Notice.

- E. **Withholding of Employee Contributions.** Upon enrollment of the Alternate Recipient, the Employer, in compliance with federal law, shall withhold from the Participant's income any employee contributions required under the Plan. **Should a Participant contest the withholding under the Notice, the Employer will continue to withhold such employee contributions until notified by the Issuing Agency to discontinue withholding.**

VI. **Administration of Qualified Medical Child Support Orders.**

- A. **Actions by Plan Fiduciaries.** If a Plan fiduciary acts in accordance with the provisions of ERISA in treating a medical child support order as being (or not being) a QMCSO, the Plan's obligation to the Participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.

The Employer (and any other Plan sponsor) and its employees and agents, the Plan, the Plan Administrator and its representatives, and the Plan's committees, fiduciaries and agents are not liable:

1. for any loss, cost or suffering occasioned by any delay in determining whether a medical child support order is a QMCSO; or
2. for any coverage made or sums withheld as a result of such determination, provided such determination is made in accordance with ERISA's fiduciary responsibility provisions.

All determinations made and actions taken by the Plan Administrator or its representatives pursuant to these Procedures shall be conclusive and binding upon the Plan, the Participant and the Alternate Recipient.

- B. **Treatment of Alternate Recipients.** An Alternate Recipient shall be considered a "Beneficiary" under the Plan for purposes of any provision of ERISA; and shall be considered a "Participant" for purposes of the reporting and disclosure requirements of ERISA.
- C. **Payment to Alternate Recipient, Parent or Legal Guardian.** Unless otherwise provided in the order, any payment for benefits made by the Plan pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.
- D. **Taxation of Coverage.** As a general matter, if the Alternate Recipient does not qualify as the Participant's "tax dependent" under the Internal Revenue Code of 1986, as amended, the coverage provided to the Alternate Recipient will be taxed to the Participant and any required employee contributions for coverage cannot be made on a pre-tax basis through the Plan.
- E. **Determination of Qualified Status.** If the qualified status of a medical child support order is being determined by an entity other than the Plan Administrator (or its designee), such as a court of competent jurisdiction, the Plan Administrator may defer to the decision of such other entity, provided that, if such other entity is not a court having jurisdiction over all of the parties named in the medical child support order (or a legal guardian, where appropriate), the Plan Administrator

may require releases from all parties prior to agreeing to follow the determination of such other entity. The Plan Administrator may file appropriate pleadings, send copies of these Procedures to counsel for the parties and attempt to ensure that any order entered which affects the Plan is a QMCSO.

APPENDIX B
Medicaid and the Children’s Health Insurance Program (CHIP)

Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2011. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants/default.aspx Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268

CALIFORNIA – Medicaid	GEORGIA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	MONTANA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-8183
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nc.gov Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	VERMONT– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Website: http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml Phone: 1-888-564-9669	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	WEST VIRGINIA – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: www.dhhr.wv.gov/bms/ Phone: 304-558-1700
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531
UTAH – Medicaid and CHIP	
Website: http://health.utah.gov/upp Phone: 1-866-435-7414	

To see if any more States have added a premium assistance program since July 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)

APPENDIX C

Domestic Partner Benefits

A. Eligibility of Domestic Partners.

If so indicated in the Adoption Agreement, the domestic partner of a Participant may be covered under a Component Benefit, if the criteria for establishing a domestic partnership applicable to that Component Benefit is met.

B. When Coverage Begins.

If elected at an open enrollment period, coverage of a domestic partner under the Plan begins on the first day of the Period of Coverage following the date on which the participant files an Election Form and establishes the domestic partnership to the satisfaction of the Plan Administrator. If elected at the time of hire, coverage begins on the first date of the period month following date of hire.

C. Termination of Coverage.

Coverage of a domestic partner will end at the same time coverage of the Participant ends, or when the domestic partnership ends, whichever comes first.

D. Continuation of Coverage.

Article V discusses the right to continuation coverage under COBRA. Depending on the Component Benefit and the terms applicable to a domestic partner (ask the Plan Administrator for more details), a domestic partner covered under the Plan will generally have the same rights to continuation of Group Health Plan coverage that a covered Spouse would have, with the following exceptions:

- The termination of a domestic partnership will not be treated as a qualifying event (i.e., not a divorce or legal separation). Instead, upon the termination of a domestic partnership, the former domestic partner may convert to a direct payment contract under the same conditions as a Dependent.
- The child of a domestic partner is not entitled to coverage unless the child qualifies as a Dependent of the Participant.
- If the child of a domestic partner does qualify as a “Dependent” of the Participant, termination of the domestic partnership will not be treated as a loss of dependent child status for the purposes of COBRA continuation coverage.

E. Contributions Towards the Cost of Coverage.

The Participant must pay for the cost for Component Benefit coverage of a domestic partner in accordance with the Employer’s procedures for Employee contributions. If the domestic partner is not a dependent under federal tax law, the increase in the employee’s cost of coverage for the domestic partner must be paid on an after-tax basis. In addition, if the domestic partner is not a dependent, the increase in amount that the Employer/Plan Sponsor pays for coverage of a domestic partner (if any) must be treated as taxable wages (i.e., subject to income tax withholding, FICA and FUTA).

ADOPTION AGREEMENT
WELFARE PLAN AND SUMMARY PLAN DESCRIPTION
FOR
RESEARCH FOUNDATION FOR MENTAL HYGIENE, INC.

Article I. GENERAL INFORMATION

- Section 1.01** **Name of Plan:** Research Foundation for Mental Hygiene Welfare Plan
- Section 1.02** **Employer/Plan Sponsor:** Research Foundation For Mental Hygiene, Inc.
- Section 1.03** **Address:** 150 Broadway, Suite 301
Menands, NY 12204
- Section 1.04** **EIN:** 14-1410842
- Section 1.05** **3-Digit Plan #:** 509
- Section 1.06** **Effective Date:** January 1, 2012
- Section 1.07** **Component Agencies Participating in Plan:**
New York State Psychiatric Institute
Institute for Basic Research in Developmental Disabilities
Nathan Kline Institute
- Section 1.08** **Plan Year:** Begins 01/01 and ends 12/31
- Section 1.09** **Is the Plan maintained pursuant to a collective bargaining agreement?**
 Yes No
- Section 1.10** **Plan Administrator:** Research Foundation for Mental Hygiene, Inc.
(a) Address: 150 Broadway, Suite 301
 Menands, NY 12204
 Telephone: 518-474-5661
- Section 1.11** **Trustee(s) (if any):** None
- Section 1.12** **Agent For Service of Legal Process:**
(a) Employer (at the address above)
 Process may also be served on any Trustee.
- Section 1.13** **COBRA Administrator:**
(a) Plan Administrator

Article II. COMPONENT BENEFITS PROVIDED UNDER THIS PLAN:

- Section 2.01** **Group Health Plan(s)** (Check all that are included in the Plan)
- (a) **Health Coverage**
- (i) Coverage option: Empire EPO (Effective 2/1/2012)
 Claims Administrator/Insurer: Empire Blue Cross
 Group Policy No.: 720639
 Address: (Claims) P.O. Box 1407, Church Street Station
 New York, NY 10008-1407
 (Local) 11 Corporate Woods
 Albany, NY 12211
 518-367-3208
 Website: www.empireblue.com
- Pre-existing condition exclusions apply? Yes No
- This coverage option is: Insured Self-insured
- Premium paid by: Employer Employee

Employee premiums are paid: pre-tax through 125 plan after-tax
Type of Administration: Insurer Administration
 Employer Administration
 Third-party Claims Administration

(ii) Coverage option: Empire PPO (Effective 2/1/2012)
Claims Administrator/Insurer: Empire Blue Cross
Group Policy No.: Group Policy No.: 720639
Address: (Claims) P.O. Box 1407, Church Street Station
New York, NY 10008-1407
(Local) 11 Corporate Woods
Albany, NY 12211
518-367-3208
Website: www.empireblue.com
Pre-existing condition exclusions apply? Yes No
This coverage option is: Insured Self-insured
Premium paid by: Employer Employee
Employee premiums are paid: pre-tax through 125 plan after-tax
Type of Administration: Insurer Administration
 Employer Administration
 Third-party Claims Administration

(iii) Coverage option: Medibblue Freedom PPO (effective 2/1/2012)
Claims Administrator/Insurer: Empire Blue Cross
Group Policy No.: 720644
Address: (Claims) P.O. Box 1407, Church Street Station
New York, NY 10008-1407
(Local) 11 Corporate Woods
Albany, NY 12211
518-367-3208
Website: www.empireblue.com
Pre-existing condition exclusions apply? Yes No
This coverage option is: Insured Self-insured
Premium paid by: Employer Employee
Employee premiums are paid: pre-tax through 125 plan after-tax
Type of Administration: Insurer Administration

(b) **Dental Coverage**

(i) Coverage option: Metlife PDP
Claims Administrator/Insurer: Metropolitan Life Insurance Company
Group Policy No.: 117655-1-G
Address: 200 Park Avenue
New York, NY 10166
Telephone: 800-638-6420
Pre-existing condition exclusions apply? Yes No
This coverage option is: Insured Self-insured
Premium paid by: Employer Employee
Employee premiums are paid: pre-tax through 125 plan after-tax through
125 Plan
Type of Administration: Insurer Administration

(c) **Vision Coverage**

(i) Coverage option: N/A

(d) **Prescription Drug Coverage**

- (i) Coverage option: INCLUDED IN HEALTH COVERAGE
- (e) **Employee Assistance Program**
 - (i) Coverage option: N/A
- (f) **Health Flexible Spending Account**
 - Claims Administrator: Diversified Administration Corporation
 - Contract Number: N/A
 - Address: 369 North Main Street, P.O. Box 299
Marlborough, CT 06447
 - Telephone: 860-295-6531
 - This coverage option is: Insured Self-insured
 - Premium paid by: Employer Employee
 - Employee premiums are paid: pre-tax through 125 plan after-tax through 125 Plan (COBRA only)
 - Type of Administration: Third-party Claims Administration

Section 2.02

Other Component Benefits (Not Group Health Plans)

- (a) **Life Insurance (Basic)**
 - (i) Coverage option: Basic Life Insurance and Accidental Death and Dismemberment
 - Claims Administrator/Insurer: Metropolitan Life Insurance Company
 - Group Policy No.: 17655-1-G
 - Address: One Madison Avenue
New York, NY 10010-3690
 - Telephone: 630-978-6179
 - This coverage option is: Insured Self-insured
 - Premium paid by: Employer Employee
 - Employee premiums are paid: pre-tax through 125 plan after-tax
 - Type of Administration: Insurer Administration
- (b) **Life Insurance (Supplemental/Dependent)**
 - (i) Coverage option: Metlife Optional Life Insurance
 - Claims Administrator/Insurer: Metropolitan Life Insurance Company
 - Group Policy No.: 117655
 - Address: 200 Park Avenue
New York, NY 10166
 - Telephone: 630-978-6179
 - This coverage option is: Insured Self-insured
 - Premium paid by: Employer Employee
 - Employee premiums are paid: pre-tax through 125 plan after-tax
 - Type of Administration: Insurer Administration
- (c) **Supplemental Short-Term Disability (non-statutory)**
 - (i) Coverage option: N/A
- (d) **Long-Term Disability**
 - (i) Coverage option: Metlife
 - Claims Administrator/Insurer: Metropolitan Life Insurance Company
 - Group Policy No.: 117655-1-G
 - Address: 200 Park Avenue
New York, NY 10166
 - Telephone: 800-300-4296
 - This coverage option is: Insured Self-insured
 - Premium paid by: Employer Employee

Employee premiums are paid: pre-tax through 125 plan after-tax
Type of Administration: Insurer Administration

Article III. ELIGIBILITY

Section 3.01 Health Insurance Not Applicable

- (a) Eligible: (check all that apply)
- (i) Employees regularly scheduled to work at least 0.50 FTE.
 - (ii) Dependents/Domestic Partner:
 - Spouse Including same-gender Spouse
 - Dependent Child(ren) to Age 26, or age N/A if a full-time student
 - Disabled Dependent Child(ren), regardless of age
 - Domestic Partner
- (b) Ineligible: (check all that apply)
- (i) Employees who are members of a collective bargaining unit, when benefits are the subject of good faith bargaining between the Employee and employee representatives.
 - (ii) Leased employees.
 - (iii) Persons engaged as independent contractors, even if reclassified as a common law employee for any purpose.
 - (iv) Other: (specify) Hourly Employees; Fellows; salaried Employees less than 0.50 FTE.
- (c) Waiting period: _____ months following date of hire.
Other: Entry date is 1st day of second month following date of hire or change into eligible status

Section 3.02 Dental Insurance Not Applicable

- (a) Eligible: (check all that apply)
- (i) Salaried Employees regularly scheduled to work at least 0.50 FTE.
 - (ii) Dependents/Domestic Partner:
 - Spouse Including same-gender Spouse
 - Dependent Child(ren) to Age 26, or age N/A if a full-time student
 - Disabled Dependent Child(ren), regardless of age
 - Domestic partner
- (b) Ineligible: (check all that apply)
- (i) Employees who are members of a collective bargaining unit, when benefits are the subject of good faith bargaining between the Employee and employee representatives.
 - (ii) Leased employees.
 - (iii) Persons engaged as independent contractors, even if reclassified as a common law employee for any purpose.
 - (iv) Other: (specify) Hourly Employees; Fellows; salaried Employees less than 0.50 FTE.
- (c) Waiting period: _____ months following date of hire.
Other: 6 consecutive months at not less than 0.50 FTE.

Section 3.03 Vision Insurance Not Applicable

Section 3.04 Prescription Drug Insurance Not Applicable

Section 3.05 Employee Assistance Program Not Applicable

Section 3.06 Life Insurance (Basic) and Accidental Death and Dismemberment N/A

- (a) Eligible: (check all that apply)
- (i) Salaried Employees regularly scheduled to work at least 0.80 FTE.

- (ii) Dependents/Domestic Partner:
 - Spouse
 - Dependent Child(ren) to Age ____, or age ____ if a full-time student
 - Disabled Dependent Child(ren), regardless of age
 - Domestic partner
- (b) Ineligible: (check all that apply)
 - (i) Employees who are members of a collective bargaining unit, when benefits are the subject of good faith bargaining between the Employee and employee representatives.
 - (ii) Leased employees.
 - (iii) Persons engaged as independent contractors, even if reclassified as a common law employee for any purpose.
 - (iv) Other: (specify) Hourly Employees; Fellows; salaried Employees regularly scheduled to work less than 0.80 FTE.
- (c) Waiting period: _____ months following date of hire.
 other: 3 months of service at not less than 0.80 FTE.

Section 3.07 Life Insurance (Supplemental and Dependent) Not Applicable

- (a) Eligible: (check all that apply)
 - (i) Salaried Employees regularly scheduled to work at least 0.80 FTE.
 - (ii) Dependents/Domestic Partner:
 - Spouse
 - Dependent Child(ren) to Age 19, or Age 23 if a full-time student
 - Disabled Dependent Child(ren), regardless of age
 - Domestic partner
- (b) Ineligible: (check all that apply)
 - (i) Employees who are members of a collective bargaining unit, when benefits are the subject of good faith bargaining between the Employee and employee representatives.
 - (ii) Leased employees.
 - (iii) Persons engaged as independent contractors, even if reclassified as a common law employee for any purpose.
 - (iv) Other: (specify) Hourly Employees, Fellows, salaried Employees less than 0.80 FTE.
- (c) Waiting period: _____ months following date of hire.
 other: 3 months at not less than 0.80 FTE.

Section 3.08 Supplemental Short-Term Disability Not Applicable

Section 3.09 Long-Term Disability Not Applicable

- (a) Eligible: (check all that apply)
 - (i) Salaried Employees regularly scheduled to work at least 0.80 FTE.
 - (ii) Dependents/Domestic Partner:
 - Spouse
 - Dependent Child(ren) to Age ____, or age ____ if a full-time student
 - Disabled Dependent Child(ren), regardless of age
 - Domestic partner
- (b) Ineligible: (check all that apply)
 - (i) Employees who are members of a collective bargaining unit, when benefits are the subject of good faith bargaining between the Employee and employee representatives.
 - (ii) Leased employees.
 - (iii) Persons engaged as independent contractors, even if reclassified as a common law employee for any purpose.
 - (iv) Other: (specify) Hourly Employees, Fellows, salaried Employees less than 0.80 FTE.

- (c) Waiting period: _____ months following date of hire.
 other: 12 months of service at not less than 0.80 FTE

Section 3.10 Other: Health Care Flex Program

- (a) Eligible: (check all that apply)
- (i) Employees regularly scheduled to work 0.50 FTE.
 - (ii) Dependents/Domestic Partner:
 - Spouse (Opposite Sex Spouse only)
 - Dependent Child(ren) to Age 26
 - Disabled Dependent Child(ren), regardless of age
 - Domestic partner
- (b) Ineligible: (check all that apply)
- (i) Employees who are members of a collective bargaining unit, when benefits are the subject of good faith bargaining between the Employee and employee representatives.
 - (ii) Leased employees.
 - (iii) Persons engaged as independent contractors, even if reclassified as a common law employee for any purpose.
 - (iv) Other: (specify) Hourly Employees, Fellows, salaried Employees less than 0.50 FTE.
- (c) Waiting period: _____ months following date of hire.
 other: None

Article IV. PARTICIPATION

Section 4.01 Health Insurance

- (a) Entry Date: Initial Eligibility
- (i) Date Eligibility requirements of Section 3.01 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
- (i) Required: Participation will not commence until Election Form is received by the Plan Administrator. Election Form must be received within 7 days after eligibility requirements are satisfied, or enrollment will be delayed until a later Enrollment Period.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
- (i) on the last day of the month, if eligibility is lost between the 1st and the 15th of the month; and on the last day of the following month, if eligibility is lost between the 16th and the last day of the month.
 - (ii) on the day eligibility is lost.

Section 4.02 Dental Coverage

- (a) Entry Date: Initial Eligibility
- (i) Date Eligibility requirements of Section 3.02 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
- (i) Required: Participation will not commence until Election Form is received by the Plan Administrator. Election Form must be received within 7 days after eligibility requirements are satisfied, or enrollment will be delayed until a later Enrollment Period.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
- (i) on the last day of the month in which eligibility is lost.
 - (ii) on the day eligibility is lost.

Section 4.03 Vision Coverage (Not Applicable)

- (a) Entry Date: Initial Eligibility
 - (i) Date Eligibility requirements of Section 3.03 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
 - (i) Required: Participation will not commence until Election Form is received by the Plan Administrator. Election Form must be received within __ days after eligibility requirements are satisfied, or enrollment will be delayed until a later Enrollment Period.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
 - (i) on the last day of the month in which eligibility is lost.
 - (ii) on the day eligibility is lost.

Section 4.04 Prescription Drug Coverage (Included in Health Coverage)

- (a) Entry Date: Initial Eligibility
 - (i) Date Eligibility requirements of Section 3.04 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
 - (i) Required: Participation will not commence until Election Form is received by the Plan Administrator. Election Form must be received within __ days after eligibility requirements are satisfied, or enrollment will be delayed until a later Enrollment Period.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
 - (i) on the last day of the month in which eligibility is lost.
 - (ii) on the day eligibility is lost.

Section 4.05 Employee Assistance Program (Not Applicable)

Section 4.06 Life Insurance / Accidental Death and Dismemberment

- (a) Entry Date: Initial Eligibility
 - (i) Date Eligibility requirements of Section 3.06 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
 - (i) Required: Participation will not commence until Election Form is received by the Plan Administrator. Election Form must be received within __ days after eligibility requirements are satisfied, or enrollment will be delayed until a later Enrollment Period.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
 - (i) on the last day of the month in which eligibility is lost.
 - (ii) on the day eligibility is lost.

Section 4.07 Life Insurance (Supplemental/Dependent)

- (a) Entry Date: Initial Eligibility
 - (i) Date Eligibility requirements of Section 3.07 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
 - (i) Required: For designation of Beneficiary only.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
 - (i) on the last day of the month in which eligibility is lost.
 - (ii) on the day eligibility is lost.

Section 4.08 Supplement Short-Term Disability (non-statutory) Not Applicable

Section 4.09

Long-Term Disability

- (a) Entry Date: Initial Eligibility
 - (i) Date Eligibility requirements of Section 4.09 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
 - (i) Required: Participation will not commence until Election Form is received by the Plan Administrator. Election Form must be received within ___ days after eligibility requirements are satisfied, or enrollment will be delayed until a later Enrollment Period.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
 - (i) on the last day of the month in which eligibility is lost.
 - (ii) on the day eligibility is lost.

Section 4.10


Other: Health Care Flex Program

- (a) Entry Date: Initial Eligibility
 - (i) Date Eligibility requirements of Section 4.10 are satisfied
 - (ii) First day of the month following satisfaction of eligibility requirements.
- (b) Election Form is:
 - (i) Required: Participation will not commence until Election Form is received by the Plan Administrator. Election Form must be received within ___ days after eligibility requirements are satisfied, or enrollment will be delayed until a later Enrollment Period.
 - (ii) Not required. Enrollment is automatic.
- (c) Following loss of eligibility, coverage ends
 - (i) on the last day of the month in which eligibility is lost.
 - (ii) on the day eligibility is lost.

This Amended and Restated Plan is adopted this 25 day of April, 2012.

RESEARCH FOUNDATION FOR MENTAL
HYGIENE, INC.

By: _____


Robert Burke, Managing Director