

Welfare Benefit Plan

Summary Plan Description

WRAP Plan

Welfare Plan for Employees of
Nazareth University

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Summary Plan Description

Your Employer has adopted the health and welfare benefit plan named above (“the Plan”) to provide you and other employees health and welfare benefits. The Plan provides various Benefits.

The Plan is required to comply with certain federal laws and regulations that may change with the passage of new or revised laws. As such, your Employer has the right to amend the provisions of the Plan to comply with federal regulation and for any other reason. If your Employer makes changes to the Plan, you will be notified about changes affecting your rights under the Plan.

This Summary Plan Description (SPD) summarizes the important features of the Plan, including your benefits and obligations under the Plan. Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. These benefits are provided under various insurance contracts, service providers, and/or paid from the general assets of your Employer. The Benefit Documents for each Benefit are part of this SPD only to the extent it provides detailed descriptions regarding each Benefits’ eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions.

Certain terms in the SPD have a special meaning when used in the Plan. These terms are capitalized throughout the SPD and are defined in more detail in the DEFINITIONS section of the SPD. If any information in this SPD conflicts with the terms of the Plan document, the terms of the Plan document—not this SPD—will apply.

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EMPLOYER INFORMATION

Who established the Plan?

Your Employer who adopted the Plan is:	Nazareth University
Business Address:	4245 East Avenue Rochester, NY 14618
Business Telephone Number:	585-389-2525
Federal Tax Identification Number:	16-0743088

PLAN INFORMATION

Amended and Restated Plan

The official Name of the Plan is:	Welfare Plan for Employees of Nazareth University
Plan Number:	512
Plan Year:	January 1 through December 31 of the same calendar year.
Your Employer originally adopted the Plan on:	<u>January 1, 2000.</u>
This amended and restated Plan shall take effect on:	<u>January 1, 2024.</u>

ELIGIBILITY

Q1. Who is eligible for Benefits?

You are eligible to participate in the Plan under certain Benefits if you are an employee of your Employer and are a:

- Employee
- Retiree

and meet certain criteria, as provided in Appendix B.

Q2. Are my Dependents eligible to be covered by the Plan?

Yes, Dependents can be covered by the Plan under certain Benefits.

Q3. How do I enroll in Benefits?

Once you meet the eligibility criteria, you may enroll in Benefits as indicated in the Benefit Document. See the Appendix B for additional information.

To enroll, follow the procedures below:

Initial Enrollment

If you are eligible to participate in the Plan, you must submit your elections and any supporting documents, if applicable, in a timely manner in accordance with your Employer's enrollment procedures. If you miss your enrollment period, you will have to wait until the next open enrollment period or experience another qualifying event to enroll in the Plan.

Annual Open Enrollment

You may change your coverage (or elect coverage in the Plan if you did not elect coverage when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment materials on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year.

Dependents

Coverage of Dependents may be contingent on receiving required documents, as requested by the Plan Administrator. If applicable, and you fail to provide the required documents in a timely manner and you enroll a Dependent in coverage, the Dependent may be removed retroactively to the first date of eligibility.

Q4. Can I change Benefits throughout the year?

Yes, you may be eligible to enroll in a Major Medical Option under certain circumstances.

If you initially declined coverage or are enrolled in coverage, but wish to change your enrollment, the Plan provides special enrollment periods that allow you to either elect coverage or change your coverage. You must make a written request to the Plan Administrator within the applicable time frame.

The Plan provides the following special enrollment periods 1) loss of other coverage; 2) gain of a new Dependent through marriage, birth, adoption, or placement for adoption; and 3) change in coverage under a state's Children's Health Insurance Program (CHIP). Please refer to the applicable Benefit Document for additional information.

Q5. When does coverage begin and end?

Coverage begins on the date you are first eligible and ends on the date or end of the month (as applicable under each Component Plan) in which the employee ceases to satisfy the eligibility requirements, as described in the Benefit Document. See the Appendix B for additional information.

Generally, coverage will end because of divorce, death, change in employment status (including termination), failure to pay Contributions, the Dependent Child reaching a Plan Component's limiting age, or a Plan amendment or termination. If you experience a divorce, you will not lose coverage, but your spouse will lose coverage. If your Dependent Child reaches a Plan Component's limiting age, you will not lose coverage, but your child will lose coverage. If you experience a change in employment status, you and your Dependents may lose coverage.

Q6. What should I do if an Eligible Dependent loses eligibility status?

You are required to notify the Plan Administrator in writing, **in a timely manner**, of an Eligible Dependent's change in status. If you fail to notify the Plan Administrator when an Eligible Dependent becomes ineligible for coverage, you may be required to reimburse the Plan for costs incurred by the Plan and the Plan Administrator may take other action, as permitted by the Plan.

Please note that coverage for that Eligible Dependent may end on the date of the event, as provided in the Plan document. For example, if you cover a spouse as an Eligible Dependent in the Health Care Plan, the spouse's coverage will end on the date of the divorce, even if you notify the Plan much later.

BENEFITS AND FUNDING

Q1. What is the purpose of the Plan?

The Plan is a welfare benefit plan that is intended to provide you with a range of Benefits to promote your health and welfare.

Q2. What is the Plan's funding method?

The Plan is funded through insurance contracts.

Q3. What Benefits are provided by the Plan?

The Plan provides the Benefits listed on Appendix A to this SPD.

Q4. What is the source of Contributions?

Depending on the Plan Component, premium contributions are either paid by:

- Employer Contributions only;
- Employee Contributions only; and/or,
- Both Employer and Employee Contributions.
- Retiree Contributions. The University will set the amount of the Employer Contribution and the Retiree must pay the difference.

Q5. How do I pay for Benefits?

The cost of Benefits may be deducted from your pay on either or both, (depending on the benefit) a:

- Pre-tax Basis; or,
- Post-tax Basis.

It is important to note that if you intend to enroll your domestic partner, the cost of their coverage may be added to your wages as taxable income. Consult with your tax or legal advisor for further guidance.

COORDINATION OF BENEFITS

Q6. What happens if I am covered by two or more health plans?

Coordination of benefits is governed by the Benefit Document applicable to each Benefit. To the extent the Benefit Document does not contain a provision affecting coordination of benefits, this Plan and any of its Benefits will be secondary payer (i.e., pay after the other coverage pays).

Q7. What if the other health plan is Medicare?

If the other health plan is Medicare, this Plan will be the primary payer (i.e., pay before the other coverage) unless you have chosen Medicare as your primary plan or unless otherwise required by law.

Q8. Will the Plan be primary or secondary payer if I am covered by Medicare?

If you are covered by Medicare, the Plan intends to pay either primary or secondary as follows.

- If you are a Retiree and covered by the Plan and Medicare, Medicare will be the primary payer (former employees are not considered to have coverage by virtue of current employment status).
- If you are 65 or older and your Employer has less than 20 employees, Medicare will be the primary payer.
- If you are 65 or older and your Employer has more than 20 employees, Medicare is the secondary payer.
- If you are disabled and your Employer has 100 or more employees, Medicare is the secondary payer.
- If you have End Stage Renal Disease (ESRD) and you are in the first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.

- If you have ESRD and are covered by COBRA continuation coverage and you are in your first 30 months of Medicare coverage, Medicare is the secondary payer during the 30-month coordination period.
- If you are 65 or older and are covered by Medicare and COBRA continuation coverage, Medicare is the primary payer and COBRA is the secondary payer.
- If you are disabled and covered by Medicare and COBRA, Medicare is the primary payer and COBRA is the secondary payer.

CLAIMS AND APPEALS

You must follow the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document. Notwithstanding the foregoing, in no event shall the Claims submission rules and Claims appeal procedures contained in the applicable Benefit Document provide fewer rights to you than the rights prescribed in Labor Regulation section 2560.503-1.

If the applicable Benefit Document does not include Claims and appeals procedures, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section and Section Five of the Plan document.

Q1. How do I appeal a Claim or benefit determination?

If you disagree with a benefit or Claims determination, you must submit a written request to the Claims Administrator. Please see Appendix A for contact information, including the address of the Claims Administrator for the Benefit.

Q2. Where can I find the specific appeals procedures for each Benefit?

Each Benefit is governed by policies and procedures contained in its respective Benefit Document. In addition, federal law requires that certain health care Claims and disability Claims be administered in a particular manner.

Q3. Can I file a lawsuit against the Plan, my Employer, the Claims Administrator, or any other entity?

Yes, but you must first follow the Claims procedures outlined in the Benefit Document and receive a final determination from the Claims Administrator. Moreover, if you wish to file your Claim in court, you must do so within one year from the date you receive the final notice of adverse benefit determination.

Q4. What should I do if I want to pursue a legal action against the Plan?

You must first go through the Claims procedure applicable to the Benefit. Thereafter, you may file a lawsuit in the state or federal court in New York.

Q5. If I need to take legal action under the Plan, who is the agent for service of legal process?

The individual named below can be served with legal papers regarding the Plan.

Nazareth University
Attn: General Counsel
4245 East Avenue
Rochester, NY 14618

Service of legal process also may be directed to the Plan Administrator.

HEALTH CARE PLANS

Q6. What types of Claims can I appeal?

You can appeal any Claim for benefits, which includes a request for coverage determination, a pre-authorization or approval of a Plan benefit, or a utilization review determination in accordance with the terms of the Plan. Depending on the type of Claim, your Claim will fall into one of the following categories:

- **Urgent Care Claims** – Claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that could cause severe pain.
- **Pre-Service Claims** – Claims that require notification or approval prior to receiving medical care.
- **Concurrent Care Claims** – Claims that were previously approved for treatment.
- **Post-Service Claims** – Claims that are filled for payment of benefits after medical care has been received.

Q7. After I submit a Claim, when should I expect a response?

The timeframe for a Plan Component to provide notice of a Claim determination varies based on the type of Claim filed:

CLAIM TYPE	DEADLINE FOR MAKING INITIAL DETERMINATION
Urgent care	As soon as possible, and no later than 72 hours after receiving the Claim
Pre-service	Within a reasonable time period, and no later than 15 days after receiving the Claim*
Post-service	Within a reasonable time period, and no later than 30 days after receiving the Claim*

For concurrent medical care Claims, if the treatment was previously approved, the request to extend the treatment will be processed within 24 hours of the receipt of the request if the request is made 24 hours prior to the end of the approved treatment. However, if the request is not made at least 24 hours prior to the end of the approved treatment, the request will be processed as an urgent care Claim.

Extension of Claim Determination Deadline

- **Urgent Care Claims.** If the Plan Component needs more information, it must tell the Claimant within 24 hours and give the Claimant at least 48 hours to respond. Then the plan must decide the Claim within 48 hours after receiving the missing information or within 48 hours of the deadline for the Claimant to supply the missing information, whichever comes first.
- **Pre-Service Claims and Post-Service Claims.** The Plan Component may extend the time period up to 15 days more if, for reasons beyond its control, the plan cannot make the decision within the first deadline. If the Plan Component requests more information, the Claimant has at least 45 days to supply it. The Plan Component then must decide the Claim within 15 days after receiving the additional information or within 15 days of the deadline for the Claimant to supply the additional information, whichever comes first.

Q8. If my Claim is denied, will I receive a notification?

Yes, if your Claim is denied in full or in part, you will receive a written notice of adverse benefit determination. The notice will contain the following information:

- i. Information sufficient to identify the Claim.
- ii. The specific reason for the denial.
- iii. Reference to the specific Plan provisions on which the denial was based.
- iv. A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- v. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- vi. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- vii. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.
- viii. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either a) an explanation of the scientific or clinical judgment for the determination, or b) a statement that such explanation will be provided free of charge, upon request.
- ix. If the denial involves an urgent care Claim, the notice will also include a description of the expedited review process applicable to such Claims.

Q9. In addition to providing the notice of adverse benefit determination, is there anything else the Claims Administrator must do if a Claim is denied?

Yes, the Claims Administrator is required to take the following steps:

- Ensure that any notice includes information sufficient to identify the Claim, including the date of service, the health care provider, and the amount of the Claim. Moreover, the Plan must provide notice of the opportunity to request the diagnosis code, the treatment code, and its corresponding meaning;
- Ensure the notice includes the denial code and its corresponding meaning and the standard used to deny the Claim;
- Provide a description of the internal appeal and external review processes available under the Plan;
- Provide a description of how to initiate an appeal; and
- Disclose the availability of any applicable office of health insurance consumer assistance or ombudsman available to assist with internal Claims and appeals or external review processes, including contact information.

Q10. If my Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The Claims Administrator will review the appeal upon receipt and will follow the terms of the Plan. An appeal decision will be made within the time frame provided by the Plan and will be reviewed even if information or documents are missing from the appeal.

A document, record, or other information is relevant to a Claim if it

- (a) was relied upon in making the Claim determination;
- (b) was submitted, considered, or generated in the course of making the Claim determination, even if it was not used to make the Claim determination;
- (c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that Claim reviews follow the terms of the Plan has been applied consistently; or
- (d) constituted a statement of policy or guidance with respect to the Plan concerning the denied Claim.

The review will take into account all comments, documents, records, and other information submitted by you relating to the Claim, even if the information was not submitted or considered in the initial Claim review. The review will not rely on the initial denial and will be performed by a fiduciary of the Plan who is neither the individual who denied the Claim nor a direct report of that individual.

Q11. Is there an expedited process for an urgent care Claim?

Yes, you are entitled to an expedited review process that permits you to submit your request orally or in writing and that permits all necessary information to be shared by telephone, facsimile, or other similarly expeditious method.

Q12. If I appeal a Claim determination, what happens next?

First Appeal

Once you have submitted an appeal, you will receive a written response, as follows:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Plan Component.
- **Pre-Service Claim.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Plan Component.
- **Post-Service Claim.** Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Plan Component.
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the adverse determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of Claim.

Second Appeal

If specified in the Benefit Documents for each Plan Component or in documentation given to you by the Claims Administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

The appeal decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim.** Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim.** Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim.** The response will be made in the appropriate time period based upon the type of Claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

Q13. Will I receive a written notification of a claim determination on review (i.e., an appeal)?

Yes, you will receive a final notice of adverse benefit determination. The notice will include the following information:

- i. Information sufficient to identify the Claim.
- ii. The specific reason for the denial.
- iii. Reference to the specific Plan provisions on which the denial was based.
- iv. A description of any additional material or information necessary for you to perfect the Claim and an explanation of why the material or information is necessary.
- v. A description of the Plan's review procedures and the time limits applicable to the procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- vi. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- vii. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.

- viii. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical judgment for the determination, or (ii) a statement that such explanation will be provided free of charge, upon request.
- ix. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Q14. If my appeal is denied, do I have any other rights?

Yes, you may have the right to request an independent, external review. Your external review will be conducted by an independent review organization not affiliated with the Plan. This independent review organization may overturn the Plan's decision, and the independent review organization's decision is binding on the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal Claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

DISABILITY PLANS

Q15. When will I receive a Claim determination?

You will receive a written or electronic notification of the Plan's Claim decision within 45 days.

Q16. Will the Claim determination period ever be extended?

Yes, the Plan may extend the review period twice, each time by 30 days, if the extension is necessary due to circumstances beyond the control of the Plan. If an extension is necessary, the Plan will notify you in writing.

Q17. What if I did not submit all the necessary information to process my Claim?

The Plan will send you a written notice and will provide a description of the required documents or information. You will then have 45 days to submit the additional information to the Plan.

Q18. Will I receive a notice if my Claim is denied?

Yes, you will receive a notice that will contain the following information:

- i. Information sufficient to identify the Claim.
- ii. The specific reason for the denial.
- iii. Reference to the specific Plan provisions on which the denial was based.
- iv. A description of any additional material or information necessary for you to perfect the Claim and an explanation of why such material or information is necessary.
- v. A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under ERISA Section 502 following a denial on review, if applicable.
- vi. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- vii. If the denial was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the denial and a copy will be provided free of charge to you upon request.

Q19. If my Claim is denied, what should I do?

When you receive a denial, you will have **180 days** following receipt of the notification in which to appeal the decision. You may submit written comments, documents, records, and other information relating to the Claim. If you request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Q20. If I appeal a Claim determination, what happens next?

Once you have submitted an appeal, you will receive a written response within 45 days after receipt of your request to review a Claim determination. The 45-day period may be extended by 45 days if the Plan determines that special circumstances require an extension. If an extension is required, you will receive a written notification.

NON-HEALTH/NON-DISABILITY PLANS

Q21. What if a Plan Component is not a Health Care or Disability Component?

Generally, any Plan Component that is not a Health Care or Disability Component will review a Claim within 90 days and provide written notification of its decision. The 90-day period may be extended by 90-days in certain circumstances. If you disagree with the Claim decision, you may file an appeal within 60 days of your receipt of the written notice of denial of a Claim. The Plan administrator will then render a decision within 60 days after receipt of the request for review. In special circumstances, the Plan may make a determination within 120 days after the receipt of your request for review. If such an extension is required, you will be notified in writing.

MISCELLANEOUS

LEAVE OF ABSENCE

Q1. What happens to my Benefits if I take a leave of absence?

Depending on the leave policies and procedures adopted by your Employer, you may be able to continue certain Benefits while on an approved leave of absence. If you are eligible to continue certain Benefits, you may be required to complete certain forms or documents and pay towards the cost of coverage.

Q2. Is my Employer required to comply with the Family and Medical Leave Act (FMLA)?

Yes, your Employer is required to comply with FMLA. The Plan Administrator must continue Health Care Plan coverage while you are on leave protected by the FMLA.

Q3. What happens if my leave is protected by FMLA?

If your leave is protected under FMLA, you may continue your group health care coverage under the Plan (e.g. Medical, Dental, Vision) for you and any covered Dependents as long as you continue to pay your portion of the cost for your Benefits during the leave.

Your Employer may offer the following options for payment of Contributions:

- **Paid Leave** – Contributions will be automatically deducted from payroll.
- **Unpaid Leave** – You will be required to submit payment to your Employer for any required Contributions. If you do not pay Contributions in a timely manner, you will be provided a notice of cancellation and will have **15 days** from the date of the notice to make the required payment. If you fail to make the payment in the permitted time, your coverage will be cancelled. However, upon return to work, your coverage will be reinstated.

Any coverage that are terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required contributions, including any catch-up payments attributable to the period prior to your return from leave, if applicable.

Q4. What happens if I experience a “change in status” while on FMLA leave?

If you experience a “change in status” (e.g., change in marital status, number of Dependents, residency, or employment status), you may change your coverage election as if you were actively employed.

Q5. What happens if I do not return to work following my FMLA leave?

If you do not return to work following your FMLA leave, you may be entitled to COBRA continuation coverage, if applicable. You may also be required to reimburse your Employer for costs of coverage provided to you while you were on unpaid FMLA leave.

Q6. What happens if my leave is protected under USERRA?

If your leave is protected under USERRA, you may elect to continue coverage under the Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election and payment of coverage. Moreover, upon return from leave protected under USERRA, your coverage will be reinstated (i.e., begin again).

MISCELLANEOUS

Q7. Can I assign my rights under the Plan to another person or third party?

The assignment of benefits is governed by the Benefit Document. However, if the Benefit Document does not contain such a provision, the Plan will not permit the assignment of any rights under the Plan to another person or third party.

Even if an assignment is permitted under the Benefit Document, the Plan Administrator, or any delegated third-party, has the right to determine the validity of the assignment.

Q8. Is this document a contract between me and my Employer?

No, this document is an SPD and is intended to summarize general provisions of the Plan. This document does not constitute a contract of any type between you and your Employer. Nothing in this document shall give you any right of employment.

DEFINITIONS

When used in this SPD with initial capital letters, the following words will have the meanings described below unless the content indicates other meanings are intended. If any defined term in this SPD conflicts with the same term contained in an insurance contract or other document, the other document shall govern.

BENEFIT – Each benefit available under the Plan, as identified in Appendix A.

BENEFIT DOCUMENT – Any policy, contract, or other document that governs the terms of the Benefit.

CHILD(REN) – Your child(ren) as defined in a Benefit Document.

CLAIM – A request for benefits made by you under the terms of the Benefit Document.

CLAIMS ADMINISTRATOR – The Plan Administrator or the third party appointed by the Plan Administrator to review claims submitted by you, including appeals, as applicable.

CONTRIBUTIONS – The amount paid by you or your Employer equal to the cost of coverage under a Benefit.

DEPENDENT – Your dependent as defined in the applicable Benefit Document.

DISABILITY PLAN – The Benefit that provides a Participant supplemental income during a limited or extended period of time due to the inability to work as a result of illness, injury, or accident. The Disability Plan includes a short-term disability plan, other than state-mandated benefits, and a long-term disability plan.

DOMESTIC PARTNER – Your Domestic Partner as defined in the Benefit's insurance contract or other document for eligibility requirements.

ELIGIBLE DEPENDENT – A Dependent that is eligible for coverage under one or more of the Benefits.

EMPLOYER – Your Employer who adopted this Plan is Nazareth University. Your Employer will also serve as the Plan Administrator, as defined in the Employee Retirement Income Security Act (ERISA), who is responsible for the day-to-day operations and decisions regarding the Plan, unless a separate Plan Administrator is appointed for all or some of the Plan responsibilities.

HEALTH CARE PLAN – Any Benefit that provides medical care, including a Major Medical Option, dental, vision, or an employee assistance program.

MAJOR MEDICAL OPTION – A Benefit that provides medical benefits, other than vision or dental benefits, to eligible employees and their Eligible Dependents.

PARTICIPANT – An employee of your Employer who has satisfied the eligibility requirements and entered the Plan.

PLAN – The Plan described in this SPD is the Welfare Plan for Employees of Nazareth University.

PLAN ADMINISTRATOR – Your Employer is responsible for the day-to-day administration of the Plan and is the Plan Administrator unless an appointed Plan Administrator is named in the Administrative Information section of this SPD.

PLAN SPONSOR – The Plan Sponsor is Nazareth University.

ADMINISTRATIVE INFORMATION

Q1. Who has the authority to make determinations under the Plan?

The Plan Administrator has discretionary authority to interpret and make determinations under the Plan. The Plan Administrator may delegate its authority to third parties regarding Claims administration (e.g., the review and processing of Claims), ministerial services (e.g., recordkeeping, mailing of notices, etc.), and other services, as necessary.

Q2. What are some of the duties of the Plan Administrator?

The Plan Administrator's duties include, but are not limited to, the following:

- Administering the Plan in accordance with its terms;
- Determining all questions of eligibility, status, and coverage under the Plan;
- Interpreting the Plan, including ambiguities, inconsistencies, omissions, and disputed terms;
- Making factual findings;
- Deciding disputes that may arise relative to a covered person's rights;
- Recommending procedures for filing a Claim for Benefits, review Claim denials, and appeals relating to them, and uphold or reverse such denials;
- Keeping and maintaining the Plan document and all other records pertaining to the Plan;
- Appointing and supervising a third-party administrator to pay Claims;
- Performing all necessary reporting, as required by ERISA, if applicable;
- Establishing and communicating procedures to determine an order's status as a qualified medical child support order;
- Delegating to any person or entity powers, duties, and responsibilities, as necessary; and
- Performing functions necessary for the Plan's administration.

Q3. Can changes be made to the Plan?

Yes. While the Employer intends to maintain the Plan indefinitely, the Employer may, in its sole discretion, at any time, amend, suspend, or terminate the Plan in whole or in part. This includes amending Benefits provided under Plan. If an amendment, suspension, or termination is enacted, the Employer will provide notice, as required by law.

Q4. What happens if the Plan Administrator or its delegates makes a clerical error?

If the Plan Administrator or its delegated agent make a clerical error, the error will not invalidate coverage. Rather, coverage effective dates will be determined solely in accordance with the provisions of the Plan, including any Benefit Document. Moreover, as permitted by law, the Plan Administrator will make an equitable adjustment as a result of an error or delay.

Q5. If the Plan receives a premium refund, will the reimbursement be paid to Participants?

If the Plan has an insured Major Medical Option, the Plan may receive a refund of premium payments. For example, the Plan may receive a medical loss ratio rebate or an experience adjustment. If this occurs, your Employer will determine if the refund is a Plan asset. If so, the Plan Administrator will have discretion to pay the refund to Participants as follows:

- Distribute a refund to Participants within 90 days of receipt,
- Use the refund to reduce Participants' portion of future premiums under the Plan; or
- Use the refund to enhance future Benefits under the Plan.

If the Plan Administrator determines the refund does not belong to the Plan, the Employer may determine how to use the refund and the Participants will not have any right to reimbursement.

Q6. Who is responsible for the day-to-day operations of the Plan?

Your Employer is responsible for the Plan's day-to-day administration unless a Plan Administrator is appointed below. If no Plan Administrator is appointed below, your Employer will be the Plan Administrator.

To assist in operating the Plan efficiently and accurately, your Employer may appoint additional persons or organizations to act on its behalf or to perform certain functions. The Plan Administrator may provide the Claims administration through a third-party Claims Administrator.

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator will also answer any questions you may have about the Plan. The Plan Administrator has the exclusive right to interpret the Plan's provisions. You may contact the Plan Administrator for any further information about the Plan.

Q7. Who is responsible to administer the Plan's Claims?

The Claims Administrator is responsible to administer the Plan's Claims. The Claims Administrator is:

- The Insurance Issuer appointed by the Employer.
- The Employer.

Refer to the chart in Appendix A for contact information.

Q8. How can I obtain additional information about the Plan?

For additional information regarding the Plan, contact the Plan Administrator listed above, or refer to the Plan document. Copies of the Plan document are available free of charge from the Plan Administrator upon request.

Q9. If I receive a medical child support order, what should I do?

If you receive a medical child support order, send the order to the Plan Administrator. The Plan Administrator will then review the order to determine if it is a "qualified medical child support order" (QMCSO). If it is determined the order is a QMCSO, the Plan will automatically change your coverage to extend coverage to the Child. Coverage for the Child will begin on the date specified in the order, or if none is specified, the date of the order, as permitted under a Benefit.

You are permitted to obtain, without charge, a copy of the policy and/or procedures governing the QMCSO from the Plan Administrator.

Q10. When can the Plan Administrator retroactively terminate coverage provided under a Health Care Plan?

A retroactive termination of coverage is referred to as a "rescission." The Plan Administrator may retroactively terminate your coverage or the coverage of your Eligible Dependent if you commit fraud or if you intentionally misrepresent a material fact to the Plan.

Q11. What is considered fraud or intentional misrepresentation?

Fraud or intentional misrepresentation occurs when you obtain Benefits by fraudulently or intentionally misrepresenting a material fact to the Plan. If you fraudulently or intentionally misrepresent a fact, the Plan Administrator may take certain action, as permitted by law, at its sole discretion.

YOUR RIGHTS UNDER ERISA

Q1. Is the Plan subject to the Employee Retirement Income Security Act (ERISA)?

Yes, the Plan is subject to ERISA and you have certain rights summarized in this section.

Q2. What are my legal rights and protections under the Plan?

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 the following.

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and any collective bargaining agreements, and, if required by ERISA to be filed, 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 Benefit Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (if required by ERISA to be prepared) and updated SPD. The administrator may charge a reasonable fee for the copies.
3. 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 Health Care Plan Coverage

The Plan Administrator is required to continue Health Care Plan coverage for you if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights.

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 an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 after exhausting the Plan's Claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. 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 your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants and certain Eligible Dependents covered under this Plan can elect a temporary extension of coverage (called "COBRA continuation coverage") when coverage under the Plan would otherwise end because of a Qualifying Event. This notice is intended to inform Participants and Eligible Dependents, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage. Complete instructions on COBRA continuation coverage, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Qualified Beneficiaries.

Q1. What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of coverage under the Plan that must be offered to Qualified Beneficiaries. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the coverage that the qualified beneficiary had immediately before the Qualifying Event, or if

the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Q2. Who can become a qualified beneficiary?

In general, a qualified beneficiary can be any of the following.

- Any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day either a Participant, a Participant's spouse, or a Participant's Dependent Child.
- Any Child who is born to or placed for adoption with a qualified beneficiary who was an employee during a period of COBRA continuation coverage.
- A Participant who retired on or before the date of substantial elimination of coverage under the Plan because of your Employer's bankruptcy proceeding under Title 11 of the U.S. Code. The Participant's spouse, surviving spouse, or Dependent Child is also a qualified beneficiary, if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse, or Dependent Child was covered under the Plan.

An individual is not a qualified beneficiary if the individual's status as a Participant is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer earned income that did not constitute income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then the individual's spouse or Dependent Child will also not be considered a qualified beneficiary by virtue of the relationship to the individual. A Domestic Partner is not a qualified beneficiary.

Each qualified beneficiary (including a Child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) have the opportunity to make an independent election to receive COBRA continuation coverage.

Continuation Coverage for Domestic Partners

An individual covered under the Plan due to his or her status as an employee's domestic partner is not provided with federal continuation coverage rights under COBRA. However, the Plan will provide such domestic partners with continuation coverage that mirrors the rights and obligations of continuation coverage of the spouse of an employee under COBRA.

If you are covered under the Plan as a dependent because of your status as an employee's domestic partner, you will be treated as a qualified beneficiary ("domestic partner qualified beneficiary") if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your domestic partner dies;
- Your domestic partner's hours of employment are reduced;
- Your domestic partner's employment ends for any reason other than his or her gross misconduct;
- The employee-domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- Your domestic partnership terminates.

Notification requirements. If you become eligible for these continuation coverage rights because of the termination of your domestic partnership, you must notify the Plan Administrator in writing within 60 days after the later of (1) the date your domestic partnership terminates; or (2) the date on which you lose (or would lose) coverage under the terms of the Plan as a result of the termination of the domestic partnership. Your notice must indicate that your domestic partnership has terminated, the date of such termination, and your name and address. You must provide this notice to:

Nazareth University
Attn: Human Resources
4245 East Avenue
Rochester, NY 14618
darnold8@naz.edu

You may lose your right to elect continuation coverage if proper procedures are not followed within the time periods described.

As a domestic partner qualified beneficiary, your election requirements, length of continuation coverage, cost of continuation coverage, payment obligations, and termination of the continuation coverage rights will be equivalent to those of an eligible spouse who is a qualified beneficiary under COBRA as described in this "Continuation of Coverage Rights" section.

If you have any questions about continuation coverage requirements and benefits for domestic partners, please contact the Plan Administrator.

Q3. What is a qualifying event?

A Qualifying Event is any of the following if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

- The Participant's death.
- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a Participant's employment.
- The divorce or legal separation of a Participant from the Participant's spouse. If the employee reduces or eliminates the Participant's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
- A Participant's enrollment in any part of the Medicare program.

- A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).
- An Employer's bankruptcy proceeding under Title 11 of the U.S. Code in respect to a Participant who is retired from employment at the time will also be a Qualifying Event for Participants in this Plan.

If the Qualifying Event causes the Participant or the Participant's covered spouse or a Dependent Child to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of your Employer's bankruptcy, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the individuals losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met.

Taking FMLA leave does not constitute a Qualifying Event. A Qualifying Event will occur, however, if the Participant does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from that date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.).

Q4. What factors should be considered when determining to elect COBRA continuation coverage?

You may have the right to request special enrollment in another health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after Plan coverage ends because of a Qualifying Event listed above. You may also have the same special right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

Q5. What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

Q6. What is the election period and how long must it last?

The election period is the time period within which the qualified beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of 1) the date the qualified beneficiary would lose coverage because of the Qualifying Event, or 2) the date notice is provided to the qualified beneficiary of the qualified beneficiary's right to elect COBRA continuation coverage.

Q7. Is a Participant or qualified beneficiary responsible for informing the Plan Administrator of the occurrence of a qualifying event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. Your Employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is

- the end of employment or a reduction of hours of employment,
- the Participant's death,
- the commencement of your Employer's bankruptcy proceeding, or
- the Participant's entitlement to any part of Medicare.

For the other Qualifying Events (divorce or legal separation of the Participant and spouse, or a Dependent Child's losing eligibility for coverage as a Dependent Child), the Participant or the other qualified beneficiary must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if a written notice is not provided to the Plan Administrator or its designee during the 60 day notice period, any qualified beneficiary who loses coverage will not have the option to elect continuation coverage. The notice must be sent to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice must be provided to the COBRA administrator or the Employer following the Plan's reasonable procedures established in compliance with COBRA regulations. Depending on the established procedures, this may be through the COBRA administrator's website, email, or mail, or the Employer's email, mail, or by hand delivery. Oral notice, including notice by telephone, is not acceptable. To provide notice to your Employer contact:

Nazareth University
 Attn: Human Resources
 4245 East Avenue
 Rochester, NY 14618
darnold8@naz.edu

The COBRA administrator or your Employer may provide you with a form to complete your notice. In general, your notice must include:

- the Plan's name; Welfare Plan for Employees of Nazareth University
- the name and address of the Participant and any other qualified beneficiaries, and
- the Qualifying Event and the date it happened.

If mailed, your notice must be postmarked no later than the last day of the required notice period.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts. For example, in order to qualify for a disability extension of COBRA continuation coverage.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Participants may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost. If the qualified beneficiary does not elect COBRA continuation coverage within the 60-day election period described above, the right to elect COBRA continuation coverage will be lost.

Q8. Will a waiver made before the end of the election period end a qualified beneficiary's election rights?

If, during the election period, a qualified beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. The waiver's revocation is an election of COBRA continuation coverage. If a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Q9. Is COBRA continuation coverage available if a qualified beneficiary has Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are entitled to Medicare benefits on or before the date on which COBRA continuation coverage is elected. But a qualified beneficiary's COBRA continuation coverage will terminate automatically if, after electing COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare or becomes covered under another health Plan.

Q10. When may a qualified beneficiary's COBRA continuation coverage be terminated?

A qualified beneficiary may waive COBRA continuation coverage during the election period. Except for an interruption of coverage in connection with a waiver, a qualified beneficiary's COBRA continuation coverage must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates.

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the qualified beneficiary.
- The date upon which your Employer ceases to provide any health Plan (including a successor Plan) to any employee.
- The date, after the date of the election, that the qualified beneficiary first becomes covered under a health Plan.
- The date, after the date of the election, that the qualified beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).
- The later of the following two dates if the qualified beneficiary is entitled to a disability extension.
 1. The end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension.
 2. The earlier of 1) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled, or 2) 29 months after the date of the Qualifying Event.

The Plan can terminate for cause a qualified beneficiary's coverage on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries (for example, for submitting a fraudulent Claim).

If the Plan's obligation to make COBRA continuation coverage available to the qualified beneficiary ceases, and an individual who is not a qualified beneficiary receives coverage under the Plan solely because of the individual's relationship to a qualified beneficiary, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

Q11. What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the Qualifying Event type and the qualified beneficiary's status, as shown below.

- If a Qualifying Event is based on a Termination of Employment or reduction of hours of employment, the maximum coverage period ends
 - 18 months after the Qualifying Event if there is not a disability extension, and
 - 29 months after the Qualifying Event if there is a disability extension.
- If a Participant enrolls in Medicare before experiencing a Qualifying Event that is a Termination of Employment or a reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the Participant ends on the later of
 - 36 months after the date the Participant becomes enrolled in Medicare (this extension does not apply to the covered employee); or
 - 18 months (29 months, if there is a disability extension) after the date of the Participant's Termination of Employment or reduction of hours of employment.
- If a qualified beneficiary is a Child born to or placed for adoption with a Participant during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.
- For any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.
- For a Qualifying Event due to bankruptcy, there will be a maximum coverage period for a qualified beneficiary.

For a Qualifying Event due to bankruptcy, the maximum coverage period for a qualified beneficiary who is the Participant ends on the date of the retiree's death. For a qualified beneficiary who is the Participant's covered spouse, surviving spouse, or Dependent Child, the maximum coverage period ends on the earlier of 1) the qualified beneficiary's death, or 2) 36 months after the retiree's death.

Q12. Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed by a second Qualifying Event that gives rise to a 36-month maximum coverage period within the original 18- or 29-month period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the maximum coverage period for COBRA continuation coverage be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures described above.

Extension of Federal COBRA Coverage under New York State Law

Employees and their dependents who are eligible for federal COBRA coverage in fully insured medical plans which are issued in New York State may have their medical coverage continued for up to 36 months. Under this law, these employees will be eligible for the same 18 months of continuation under COBRA and an additional 18 months of continuation of their medical coverage only under New York state law for a total of 36 months continuation for their medical coverage.

Q13. How does a qualified beneficiary become entitled to a disability extension?

A disability extension will be granted if a qualified beneficiary 1) has a Qualifying Event because of a termination or a reduction of hours of the Participant's employment, and 2) is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the qualified beneficiary must also notify the Plan Administrator of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee and in accordance with the procedures described above.

Q14. Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

Q15. What is considered timely when paying for COBRA continuation coverage?

Payment is made timely if made no later than 30 days after the first day of the coverage period.

The Plan does not require payment for any period of COBRA continuation coverage for a qualified beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that qualified beneficiary. Payment is considered made on the date on which it is postmarked to those providing COBRA continuation coverage.

If you make a timely payment and the payment is less than the amount the Plan requires, the Plan Administrator may consider the amount timely if 1) the amount owed is insignificant, and 2) you pay the amount owed within a reasonable period. A reasonable period is 30 days and an insignificant amount is considered \$50 or 10% of the required amount. Please see the Plan document for additional information.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Administrator Informed of Address Changes

To protect your family's rights, you should keep the Plan Administrator informed of any changes in your family members' addresses. You should also keep a copy, for your records, of any notices that you send to the Plan Administrator or its designee.

PRIVACY RIGHTS UNDER HIPAA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how your Protected Health Information (PHI) may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PHI or Electronic Protected Health Information (ePHI) means individually identifiable health information held by, or on behalf of, the Plan.

Uses and Disclosures of Your Information

The Plan Administrator on behalf of the Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan—including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your Claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and Claims management purposes. Note that the Genetic Information Nondiscrimination Act (GINA) prohibits using PHI that is genetic information for underwriting purposes. In addition, the Plan may disclose your PHI to the Plan Administrator so that the Plan Administrator can perform administrative functions on behalf of the Plan, such as facilitating Claims or appeals.

The Plan also may use or disclose your PHI where required or permitted by law. The Plan Administrator on behalf of the Plan is permitted to use or disclose PHI:

- when required by law;
- for public health activities;
- to report Child or domestic abuse;
- for governmental oversight activities;
- pursuant to judicial or administrative proceedings;

- for certain law enforcement purposes;
- for a coroner, medical examiner, or funeral director in order to obtain information about a deceased individual;
- for organ, eye, or tissue donation purposes;
- for certain government-approved research activities;
- to avert a serious threat to an individual's or the public's health or safety;
- for certain government functions, such as related to military service or national security;
- to comply with workers' compensation laws;
- to a family member or close friend that you have identified and who is directly involved in your care or payment for your care; or
- to notify a family member or other individual involved in the care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

For any other uses and disclosures of your PHI, the Plan will obtain your written authorization. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes. You may revoke this authorization in writing at any time, provided the Plan has not yet acted while relying on your authorization.

Stricter State Privacy Laws – Under the HIPAA privacy and security rules, the Plan is required to comply with state laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter). The Plan maintains a policy to ensure compliance with these laws.

Your Rights With Respect To Your Health Information

You have several rights with respect to your PHI, which are described below. Please call the Privacy Officer listed below if you have questions about your rights.

- You have the right to request restrictions on how your PHI may be used or disclosed. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.
- You have the right to receive your PHI confidentially, such as at a location other than your home, if you state in writing that disclosing the information through normal means could endanger you.
- You have the right to inspect and copy your PHI that is maintained by the Plan in a designated record set or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies.
- You have the right to request an amendment to your PHI that the Plan maintains in a designated record set. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.
- You have a right to request an accounting of disclosures that the Plan has made of your PHI during the six years before your request, except for disclosures that you have authorized or for disclosures related to routine treatment, payment, or health care operations of the Plan.
- You have a right to request a paper copy of this notice, even if you have agreed to receive this notice electronically.

Our Duties With Respect To Your Individually Identifiable Health Information

The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI.

Questions?

If you have questions or would like more information about the Plan's privacy policies, you may contact the Privacy Officer. The Privacy Officer is responsible for developing and implementing the Plan's privacy policies and procedures.

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the U.S. Department of Health and Human Services. You cannot be retaliated against for filing such a complaint.

OTHER LEGAL NOTICES

Q1. Do I have any other legal rights and protections under the Plan?

Yes, the Plan is required to comply with other federal regulations, which guarantee certain legal rights and protections, as follows.

Your Rights Under the Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA or ACA) provides certain consumer protections, including the elimination of annual and lifetime limits on benefits, the provision of preventive services without cost sharing, the limitation of out-of-pocket annual costs, the coverage of essential health benefits, the elimination of waiting periods of more than 90 days for coverage to begin, the elimination of pre-existing conditions, and the guarantee of issue and renewal of coverage. As applicable, these provisions are contained within the Benefit Document of the Major Medical Option.

Your Rights Under the Americans With Disabilities Act

The Americans with Disabilities Act (ADA) provides that your Employer may not discriminate against you on the basis of disability. In addition, it generally restricts your Employer from obtaining medical information from you but permits your Employer to obtain medical information or request medical examinations as part of a voluntary Wellness Program. Your Employer may not deny you the right to access the Wellness Program on the basis of disability. If you have a disability, your Employer is required to provide a reasonable accommodation or adjustment that allows you to participate in the Wellness Program. Any information provided to your Employer due to participation in the Wellness Program must remain confidential. To request an accommodation, please contact the Plan Administrator or follow the instructions contained in the "Notice Regarding Wellness Program."

Your Rights Under the Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides that Health Care must be maintained during any period of unpaid leave covered by FMLA under the same conditions as if you continued to work. Moreover, FMLA requires that you be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. If your leave extends beyond the end of

your FMLA entitlement, you do not have return rights under FMLA. If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse your Employer for its share of health care premiums or Contributions paid on your behalf during your FMLA leave.

Your Rights Under the Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) provides that your Employer may not discriminate against you on the basis of genetic information, including adjusting premiums and contribution amounts.

Your Rights Under the Health Insurance Portability and Accountability Act (Special Enrollment)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides certain special enrollment rights if you decline coverage in the Major Medical Option for yourself or your Eligible Dependents because of other coverage. If you or your Eligible Dependents lose eligibility for that other coverage or if your Employer stops contributing toward your or your Dependent's other coverage, you may be able to enroll yourself and your Eligible Dependent in the Major Medical Option. Generally, you must request enrollment within 30 days after your or your Eligible Dependent's other coverage ends or after your Employer stops contributing toward the other coverage.

If the other coverage is Medicaid or the Children's Health Insurance Program (CHIP), you must request enrollment within 60 days after your or your Eligible Dependent's Medicaid or CHIP coverage ends. Finally, if you have a new Eligible Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Eligible Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Your Rights Under the Health Insurance Portability and Accountability Act (Health Factors)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits the Major Medical Option from discriminating against you or your Eligible Dependents based on a health factor. Health factors include your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. Compliance with this provision is not determinative of compliance with any other federal or state laws, including COBRA or ADA.

Your Rights Under the Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) provides that if any Major Medical Option under the Plan 1) provides for both medical and surgical benefits and mental health or substance use disorder benefits, and 2) is not subject to increased cost exemption (within the meaning of the MHPAEA), the following conditions apply:

- The Major Medical Option may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Major Medical Option may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any health insurance option with respect to mental health or substance use disorder benefits will be made available by the Plan Administrator (in accordance with the MHPAEA) to any current or potential Participant upon request.
- The reason for any denial under the Plan for reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant will, on request or as otherwise required under the MHPAEA, be made available by the Plan Administrator to the Participant in accordance with the Claims procedures applicable to the group medical coverage feature.
- The Plan will be operated and constructed in all respects in compliance with the MHPAEA.

"Mental health benefits" and "substance use disorder benefits" are defined in the Major Medical Option applicable to the health insurance option, pursuant to applicable state and federal law, and consistent with generally recognized standards of current medical practice.

Your Rights Under Michelle's Law

Michelle's Law provides that a Major Medical Option of the Plan that requires a certification of student status for any period of coverage of an Eligible Dependent will comply with Public Law No. 110-381 (2008), as amended from time to time. Eligibility for such coverage for an Eligible Dependent who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence will be extended if the leave normally would cause the Eligible Dependent to lose eligibility for coverage under any Major Medical Option's coverage due to loss of student status. This eligibility extension shall last up to one year beginning on the first day of the medically necessary leave of absence or the date the coverage would otherwise terminate due to loss of student status, whichever is earlier.

Your Rights Under Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (NHPA) provides that the Major Medical Option of the Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Major Medical Option may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your Maternity Hospital Stay Rights under New York State Law

If a group health insurance plan issued in the State of New York provides benefits for pregnancy or childbirth, the plan also must provide postdelivery hospitalization for the mother and newborn child for a minimum of 48 hours for vaginal delivery, and 96 hours for a cesarean section delivery. If the mother agrees to a shorter hospital stay, the plan must provide at least one home care visit in addition to any other home health care provided by the health insurance policy. Maternity benefits also must include parent education, training and assistance in breast or bottle feeding, and any necessary newborn clinical assessments.

Your Rights Under Title VII of the Civil Rights Act of 1964

Title VII of the Civil Rights Act of 1964 (Title VII) provides that your Employer cannot discriminate against you on the basis of religion. Title VII permits you to request an accommodation to participate in a Wellness Program Plan due to a sincerely-held religious belief, practice, or observance and requires your Employer to provide the reasonable accommodation or adjustment unless the request imposes an undue hardship.

Your Rights Under USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides for continuation of Health Care Plan coverage if you are called for active-duty military service. The maximum length of extended coverage under USERRA is the lesser of

- 24 months beginning on the date that the military leave begins, or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional two-percent administration fee. If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the U.S. Department of Veterans Affairs) incurred as a result of the military service.

Your Rights Under Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires that a Major Medical Option that provides medical and surgical benefits with respect to a mastectomy 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
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedema.

These services must be provided in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles, copays, and coinsurance provisions applicable to other such medical and surgical benefits provided under the applicable medical option. Please refer to the Major Medical Option's summary of benefits coverage for additional information. If you have other questions, please contact the Plan Administrator.

Q2. Is there anything else I should know if I want to enroll my Domestic Partner?

Yes. Unless otherwise provided by the Plan Documents, you must be aware of the following:

Imputed Income: Under current federal income tax laws, the value of providing medical benefits to a Domestic Partner and the Domestic Partner's Eligible Dependent Children is considered taxable to you—unless they are considered your Dependents for purposes of federal income taxes. This means you will pay federal, state, and local income taxes, as well as employment taxes, on the full value of the coverage provided to your Domestic Partner and the Domestic Partner's Dependents. This type of taxable income is known as imputed income, and your Employer will report it on your Form W-2 at the end of each year. It is important for you to understand the tax implications of covering a Domestic Partner and the Domestic Partner's Eligible Dependent Children. Please consult a tax advisor to determine the full tax and financial effect of electing this coverage.

COBRA: An individual covered under the Plan due to their status as an Employee's Domestic Partner is not provided with federal continuation coverage rights under COBRA. However, the Plan may, at the consent of the applicable Plan Component(s), provide such Domestic Partners with continuation coverage that mirrors the rights and obligations of continuation coverage of the Spouse of an Employee under COBRA. If you have any questions about continuation coverage requirements and benefits for Domestic Partners, please contact Human Resources.

Appendix A Welfare Plan for Employees of Nazareth University

Plan Components and Claims Administrators

Benefit Documents are part of this SPD. Any update to the Benefit Document will replace any earlier versions for the period defined in the updated Benefit Document.

Fully-Insured Benefits	Policy/Group No.	Type of Benefit	Claims Administrator <i>(Use the address & phone number on your ID Card if different)</i>	
Aflac 1932 Wynnton Road Columbus, GA 31999	NG255	Voluntary Cancer	Aflac PO Box 84075 Columbus, GA 31993	800-433-3036 www.aflacgroupinsurance.com/customer-service/default.aspx Email to groupclaimfiling@aflac.com
Davis Vision Inc. 175 East Houston Street San Antonio, TX 78205	505063A/XZ900	Vision	Davis Vision PO Box 1525 Latham, NY 12110	800-584-1487 www.davisvision.com
Excellus Blue Cross Blue Shield 165 Court Street Rochester, NY 14647	45256 500655	Medical – PPO Telehealth Integrated with Medical Plan(s)	Excellus PO Box 21146 Eagan, MN 55121	800-499-1275 www.excellusbcbcs.com
Hartford Life and Accident Insurance Company One Hartford Plaza Hartford, CT 06155	ETB-201079	Business Travel Accident (BTA)	The Hartford PO Box 14299 Lexington, KY 40512-4299	888-563-1124 www.thehartford.com
Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166	TM05391928	Dental – PPO	Met Life PO Box 981282 El Paso, TX 79998-1282	800-275-4638 www.metlife.com
New York Life Insurance Company of North America 51 Madison Avenue New York, NY 10010	FLY960556	Basic Life Voluntary Life	NY Life PO Box 22328 Pittsburgh, PA 15222-0328	800-225-5695 www.newyorklife.com/group-benefit-solutions
	YOK960543	Basic AD&D Voluntary AD&D		
	NYD075725	Short-Term Disability	NY Life PO Box 709015 Dallas, TX 75370-9015	
	NYK960398	Long-Term Disability		
TELUS Health 27715 Jefferson Ave., Suite 103 Temecula, CA 92590	—	Employee Assistance Program (EAP)	TELUS Health 27715 Jefferson Ave., Suite 103 Temecula, CA 92590	844-880-9142 us.lifeworks.com

Appendix B
Welfare Plan for Employees of Nazareth University

Eligibility and Participation Requirements

Active Employees

An employee who is determined to be benefit-eligible as of their start date shall be able to participate in the Plan as of the Coverage Date specified below.

Employee Class	Working Hours Minimum	Benefits Offered	Date Coverage Begins	Date Coverage Ends
All Employees	30 hours per week	All Benefits listed on Appendix A	First day of the month following date of hire	End of the month following date of Employee termination

Retirees

A retiree who is determined to be benefit-eligible as of their retirement date shall be able to continue participation in the Plan as follows:

Retiree Class	Benefits Offered	Age and Service Requirements
Tier 1 Retirees	Medical, Term Life	A birth date prior to July 1, 1948, and hired as a full-time employee prior to July 1, 1995
Tier 2 Retirees	Medical	A birth date of July 1, 1948 or after, and hired as a full-time employee prior to July 1, 1995

Dependent Eligibility

Unless specified otherwise under the applicable Plan Component’s benefit documents, coverage for dependents, if elected, begins on the date the Employee’s coverage begins (provided the Employee timely enroll them in coverage). Mid-Plan Year elections for newly acquired Dependents may also be permitted under certain circumstances.

Dependent Definitions. For purposes of eligibility and participation in this Plan, Dependent definitions shall have the same meaning set forth in each applicable Plan Component’s benefit documents.

Proof of Dependent Status. Your Employer reserves the right to verify a Dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by your Employer shall be final, binding and conclusive on all parties claiming an interest in the Plan.

Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status (“ACAFT”) under special eligibility rules for variable hour, part-time, and seasonal employees. In the event your Employer adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the “Shared Responsibility” provisions of the ACA.

For purposes of these special eligibility rules (known as either the “Look-Back Measurement Method” or “Monthly Measurement Method”), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months (“Measurement Period”). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the “Stability Period.” The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by your Employer (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from to the Plan Administrator.