



Plan Type: Group health plan  
Plan Number: 502  
Original Plan Start Date: January 1, 2001  
Restated: January 1, 2018  
Plan Year: January 1 to December 31  
Run-Out Period Following End of Plan Year for Claims Submission: 90 Days  
2 ½ Month Grace Period runs concurrently with the Run-Out Period.

The agent for service of legal process is the Plan Administrator and Plan Sponsor. Service may also be made on the designated agent for service:

Research Foundation of the City University of New York  
230 West 41st. Street, 7th Fl.  
New York, NY 10036-7207

### **Not a Contract of Employment**

No provision of the Plan is to be considered a contract of employment between you and your employer. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

The Plan has two kinds of Flexible Spending Accounts (FSAs) available under this Plan:

- 1) The Health Care FSA can be used to pay for most out-of-pocket medical, vision and dental care expenses for yourself and your Dependents as long as these expenses are not covered by your medical or dental plan.
- 2) The Dependent Care FSA can be used to pay for eligible day care expenses for a dependent child or adult relative while you or your spouse work or while your spouse is a full-time student or disabled.

You contribute tax-free dollars to your FSAs through payroll deductions. When you have an eligible medical, vision, dental or dependent care expense, you are reimbursed from the appropriate FSA.

Eligibility Requirements:

#### Health FSA and Dependent Care FSA.

Employees who work a minimum of 20 hours per week are eligible to participate in the Plan on the first of the month following the 90 day waiting period. Dependent Care FSA enrollees may enroll upon the date of hire.

The open enrollment period each year is the 30 days immediately preceding the beginning of the Plan Year.

The appointed Third Party Administrator in conjunction with the Administrator will perform the ministerial functions of record keeping for the medical care and dependent care expense portion of the Plan, and any election or reporting requirements of the Internal Revenue Code. The Third Party Administrator at the time of this writing is Advanced Benefit Strategies at 30 Mill Street, Unionville, CT 06085. Their phone number is (877) 732-8125 and fax number is (860) 673-2207. The Third Party Administrator is not a fiduciary of the Plan.

For the initial Plan Year, all employees meeting the Service Period Requirement identified above may elect to participate as of the plan effective date.

## **MEDICAL CARE EXPENSE ELECTIONS**

The Health FSA portion of the Plan provides for reimbursement of certain expenses that you incur for medical care for yourself, your spouse and/or your dependents. To participate, you must return a properly completed enrollment form to your Employer. Please see the questions and answers section below for additional information about the Health FSA portion of the Plan as well as the Dependent Care FSA portion of the Plan.

The minimum check amount is hereby set to be \$20.00. Submitted claims for less than \$20.00 will be held until an accumulation of the minimum is reached, or until the closing period for the Plan Year whichever comes first.

### ***FOR HEALTH FSA ACCOUNT (UNREIMBURSED MEDICAL/DENTAL)***

If your company offers a Health FSA, the following applies:

The maximum annual contribution amount any employee may contribute to the Health FSA is: \$2,650.00 with a minimum of \$250.00. This amount will be prorated for your initial Plan Year if less than twelve months. The maximum annual contribution permitted by the IRS is subject to COLA (Cost Of Living Adjustment) increases each tax year as determined by the IRS and established at the Plan's renewal.

### **LIMITED HEALTH FSA ACCOUNT FOR PERSONS ENROLLED IN A HEALTH SAVINGS ACCOUNT (HSA) AND A HIGH DEDUCTIBLE HEALTH PLAN.**

If you participate in a Health Savings Account (HSA) in conjunction with a High Deductible Health Plan and you enroll in the **Limited** Purpose Health Care FSA you may only submit receipts for **Un-reimbursed Vision and Dental** claims, for Preventive Health Care Screening and for claims after the IRS established minimum deductible for the current year has been met. As an example the 2018 HDHP minimum deductible is \$1,350 for self coverage and \$2,700 for family coverage. This minimum is indexed each year for inflation by the IRS. The maximum annual contribution amount any employee may contribute to the Limited Purpose Health Care FSA is \$2,650.00 with a minimum of \$250.00. This amount will be prorated for the initial Plan Year less than twelve months. See IRS Publication 502 and your HSA provider's information for a complete explanation of includible expenses and limitations.

### ***FOR DEPENDENT CARE EXPENSE ACCOUNT***

If your company offers a Dependent Care FSA option, the following applies:

The maximum annual amount any employee may contribute to the Dependent Care Benefit Plan may not exceed the amount specified in Code Section 129. Currently, the amount which may be excluded for dependent care assistance with respect to dependent care services provided during a taxable year shall not exceed \$5,000 nor less than \$250.00 if you are a single parent or, if you are married and your spouse works and you file a joint return. If you are married and file a separate return, you may set aside only \$2,500 each year. Your earned income (or the earned income of your spouse, if it is lower) for the year is the maximum limit on the amount of reimbursement which may be excluded from your gross income for that year even if you elected to set aside an amount greater than your earned income (or that of your spouse). If, however, your spouse is a student for at least five months during the year at an educational institution which meets certain requirements, or is mentally or physically incapable of caring for himself or herself, the following special rules apply: for each month that your spouse is a student or incapable of self care, he or she will be deemed to have earned income of \$200 per month if you have dependent care expenses for one person, and \$400 per month if you have dependent care expenses for more than one person.

## **PREMIUM CONTRIBUTIONS**

This part of the Plan allows employee contributions for premiums for group health, vision, dental, disability and group term life insurance amounts up to \$50,000 to be funded through a pre-tax salary reduction. When you buy group insurance through the Plan, the money will be deducted from your pay before income and social security taxes are withheld. The amount you pay for coverage will not appear on your W-2 form. This means that you will not have to pay federal income tax, social security tax or Medicare tax on the amount of your premium payments.

The Plan is voluntary. If you choose to enroll in one of the plans outlined above and offered by the Employer and are required to pay for a portion of that plan's cost, you may elect to have that portion deducted from your paycheck on a pre-tax basis. Contributions to a health savings account may also be deducted from your paycheck on a pre-tax basis. You must complete and return the enrollment form to your Plan Administrator before the deadline given by the Plan Administrator. If you do join the Plan, all the money set aside from your pay will go directly to the insurance company to pay for coverage without being subject to tax. The insurance company will pay your benefits as provided in the insurance contract. Please note, when disability insurance premiums are paid on a pre-tax basis, then disability benefits actually paid to you in the case of a disability will be taxable. If you pay for disability insurance premiums on an after-tax basis, subsequent benefits received through the disability plan will not be taxable. If your Employer allows pre-tax contributions for deposit into a health savings account, those amounts will be directed to the bank where your account is held.

### **MID-YEAR CHANGES UNDER SECTION 125 PLAN**

In general, your decision to participate in the Plan cannot be changed during the Plan Year. This means that once you join, unless you have a change in status as defined by the IRS, you can withdraw from the Plan or change coverage only during the open enrollment period before the next Plan Year begins, the changes effective for the next Plan Year only. After the Plan Year begins, federal law allows you to make changes only under a limited number of circumstances. One of these circumstances is a change in family status. Change in status events are addressed in the questions and answers section below. Federal law also allows you to make a change if your health insurance coverage significantly decreases or stops during the Plan Year, or if the cost of that coverage significantly increases during the Plan Year. If either event happens, you are allowed to revoke your choice of group health coverage and replace it with similar coverage. Otherwise, the amount of your pre-tax payroll deductions will be automatically adjusted to cover any ordinary increases or decreases in the cost of your insurance coverage during the Plan Year. The amount of your election may also need to be modified for certain highly compensated or other key employees to comply with federal law. In the unlikely event that this occurs, you will be notified. Additional circumstance: A participant may prospectively revoke enrollment in the group health insurance coverage at renewal or during the Marketplace's open enrollment period to enroll in Marketplace coverage. Benefit changes made due to a change in status must be made within 30 days of the change in status and any change to your election must be consistent with your change in status.

***Special enrollment rights:*** Eligible but not enrolled Employees or Dependents who either lose coverage under a Medicaid or state Children's Health Insurance Plan (i.e. CHIP) as a result of loss of eligibility or the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance Plan (i.e. CHIP), may request coverage under the Employers "qualified group health plan" within 60 days after eligibility is determined or may request enrollment in the group health plan within 60 days of the date coverage terminates under the Medicaid or State Plan and elect a pre-tax salary reduction under this Plan in relation to any premium contribution required by the employee for the group health plan. The Employee and or their Dependent/s must be allowed to dis-enroll employer coverage and enroll in a State Plan without a gap in coverage and subsequently stop any pre-tax salary reduction for their coverage.

Once an individual has become a covered participant under the Plan, the Plan will not rescind coverage of the individual unless he or she committed fraud or made an intentional misrepresentation of material fact. A rescission of coverage is the cancellation or discontinuation of coverage, other than for failure to pay premiums,

which has a retroactive effect. The Plan or issuer will provide notice of the rescission 30 days in advance; the notice will inform the affected group or participant of the opportunity to appeal the determination to rescind.

The Plan does not impose any cost-sharing requirements, including copayments, coinsurance, coinsurance charges or deductibles, on preventive care, including certain immunizations, child preventative care and women's preventive care and screenings. Health care flexible spending arrangements may not reimburse expenses on a tax-favored basis for over-the-counter drugs without a prescription.

The Plan Administrator can answer your questions about the Plan and will provide you with any forms you need. The Plan Administrator also keeps the Plan's records and is responsible for premium payment to the insurance company.

## **QUESTIONS AND ANSWERS ABOUT THE PLAN:**

### **Are there any fees that I may have to pay?**

You are responsible for fees associated with a re-issue of a reimbursement check sent to you and fees associated with replacement of lost or destroyed debit cards.

### **What are the benefits under the Health FSA part of the Plan?**

The Plan will reimburse you for expenses described below that you have paid or are required to pay out of your own pocket (only to the extent that such expense is not reimbursed through the Health Plan or otherwise) for you and your dependent(s). A person qualifies as your dependent if (a) the person lived with you for the entire year as a member of your household or is related to you, and (b) the person was a U.S. citizen or resident, and (c) you provided over half that person's total support for the year. A dependent child must (a) have the same principal residence as the taxpayer for more than half the tax year, with certain exceptions (resident test); (b) be the taxpayer's child or stepchild (by blood or adoption), foster child, sibling or stepsibling, or a descendant of one of them (c) be under age 19 at the end of the taxable year, under age 24 if a full-time student for at least five months of the year, or permanently and totally disabled and (d) not provide more than one-half of his or her own support for the year OR a qualified child who has not attained the age of 27 by the end of the employee's *taxable year*. The term "child" includes children, stepchildren, legally adopted children, children placed with the employee for adoption, and eligible foster children.

When you elect to participate in the Plan, you decide how much you want to set aside on a pre-tax basis through the Plan. This full election is available for reimbursement within the Plan Year (and during any subsequent run-out period as outlined below) for expenses incurred **during** the Plan Year. The amounts contributed to your medical care expense account for one year may not be used to reimburse you for expenses incurred in a differed year. Any amounts left in your account after the run-out period will be forfeited. You can be reimbursed for medical and dental expenses that are directly related to the treatment of a specific medical condition or for transportation primarily for and essential to medical care for that medical condition. A partial list of eligible expenses is available in the plan description booklet provided by Advanced Benefit Strategies (the Co-Administrator). Reimbursement requests can be either faxed or mailed to Advanced Benefit Strategies. The receipt should include the date of service, the amount that you owe for the service, and the name of the provider. Cancelled checks are not proper documentation for purposes of reimbursement. You cannot be reimbursed for services that have not yet been rendered. Refer to IRS Publication 502 Medical Expenses for further information on determining who is considered your eligible dependent(s) under the Plan.

### **What are the benefits under the Dependent Care FSA part of the Plan?**

The Plan will reimburse you for expenses described below that you have paid or are required to pay out of your own pocket, if those expenses enable you to be gainfully employed, and if they are for care of your spouse, if he or she is physically or mentally incapable or caring for himself or herself, or a dependent for federal income tax purposes who is either less than 13 years old or physically or mentally incapable of caring for himself or herself and whose income for the year does not exceed the federal exemption. When you elect to participate in the Plan, you decide how much you want to set aside on a pre-tax basis through the Plan. The maximum amount of reimbursement to which you are entitled in any plan year is the amount that has been contributed to your

account during such year. Expenses eligible for reimbursement through this portion of the Plan include home day-care, day-care centers, day camp, before or after school care and nanny care. The amounts contributed to your dependent care expense account for one year may not be used to reimburse you for expenses incurred in a different year. Any amounts left in your account after the run-out period will be forfeited. You may not claim reimbursement for amounts owed to a person if either you or your spouse is entitled to claim a personal exemption on your federal tax return for that person. Reimbursement requests can be either faxed or mailed to Advanced Benefit Strategies. The receipt should include the date of service, the amount that you owe for the service, and the name of the provider. Cancelled checks are not proper documentation for purposes of reimbursement. You cannot be reimbursed for services that have not yet been rendered. Refer to IRS Publication 503 Child and Dependent Care Expenses for further information on determining who is considered your eligible dependent(s) under the Plan.

#### **What is the IRS 2 ½ month rule?**

Pursuant to the IRS Notice 2005-42, expenses incurred during the first 2 ½ months after the end of the Plan Year will be applied to the unused funds in your account from the previous Plan Year. For example if the Plan Year ends December 31, you will have until March 15<sup>th</sup> of the following year to incur an eligible expense. If you have unused funds in your account from the previous Plan Year, that claim will be applied towards those funds before being applied to the current year's election.

This option is voluntary on the part of your employer and can be withdrawn from the Plan at any time.

#### **How do I become a Participant?**

You become a Participant by signing an Enrollment Form on which you elect one or more of the benefits available under the Plan, as well as agree to a salary reduction to pay for those benefits so elected. You will be provided an enrollment form when you first become eligible to participate. You will have thirty days in which to complete the form and turn it in to the personnel office. If you are eligible on the initial effective date of the Plan, you will be able to make your elections during the initial enrollment period. In future years, you will be furnished with a new Enrollment Form by the first day of the annual enrollment period, and be given the opportunity to confirm or change your choices made for the previous twelve-month period. Elections for the coming twelve months will become effective on the first day following the end of the enrollment period. This twelve month period is called the "Plan Year." If you are a new employee, you may become a Participant on the first pay period following the date when you have met the eligibility requirements described above.

#### **What are the 'open enrollment' periods for entering the Plan?**

The initial period for enrolling in the Plan was the thirty-day period immediately preceding January 1, 2001, the Plan's effective date. Thereafter, the enrollment period will begin thirty (30) days prior to the beginning of each proceeding Plan Year.

#### **Can I change my election during the Plan year?**

Generally, you cannot change your election whether or not to participate in the Plan, although your election will terminate if you are no longer working for the Company. Otherwise, you may change your elections only during the month of the annual enrollment period, and then, only for the coming Plan Year. You may change your previous election at any time during the Plan Year if the change is on account of and consistent with one or more of the following significant changes in your family status (called a "Life Event"):

- Your marriage, divorce or legal separation;

- Birth or adoption of your child;

- Death of your spouse or child;

- Termination of your employment, your spouse's employment, or change of either you or your spouse's employment status from full-time to part-time, or vice versa, or if either of you take an unpaid leave of absence from work;

- A change in daycare providers or a significant change in the cost of the daycare being provided (applicable to a change in the Dependent Care Expense election only)

If a Life Event occurs, you must inform the plan administrator of your new election within thirty days of the occurrence.

**How are my accounts funded?**

When you complete the Enrollment Form, you specify which benefits you wish to pay for through salary conversion. Thereafter, your accounts will be credited with that portion of your gross income you have elected to forgo through salary conversions. These portions will be credited as of each pay period. Your Account(s) would be credited with a tax-free total of your annual election, spread equally over the total number of paychecks you have during the Plan Year. If you elect Health Care FSA Reimbursement benefits, your corresponding Account will be credited to reflect the premiums you have been paid, although the full, annual amount of the benefit will at all times be available to you (less previous benefits). If you have chosen to participate in the Dependent Care FSA, your corresponding Account will be credited with the amount you set aside from each paycheck, and will accumulate until you submit a documented claim for reimbursement of eligible expenses.

**Does my election reduce my Social Security benefits?**

Since all contributions are automatically deducted from your paycheck before taxes are calculated, your taxable income is reduced. This also reduces your wage base for the purposes of calculating Social Security benefits. This may, in the long run, result in a slightly lower Social Security Benefit being paid.

**Does my employer have a right to amend the Plan?**

Yes. The employer has the right, from time to time, to amend any or all of the provisions of the Plan without the consent of any person. Each amendment shall be in writing and shall become effective on the date specified therein.

**How will I receive my benefits under the Plan?**

If you have elected to participate in either the Health FSA or the Dependent Care FSA, you will have to take certain steps to be reimbursed for your eligible expenses. When you incur an expense that is eligible for payment out of one of your Accounts, you submit a claim to Advanced Benefit Strategies on a claim form that will be supplied to you. You may not be reimbursed for any expenses with respect to your current year of participation that arise before the Plan became effective, your Enrollment Form becomes effective, or for any expense incurred after the close of the Plan Year. You will have 90 days following the Plan's year end to submit claims for services incurred during the Plan Year.

Note that it is not necessary that you have actually paid an amount due for uninsured medical and dental expenses, or for dependent care expenses - only that you have incurred the expense, and that it is not being paid for by insurance or from any other source.

**What if there is money left in my account after the Plan's run out period?**

Unused money cannot be rolled over to the next Plan Year. All funds are forfeited and will be returned in one lump sum payment to the Plan Administrator. It is important to be conservative when enrolling to be sure that all money deferred during one Plan Year will be distributed for claims incurred within the same Plan Year.

**When do I submit my claims?**

You can submit claims at any time, either by mail or fax directly to Advanced Benefit Strategies 30 Mill Street, Unionville, CT 06085 (phone (877) 732-8125, fax (860) 673-2207).

**What if I terminate my employment during the Plan Year?**

If your employment with the Company is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan. You will have sixty (60) days after the date of your termination in which to submit a claim for eligible expenses incurred by you during the time you were covered under the Plan during the current Plan Year, up to (and including) the date of your termination. Reimbursements for pre-termination medical expenses will be limited to the annual benefit you elected, reduced by any reimbursements you have already received during the Plan Year. For dependent care expenses, reimbursements for pre-termination expenses will be limited to the total amount of premium you had paid to that date, less benefits previously paid. Any amounts remaining in your account after all pre-termination expenses have been reimbursed will be forfeited.

**When are regular and special enrollments?**

After you become eligible, you may enroll in the Plan by completing the enrollment form. You may obtain forms for enrollment by contacting your employer's Human Resources Department. You may request coverage for any dependents, provided such dependents meet the eligibility requirements.

In addition, you may enroll at "Open Enrollment Periods" that are announced annually. Enrollments may also occur at "Special Enrollment Periods" in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Federal legislation dictates that the benefit choices made will remain in effect for the entire plan year, unless the employee experiences a Qualified Change in Status event. While many of the guidelines relating to eligibility and enrollment are determined by the Plan Administrator and its insurance carriers, the ability to make changes to your benefit plans is governed by the IRS and the Internal Revenue Code.

Under the Code, once you are enrolled you may only make changes to your benefit elections during Open Enrollment or if you have a Change in Status event that affects the eligibility of you or your dependents, and the requested election change corresponds with the effect on your eligibility.

A Qualified Change in Status event includes:

- A change in your Legal Marital status, such as marriage, death of a spouse, divorce, legal separation or annulment.
- A change in your Number of Dependents for tax purposes such as birth, adoption, placement for adoption, or death of a child.
- A change in Employment Status of you, your spouse, or your dependent that affects the benefit eligibility under a cafeteria plan (including this plan) or other employee benefit plan or yours, your spouse, or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, a change in worksite, switching between union and non-union or between part-time and full-time, incurring a reduction or increase in hours of employment, or any other similar change which makes the individual become (or cease to become) eligible for a particular employee benefit.
- A change in residence or worksite for you, your spouse, or your dependent.
- An event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit, including your dependent failing to satisfy eligibility requirements due to factors such as age, place of residence, and student status.

In addition, under limited circumstances, the Plan Administrator may permit you to make a mid-year election change that corresponds to changes made by your plan and your spouse's or dependent's employer plan (i.e., significant increases in cost or significant change in coverage, or during the other plan's open enrollment period). However, all election changes must be requested within 30 days of the occurrence of the Change in Status event in question.

To make an election change, contact the Plan Administrator.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the plan, provided that you request enrollment within 30 days after your other coverage ends. Request to enroll new dependents must be made within 30 days of acquiring the new dependents.

### **What are my COBRA rights?**

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health FSA includes a continuation of coverage option, which is available to certain Participants whose coverage under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail.

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end

because of a life event known as a “qualifying event.” COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have under spent accounts. A qualified beneficiary has an under spent account if the annual limit elected under the Health FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e. the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate the end of the Plan Year. All qualified beneficiaries who were covered under the Health FSA component of the Plan will be covered together for Health FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health FSA annual coverage limit and a separate COBRA premium. Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

A Participant will become a qualified beneficiary if such Participant loses coverage under the Plan because either one of the following qualifying events happens:

- (1) Such Participant’s hours of employment are reduced, or
- (2) Such Participant’s employment ends for any reason other than gross misconduct.

The spouse of such Participant will become a qualified beneficiary if there is a loss of coverage under the Plan because any of the following qualifying events happens:

- (1) The spouse-Participant dies;
- (2) The spouse-Participant's hours of employment are reduced;
- (3) The spouse-Participant's employment ends for any reason other than his or her gross misconduct; or
- (5) The spouse become divorced or legally separated from the Participant.

The dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-Participant dies;
- (2) The parent-Participant's hours of employment are reduced;
- (3) The parent-Participant's employment ends for any reason other than his or her gross misconduct;
- (4) The parents become divorced or legally separated; or
- (5) They stop being eligible for coverage under the Plan as a “dependent child”

When the qualifying event is the end of employment, reduction of hours in employment, or death of the Employee-Participant, the Plan will offer COBRA coverage to qualified beneficiaries. Such Employee-Participants do not need to notify the Employer of any of these three qualifying events. For the other qualifying events (divorce or legal separation of the Employee-Participant and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to such Employee-Participant only if such Employee-Participant notifies the Employer in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

Such qualified beneficiary may elect to continue coverage by completing the Election Form provided by the Employer at the time of the qualifying event. There is a 60-day period in which to elect COBRA coverage. The 60-day period begins on the later of the day Plan coverage is lost or the day the Election Form is provided. If such election is not mailed (or personally delivered) to the Employer on or before the day the 60-day period expires, no qualified beneficiaries will be entitled to COBRA coverage. If the Election Form is mailed back to the Employer and the postmark on the envelope is dated on or before the last day of the 60 day period, the election is considered within the 60-day period.

COBRA coverage under the Health FSA can last only until the end of the year in which the qualifying event occurred.

COBRA coverage can terminate before the end of the year. COBRA coverage will terminate early in these situations:

- (1) COBRA coverage will terminate on the first day of the month for which the qualified beneficiary's COBRA premium is not timely paid.
- (2) COBRA coverage will terminate on the date the Employer ceases to maintain the healthcare reimbursement plan for its employees.
- (3) If, after electing COBRA, a qualified beneficiary becomes covered by another group health plan that does not contain exclusion or limitation for a preexisting condition of the qualified beneficiary, COBRA coverage may terminate on the date the other coverage begins. If the other plan has applicable exclusions or limitations, COBRA coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the qualified beneficiary who becomes covered by another group health plan. *Notice Obligation:* The Employee or a family member must notify the Employer immediately if any qualified beneficiary becomes covered by another group health plan. If, for whatever reason, any qualified beneficiary receives medical benefits under our plan after coverage is to cease under this rule, then the Employee and any qualified beneficiary will be required to reimburse the plan for such amounts.
- (4) If, after electing COBRA, a qualified beneficiary becomes entitled to Medicare, COBRA coverage will terminate on the date of Medicare entitlement (applies only to the person who becomes entitled to Medicare). *Notice obligation:* The Employee or a family member must notify the Employer immediately if any qualified beneficiary becomes entitled to Medicare. If, for whatever reason, any qualified beneficiary receives medical benefits under our plan after coverage is to cease under this rule, then the Employee and any qualified beneficiary will be required to reimburse the plan for such amounts
- (5) COBRA coverage will terminate for cause on the same basis coverage is terminated for cause (e.g. submission of fraudulent claims) with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the healthcare

reimbursement plan for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

Unless such Employee-Participant voluntarily elects to pay for COBRA coverage on a pre-tax basis out of such Employee-Participant's last paycheck with the Employer, premiums must be paid by check on a monthly basis.

The premium payment for the initial premium months must be paid for any qualified beneficiary by the 45<sup>th</sup> day after the date of the qualified beneficiary's election of continuation coverage.

The initial premium payment is equal to the sum of the premiums for the initial premium months. The initial premium months are the months that end on or before the 45<sup>th</sup> day after the date of the COBRA election (i.e. not including the month in which the 45<sup>th</sup> day falls). For example, Sue's employment terminated in September. She loses coverage on September 30. Sue elects continuation coverage on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45<sup>th</sup> day after the date of her COBRA election.

No claims under continuation coverage are paid until the premium for the month of coverage is paid. *If no initial premium payment is made within the 45-day period, then coverage for the affected qualified beneficiary remains canceled and no COBRA coverage will be provided.* If payment for fewer than all initial payment months is made within the 45-day period, COBRA coverage will be provided for such month or months for which payment is made, but if the full payment due for the remaining initial premium month is not received by the 45<sup>th</sup> day after the date of the COBRA election, COBRA coverage will be canceled retroactively to the 1<sup>st</sup> day of that month and any rights under COBRA will be lost. If, for whatever reason, any qualified beneficiary receives any medical benefits under the Plan during a month for which the premium was not timely paid, such qualified beneficiary will be required to reimburse the Plan for the benefits received.

After the premium for the initial premium months, the premium payment is due the 1<sup>st</sup> of each month for that month's COBRA coverage. There is, however, a grace period for late payment, which expires on the 30<sup>th</sup> day after the 1<sup>st</sup> of each month. *If the full premium payment is not received by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the 1<sup>st</sup> of the month.* If, for whatever reason, any qualified beneficiary receives any benefits under the plan during a month for which the premium was not timely paid, then such qualified beneficiary will be required to reimburse the Plan for the benefits received. In the above example of Sue, her December premium is due December 1, but with the 30-day grace period described here, she has until December 31 to pay the December premium to avoid cancellation of her coverage.

A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add dependents if such person acquires a new dependent through marriage, birth, adoption or placement for adoption or if an eligible dependent declines coverage because of alternative coverage and later loses such coverage due to certain qualifying reasons. Except for children described in the previous paragraph, dependents who are enrolled under HIPAA's special

enrollment rights do not become qualified beneficiaries-their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

## **DISCLOSURE**

### **Statement of ERISA Rights**

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

#### **Receive Information about Your Plan and Benefits**

- 1) Examine, without charge, at the Benefits Administrator's office, as part of the Plan Administrator's (plan sponsor, i.e., your employer) office, and at other specified locations such as work sites, all documents governing the Plan, including insurance contracts, and copies of all documents filed by the Plan, such as detailed annual reports and Plan descriptions, with the United States Department of Labor applicable only if member contribution applies;
- 2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator (plan sponsor, i.e., your employer). The Plan Administrator may make a reasonable charge for these 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 Group Health Plan Coverage**

Continue health care coverage for the Participant, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. The Participant or the Participant's dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing COBRA continuation coverage rights. The Participant should be provided a certificate of creditable coverage, free of charge, from the Participant's group health plan or health insurance issuer when the Participant loses coverage under the plan, when the Participant becomes entitled to elect COBRA continuation coverage, when the Participant's COBRA continuation coverage ceases, if the Participant requests it before losing coverage, or if the Participant requests it up to 24 months after losing coverage.

#### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for you and other members, ERISA imposes duties upon the people who are responsible for the operation of your member benefit Plan. The people who operate your Plan are called "fiduciaries" of the Plan. They must handle your Plan 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 right under ERISA.

#### **Enforce Your Rights**

If your claim for a health or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Benefits Administrator and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator (plan sponsor, i.e., your employer) 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

your claim benefit is denied or ignored, in whole or in part, you may file suit in a court of competent jurisdiction. If Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the United States Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, 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 (plan sponsor, i.e., your employer). If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### **Qualified Medical Support Orders (QMSO)**

Generally your Plan benefits may not be assigned or alienated. However, an exception applies in the case of "qualified medical child support order." Basically, a qualified medical child support order is a court-ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either (1) creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or (2) enforces certain laws relating to medical child support. An "alternate recipient" is any child or a Participant who is recognized by a medical child support order as having a right to enrollment under the Participant's group health plan.

A medical support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if it received a medical child support order that applies to you and the Plan's procedures for determining whether the medical child support order is qualified.

### **Uniformed Service under USERRA**

Continued Participation in the Plan may be permitted under certain conditions when you are serving in the United States military after having been a Participant in this Plan. See your Plan Administrator for the provisions of this continuation.

### **Participation While on FMLA Leave**

A Participant who takes an unpaid leave of absence under the federal Family and Medical Leave Act of 1993 ("FMLA Leave") may continue participation in the group health plan during the leave period for a maximum period of 12 weeks in a twelve month period. In the case of FMLA leave to care for a covered service member with a serious injury or illness, a participant may continue in participation in the group health plan during the leave period for the maximum period of 26 work weeks in a single 12-month period. Leave may be provided to a leave-eligible employee upon the birth or adoption of a child, or the employee's own serious health condition or the serious health condition of an employee's spouse, parent or child, or any qualifying exigency arising out of the fact that the employee's spouse, child, or parent is on active duty or has been called to active duty. A maximum of 26 workweeks during a single 12-month period may be provided to an employee who is a spouse, child, parent or next of kin to a covered service member with a serious injury or illness incurred in the line of duty. During the course of the FMLA Leave, the employee will be responsible for the payment of premiums at the active employee rate. At the conclusion of leave, continuation may be provided through COBRA (see below.) The Plan may from time to time employ the services of an Third Party Administrator (TPA) for administration of its Family Medical Leave Act paperwork, under the direction of the Plan Administrator. Questions on the FMLA can be directed to the TPA or to your employer's Human Resources Department.

## **Patient Protection Disclosure for FSA Programs**

The Plan does not impose any preexisting condition exclusion against any participant, regardless of age.

Once an individual has become a covered participant under the Plan, the Plan will not rescind coverage of the individual unless he or she committed fraud or made an intentional misrepresentation of material fact. A rescission of coverage is the cancellation or discontinuation of coverage, other than for failure to pay premiums, which has a retroactive effect. The Plan or issuer will provide notice of the rescission 30 days in advance; the notice will inform the affected group or participant of the opportunity to appeal the determination to rescind.

Health flexible spending arrangements may not reimburse expenses on a tax-favored basis for over-the-counter drugs without a prescription.

### **CLAIMS PROCEDURE**

You may apply for reimbursement under the Plan by submitting an application in writing to the Administrator, in such form and accompanied by any other documentation as the Administrator may prescribe, setting forth:

- (a) the amount, date and nature of the expense with respect to which a benefit is requested
- (b) the name of the person, organization or entity to which the expense was or is to be paid
- (c) the name of the individual for whom the expense was incurred and, if such individual is not the Participant requesting the benefit, the relationship of such individual to the Participant
- (d) a statement that the benefit claimed is not expected to be recovered under any insurance arrangement or other plan or source and
- (e) any other information as shall be requested by the Administrator.

Claims can be filed at any time during the Plan Year or before the end of the Run-Out Period. Upon receipt of this information, the claim will be deemed to be filed with the Plan. Claims under the Plan will be decided within 30 days after the claim is filed unless the Plan notifies the claimant before the end of the 30-day period and extends that period for an additional 15 days.

If any person eligible to receive benefits under the Plan or any person claiming to be eligible to receive benefits under the Plan believes he is entitled to benefits in an amount greater than those which he is receiving or has received, he may file, within 180 days of the initial determination of benefits, a "Request for Benefit Review" ("RBR") with the local benefits office. Such a claim shall be in writing and state the nature of the claim, the facts supporting the claim, the amount claimed, any additional supportive medical information, and the social security number and address of the claimant. The local benefits office shall forward the RBR to the Administrator. An adverse benefit determination eligible for appeal includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based, among other things, on: a determination of an individual's eligibility for coverage; the imposition of a preexisting condition exclusion; or a denial of part of the claim due to the terms of a coverage documents regarding co-pays, deductibles, or other cost sharing requirements. The Administrator shall review the claim and, unless special circumstances require an extension of time, within 30 days after the receipt of the RBR, shall give written notice of his decision with respect to the RBR. If special circumstances require an extension of time, the claimant shall be so advised in writing within the initial period and in no event shall such extension exceed 45 days. Such notice shall be written in a manner calculated to be understood by the claimant and, if the claim is wholly or partially denied, set forth the specific reason or reasons for the denial, including specific references to pertinent plan provisions on which the denial is based, a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, an explanation of the claim review procedure under the Plan, a statement that the claimant may obtain relevant documents and information, and a statement of the claimant's right to sue. If claimed benefits would be payable by an insurer under a contract of insurance or by a claims agent under a contract between such agent and the Company, the

Administrator may (i) refer the claim to representatives of such insurer or claims agent, as the case may be, for decision (such decision to be subject to the approval of the Administrator) or (ii) to the extent he deems necessary or helpful in making his decision, consult with representatives of such insurer. The Administrator shall also advise the claimant that he or his duly authorized representative may request a review by the Secretary of the Company or his authorized representative of the denial by filing with the local benefits office, within 180 days after notice of the denial has been received by the claimant, a written request for such review. The claimant shall be informed that he may have reasonable access to pertinent documents and may submit comments in writing to the Administrator or his representative within the same 180-day period. If a request is so filed, review of the denial shall be made within 30 days after receipt of such request unless special circumstances require an extension of time, and the claimant shall be given written notice of the resulting final decision. If special circumstances require an extension of time, the claimant shall be so notified in writing within the initial 30-day period and in no event shall such an extension exceed 45 days. Such notice shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based and be written in a manner calculated to be understood by the claimant.

Every notice of determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

All appeals receive a full and fair review. You will be provided, free of charge, with any “new or additional evidence considered, relied upon, or generated, in connection with the claim and you will be provided with a reasonable opportunity to respond to any such new or additional evidence. You may request that the appeal process be expedited if (a) the time frames under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital Stay. When an appeal is expedited, the Plan Administrator will respond orally with a decision within 24 hours, followed up in writing.

External reviews are available in accordance with the laws of the state of which your Employer is domiciled.

### **PLAN TERMINATION**

The Employer has the authority to terminate the Plan, in part or in full, at any time. Upon termination of the Plan, all participants shall have a period of 90 days to submit all claims for expenses incurred prior to the date the Plan terminated. Claims not submitted by such date may be denied.

### **LEGAL CONTROL**

The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, subject to the applicable provisions of the Plan. This is a Summary Plan Description only. (See statement of ERISA rights.) If there is a discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document will apply.

### **KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**INCORPORATION BY REFERENCE**

The actual terms and the conditions of the separate benefits offered under this Plan are contained in separate, written documents governing each respective benefit, and will govern in the event of a conflict between the individual plan document and the Employer's Cafeteria Plan adopted through this Agreement as to substantive content. To that end, each such separate document, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

**PREMIUM ONLY PLAN  
ENROLLMENT FORM**

Employer Name: Research Foundation of the City University of New York

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Social Security Number

Participation in the Premium Only Plan is optional for all eligible employees who are enrolled in one or more of our group insurance programs. Under the Premium Only Plan, your income will be reduced to pay your share of premiums for these group insurance programs on a pre-tax basis. As a participant in the Plan:

\* Your required share of premiums will be deducted pre-tax from your pay through equal payroll deductions during the plan year. Prior to the start of the next plan year, you will have the opportunity to change your benefit elections.

\* You cannot change or discontinue your elections during the plan year unless you have a family status change as set forth in the summary plan description that is consistent with your change or discontinuance of your election (i.e. marriage, birth, divorce, etc.)

\* If premium amounts increase or decrease during the plan year, the plan administrator will automatically adjust your payroll deductions to the amount of your required contributions for the remainder of the plan year. If there is a significant increase in the cost of your health insurance premiums or a significant decrease in your health insurance coverage, you may revoke your election for health insurance coverage and replace it with an election of similar coverage.

\* Your premium elections will terminate at the time you terminate employment unless you elect to continue making contributions on an after-tax basis.

\* The plan administrator may change the amount of your elections or otherwise modify this agreement if necessary to satisfy provisions of the Internal Revenue code.

\_\_\_\_\_  
Please check the appropriate box, sign this enrollment form and return it to the plan administrator.

I elect to participate. By checking this box, I understand that my salary will be reduced to pay for group insurance premiums on a pre-tax basis. I understand that I cannot change this election until the beginning of the next plan year.

I do not want to participate. By checking this box, I understand that my salary will not be reduced to pay for group insurance premiums on a pre-tax basis. I understand that I cannot change this election until the beginning of the next plan year.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

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

This notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan to carry out payment, Health care operations and for other purposes that are permitted or required by law. This Notice also sets out legal obligations concerning your protected health information and describes your rights to access and control your protected health information.

Protected health information (or “PHI”) is individually identifiable health information including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present or future payment for the provision of health care to you.

This Notice of Privacy Practices has been drafted to be consistent with what is known as the “HIPAA Privacy Rule” and any of the terms not described in this Notice should have the same meaning as they have in the HIPAA privacy Rule.

If you have any question or want additional information about the Notice or the policies and procedures as described in the Notice, please contact: Wendy Patitucci, at Research Foundation of the City University of New York, 230 West 41st. Street, 7th Fl., , New York, NY 10036-7207. Phone Number (212) 417-8605.

### **OUR RESPONSIBILITIES**

We are required by law to maintain the privacy of your protected health information. We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to protected health information and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all protected health information that we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the contract holder for your member contract.

### **PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

The following is a description of how we are most likely to use and/or disclose your protected health information.

#### **Payment and Health Care Operations**

We have the right to use and disclose your protected health information for all activities that are included within the definition of “payment” and “health care operations” as set out in 45 CFR Section 164.501 (this provisions a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 CFR Section 164.501 for a complete list.

##### Payment

We will use and disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your protected health information when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that your received was eligible for payment under Section 125.

## Health Care Operations

We will use or disclose your protected health information to support our business functions. These functions include, but are not limited to: quality assessment and improvement, business planning and business development. For example, we may use or disclose your protected health information: (i) to respond to a customer service inquiry from you; or (ii) in connection with fraud and abuse detection and compliance programs.

## **Plan Sponsor**

We may disclose your protected health information to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

## **Potential Impact of State Law**

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individual greater privacy protections. As a result to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependence, genetic testing, reproductive rights, etc.

## **Other Possible Uses and Disclosures of Protected Health Information**

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information.

### **Required by Law**

We may use or disclose your protected health information to the extent that federal law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the Privacy Rule. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

### **Public Health Activities**

We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We may also disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

### **Health Oversight Activities**

We may use or disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits, investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

### **Abuse or Neglect**

We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your information if we believe that you have been a victim of abuse, neglect, or domestic violence.

### **Legal Proceedings**

We may disclose your protected health information: (i) in the course of any judicial or administrative proceeding; (ii) in response to and order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

### **Law Enforcement**

Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

### **To Prevent a Serious Threat to Health or Safety**

Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

### **Workers' Compensation**

We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

### **Others Involved in Your Health Care**

Using our best judgment, we may make your protected health information known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

If you are not present or able to agree to these disclosures of your protected health information, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

## **REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

The following is a description of disclosures that we are required by law to make.

### **Disclosures to the Secretary of the U.S. Department of Health and Human Services.**

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

### **Disclosures to You**

We are required to disclose to you most of your protected health information in a “designated record set” when you request access to this information. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose protected health information to such a person, you must submit a written notice of his /her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

*Even if you designate a personal representative,* the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

### **OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

Other uses and Disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

### **YOUR RIGHTS**

The following is a description of your rights with respect to your protected health information.

#### **Right to Request a Restriction**

You have the right to request a restriction on the protected health information we use or disclose about you for payment or health care operations.

We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

You may request a restriction by calling us at (212) 417-8605 or writing to Wendy Patitucci, Research Foundation of the City University of New York, 230 West 41st. Street, 7th Fl., , New York, NY , 10036-7207. It is important that you direct your request for restriction to the noted address so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (i) the information whose disclosure you want to limit; and (ii) how you want to limit our use and/or disclosure of the information.

### **Right to Request Confidential Communications**

If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by calling/writing us at the number listed in the summary page of this Notice to Wendy Patitucci, Research Foundation of the City University of New York, 230 West 41st. Street, 7th Fl., New York, NY 10036-7207. It is important that you direct your request for restriction to the noted address so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (i) the information whose disclosure you want to limit; and (ii) how you want to limit our use and/or disclosure of the information.

We will accommodate a request for confidential communications that is reasonable, and that states that the disclosure of all or part of your protected health information could endanger you. As permitted by the HIPAA Privacy Rule, “reasonableness” will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (e.g., an EOB). Unless you have made other payment arrangements, the EOB (in which your protected health information might be included) will be released to the plan participant.

If you terminate your request for confidential communications, the restriction will be removed for *all* your protected health information that we hold including protected health information that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your protected health information will endanger you.

### **Right to Inspect and Copy**

You have the right to inspect and copy your protected health information that is contained in a “designated record set”. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your protected health information that is contained in a designated record set, you must submit your request by calling us at the number listed in the summary page of this Notice. It is important that you call this number to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the one indicated might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy you protected health information in limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To

request a review, you must contact us at the number provided in this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

### **Right to Amend**

If you believe that your protected health information is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by calling or writing to Wendy Patitucci, Research Foundation of the City University of New York, 230 West 41st. Street, 7th Fl., New York, NY 10036-7207, (212) 417-8605. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for restriction to the noted address so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

### **Right of an Accounting**

You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of protected health information will be for purposes of payment or health care operations and therefore will not be subject to your right to and accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to Wendy Patitucci, Research Foundation of the City University of New York, 230 West 41st. Street, 7th Fl., New York, NY 10036-7207. It is important that you direct your request for restriction to the noted address so that we can begin to process your request. Requests sent to persons or offices other than the number/ address indicated might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

### **Right to a Paper Copy of This Notice**

You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically.

### **COMPLAINTS**

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed in this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (i) be in writing; (ii) contain the name of the entity against which the complaint is lodged; (iii) describe the relevant problems; and (iv) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.