

# **RESEARCH FOUNDATION OF THE CITY UNIVERSITY OF NEW YORK**

## **RETIREE HRA PLAN AND SUMMARY PLAN DESCRIPTION**

This document together with similar documents describing the retiree Medicare Part B premium reimbursement benefit constitute the Research Foundation of the City University of New York Retiree HRA Plan (the “Plan”) for eligible retirees of Research Foundation of the City University of New York (the “RF”). This document also serves as the Plan’s summary plan description (“SPD”).

This Plan is intended to qualify as an employer-provided health reimbursement arrangement (“HRA”), as defined under IRS Notice 2002-45, under Internal Revenue Code (“Code”) §§ 105 and 106 and regulations issued thereunder, as well as a “retiree-only” plan exempt from certain provisions of the ACA and will be interpreted to accomplish that objective.

This Plan is intended to permit non-taxable reimbursement of Medicare Part B premiums, as applicable. However, the Code requires amounts reimbursed under the Plan shall be included in the eligible retiree’s gross income in the event attributable to an individual who is not the eligible retiree’s qualified tax dependent under the Code.

### **1. Plan Administrator.**

Except to the extent that other parties have been assigned such powers or where provided otherwise in the Plan, the RF shall be the “Plan Administrator” and possess all powers necessary to administer the Plan, including, but not limited to, full discretionary authority to interpret the Plan. It shall also determine all questions relating to the Plan, including but not limited to eligibility of retirees to participate in the Plan. The RF or Plan Administrator may designate one or more of its officers or employees, or one or more other persons, including an insurance carrier or third-party administrator, to carry out some or all of the duties under the Plan. If authority to administer Plan benefits has been granted to a third party, such party shall have full discretionary authority to interpret the Plan and to determine all questions relating to benefits offered under the Plan. All final determinations made by the Plan Administrator or other party, as appropriate, shall be conclusive and binding on all parties.

The Plan Administrator is the “named fiduciary” and “plan administrator” as these terms are used in ERISA (i.e., the Employee Retirement Income Security Act of 1974, as amended). Unless otherwise specified in the Plan, the third-party who administers a Plan benefit shall be a fiduciary with respect to the determination of claims for benefits (“claims fiduciary” or “claims administrator”) and shall have discretionary authority to determine all matters with respect to whether a claim qualifies for payment of benefits, other than the determination whether the individual is eligible to participate in the particular Plan benefit.

To the extent not covered by insurance, the RF will indemnify the Plan Administrator and any employee of the RF acting on the Plan Administrator’s behalf against all claims, loss, damages, expenses and liability arising from any action or failure to act under the Plan to the fullest extent permitted under the law and the RF’s governing rules.

### **2. Eligibility.**

An RF retiree is considered eligible for benefits under the Plan as follows:

- Was hired before July 1, 2012 -
  - has reached age 55;
  - at the point of retirement has been employed full-time by the RF for a period of at least 10 years without a Break in Service (as defined below), or was classified as a part-time A employee on May 1, 1981, and has since been employed without a Break in Service; and
  - has a combination of age and years of service which equals 70 or more; or
- Was hired on or after July 1, 2012 –
  - has reached age 62; and
  - at the point of retirement has been employed full-time by the RF for a period of at least 10 years without a Break in Service, or was classified as a part-time A employee on May 1, 1981, and has since been employed without a Break in Service.

In the case of instructional personnel on a 10-month academic year assignment, 12 months of employment in a 14-month period will be considered the equivalent of one year of service. A “Break in Services” is any lapse in employment by the RF lasting more than 30 days.

Retirees who are participants in the Plan who are rehired by the RF or affiliated entity will stop participation in the Plan at the time of rehire. They will resume participation in the Plan when they subsequently retire.

Continuing eligibility for the benefits is subject to, among other requirements, compliance with the reimbursement provisions described herein.

Participation in the Plan is conditioned on completion of the relevant Medicare enrollment process, annual reimbursement election and the retiree’s satisfying any other relevant terms and conditions imposed by the Plan Administrator or any third-party administrator.

An eligible retiree may also receive the reimbursement benefit for his/her lawful spouse or domestic partner, subject to the terms and conditions of the Plan.

Questions relating to Plan eligibility shall be decided by the Plan Administrator in accordance with Appendix A. Claims relating solely to Plan eligibility and benefits shall be decided pursuant to the eligibility claims procedures in Appendix A.

**3. Benefit Entitlement and Election.** An eligible retiree of the RF (under Section 2) and his/her spouse or domestic partner is entitled to benefits under the Plan once the retiree has satisfied any applicable terms and conditions for coverage. Benefits payable under this Plan shall be paid solely pursuant to the terms of this document and/or the retiree documentation, as applicable. This document does not create any independent benefit payment responsibilities of the RF other than for reimbursement benefit set forth herein.

An eligible retirees must request each year to receive the Medicare Part B reimbursement benefit described below as either one lump sum annual reimbursement payment or two semi-annual reimbursement payments. If the eligible retiree chooses one annual lump sum payment, the required proof of payment must be submitted by March 31st of the following year. If the retiree chooses two semi-annual payments, proof of payment must be submitted by September 30th of

the current year (for January through June Medicare Part B premiums) and March 31st of the following year (for July through December Medicare Part B premiums).

The proper documentation for requesting reimbursement is a memo from the Social Security Administration (SSA) stating the amount of Medicare Part B premiums paid for each of the months for which you are requesting reimbursement, or a copy of the IRS 1099 issued by SSA.

The eligible retiree must also provide the Research Foundation with a copy of his/her Medicare enrollment card, as well as for the spouse or domestic partner.

**4. Plan Benefits.** Upon request and with proof of payment, the RF will reimburse the retiree, and their spouse or domestic partner, a percentage of the standard monthly Medicare Part B premium, less an amount that equals the rate of contribution that the retiree pays toward their RF health insurance premium, as follows:

Retirement Date	Reimbursement %
<b>Eligible Retirees:</b>	
Prior to 7/1/2004	100%
Between 7/1/2004 to 7/1/2007	79%
7/1/2007 or after	79% of Medicare part B standard rate

The Medicare Part B reimbursement benefit does not rollover from year to year. Therefore, any unrequested Medicare Part B reimbursement benefit expires at the end of the claim submission deadline for the applicable Plan Year (March 31<sup>st</sup> of the following Plan Year).

**5. Claims for Benefits and Statute of Limitations.** All claims for a benefit under the Plan shall be submitted in accordance with the terms of this Plan and shall be subject to the claims review procedure set forth in Appendix A.

All claims for benefits must be submitted by the claims filing deadline specified under Section 3. This requirement may be waived by the Plan if, through no fault of the claimant, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances. Except in the case of legal incapacitation, late claims will not be accepted if they are filed more than one year from the date or the event that gave rise to the benefit occurred.

Except as noted in Appendix A, a claimant may not commence a judicial proceeding against any person, including the Plan, a Plan fiduciary, the Plan Administrator, the RF, the Plan Sponsor, or any other person, with respect to a claim for Plan benefits without first exhausting the claims procedures set forth in Appendix A. A claimant who has exhausted these procedures and is dissatisfied with the decision on appeal of a denied claim may bring an action under Section 502 of ERISA in the United States District Court for the Southern District of New York to review the Plan's decision on appeal, but only if such action is commenced no later than the earlier of (1) the applicable statute of limitations, or (2) the second anniversary of the decision on appeal.

**6. HIPAA Privacy Requirements for Group Health Plans.** The Plan shall comply with the privacy rules and security rules under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). Appendix B sets forth the privacy rules and security rules that shall apply to the Plan.

**7. Continuation Coverage.** To the extent required by ERISA, in the event that a “qualified beneficiary” loses coverage under the Plan due to a “qualifying event” as such terms are defined under the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended and the regulations issued thereunder (“COBRA”), such qualified beneficiary shall have the continuation of coverage rights provided under COBRA as set forth in Appendix C.

**8. No Guarantee of Employment.** Nothing contained in this Plan shall be construed as a contract of employment between the RF and any retiree, or as a right of any retiree to become employed by the RF.

**9. No Alienation of Benefits.** Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, prior to actually being received by the person entitled to the benefit. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder, shall be void. The RF shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder. Additionally, a third party shall not have any standing to bring a claim for benefits against the Plan, a Plan fiduciary, the Plan Administrator, or the RF.

**10. Amendment and Termination.** The RF and the Plan Administrator (or such other person or committee the RF so designates) shall have and retain the right to make any amendment to this Plan and the terms of any benefit at any time, including the right to terminate this Plan or any benefit at any time. The right to amend or modify a benefit includes the right to change the benefit and cost sharing provisions related to that benefit.

The right reserved to the RF and the Plan Administrator to amend and terminate the Plan or any benefit, as exercised by the RF or Plan Administrator or its duly authorized delegate, shall be a power reserved to the RF as settlor or sponsoring employer, as applicable; no action taken pursuant to that right shall be subject to appeal by any person claiming a right under the Plan or any benefit except as may otherwise be provided by applicable law.

**11. Governing Law.** Subject to the terms of any benefit to the contrary, to the extent not preempted by federal law, the Plan shall be interpreted and enforced in accordance with the laws of the State of New York.

**12. Effective Date.** This document reflects an amendment and restatement of the Plan effective January 1, 2023.

**13. Right to Recover Benefit Overpayments and Other Erroneous Payments.** To the extent permitted by law, if, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a retiree or dependent, the retiree or dependent shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the insurance companies, the Plan Administrator or the RF (or designee) may recover that incorrect payment, whether or not it was made due to the insurance companies’ or the Plan Administrator’s (or its designee’s) own error, from the person to whom it was made. As may be permitted in the sole discretion of the insurance company or the Plan Administrator (or its designee), the refund or

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

**14. When Plan Coverage Ends.** Participation in the Plan and/or any benefits offered under the Plan cease on the first date on which:

- The RF terminates the Plan or the benefit in which the retiree participates;
- A retiree, spouse or domestic partner no longer meets the eligibility requirements for the Plan;
- The retiree fails to elect the reimbursement benefit for the retiree, spouse or domestic partner;
- The retiree's, spouse's or domestic partner's benefit is terminated due to fraud or intentional misrepresentation against the Plan;
- The retiree dies (subject to the spouse's right to continue coverage for three years following the retiree's death). For those spouse's who do not elect COBRA, the RF will continue the spouse's participation in the Plan for one month following the retiree's death.

**15. General Information.** The Plan's general administrative information, including the ERISA Statement of Rights can be found in Appendix D.

**16. Miscellaneous.**

- To the extent permitted by law, the Plan reserves the right terminate a covered retiree's benefits and those of his/her spouse or domestic partner, deny future benefits, take legal action against a covered retiree, and/or set off from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan, in the case of any retiree who obtains a Plan benefit wrongfully due to intentional misrepresentation or fraud.
- The RF makes no representation or warranty with respect to the quality or sufficiency of the services or supplies provided by others under the Plan or a benefit thereunder.
- The RF makes no representation or warranty with respect to the tax treatment of any benefit provided by the Plan.
- No provision of this Plan or any benefit shall be deemed to be waived unless the purported waiver is in writing and is signed.
- Retirees, spouses and domestic partners shall have no vested rights to benefit under the Plan, and Plan benefits may be reduced or terminated at any time.

Dated \_\_\_\_\_

**Research Foundation of the City University  
of New York**

By \_\_\_\_\_

Title \_\_\_\_\_

## APPENDIX A

### CLAIMS PROCEDURES

#### ELIGIBILITY CLAIMS PROCEDURES

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

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

##### 1. Determination of Eligibility

A claim for eligibility must be submitted to the Plan Administrator in writing. The Plan Administrator will generally notify the Claimant of its decision within 90 days after it receives the claim. However, if the Plan Administrator determines that special circumstances require an extension of time to decide the claim, it may take an additional 90 days to decide the claim. If an extension is needed, the Plan Administrator will notify the Claimant, in writing and before the end of the initial 90-day period of the special circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision.

##### 2. Notification of Adverse Claim Determination

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

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

##### 3. Appeal of Adverse Claim Determination

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

decision. The written appeal should clearly state the reason or reasons why the Claimant disagrees with the Plan Administrator's decision. The Claimant may submit written comments, documents, records and other information relating to the claim even if such information was not submitted in connection with the initial claim for eligibility. Additionally, upon request and free of charge, the Claimant may have reasonable access and copies of all Plan documents, records and other information relevant to the claim.

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

#### 4. Notification of Decision on Appeal

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

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

## **BENEFITS CLAIMS PROCEDURES**

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

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

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



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

#### 1. Determination of Benefits

Claims must be submitted and substantiated in accordance with the terms of Section 3 of the Plan. The Plan Administrator will notify the Claimant of the benefits determination within a reasonable period of time after receiving the claim, but not later than 30 days after the claim is received. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and provides the Claimant with written notification prior to the expiration of the initial 30-day period explaining the reason for the additional extension and when the Plan expects to decide the claim. If the initial 30-day period of time is extended due to the Claimant's failure to submit information necessary to decide a claim, the written notification will set forth the specific information required, and the Claimant will have at least 45 days to provide the requested information. In that case, the Plan's timeframe for making a benefits determination is tolled from the date the Plan Administrator sends the Claimant an extension notification until the date the Claimant responds to the request for additional information or the Claimant's time to respond expires. If the Claimant provides additional information in response to such a request, a decision will be rendered within 15 days of when the information was received by the Plan.

#### 2. Notification of Adverse Claim Determination

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

- the specific reason(s) for the denial;
- sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;
- references to the specific Plan provisions upon which the benefits determination is based;
- a description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such information is necessary;
- a statement that Claimant is entitled to receive, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for Benefits;
- a description of the Plan's internal appeals procedures, any applicable external review process, information regarding how to file an appeal, and applicable time limits, including the right to bring a civil legal action under ERISA if the claim continues to be denied on review;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request;
- the contact information for the Employee Benefits Security Administration, any applicable office of health insurance consumer assistance, or ombudsman established under the Public Health Service Act.

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

### 3. Appeal of Adverse Claim Determination

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

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

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

Additionally, before the Plan denies such a claim on appeal in whole or part based on a new or additional rationale, the Plan will provide the Claimant with the new or additional rationale at no cost as soon as possible and sufficiently in advance of the date when the

Plan Administrator must provide notice of its decision regarding the claim on appeal to give the Claimant a reasonable opportunity to respond prior to that date.

#### 4. Notification of Final Internal Decision on Appeal

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

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

- the specific reason(s) for the denial;
- sufficient information to identify the claim involved, including the date of service, the health care provider, and if applicable, the claim amount;
- references to the specific Plan provisions upon which the benefits determination is based;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Plan documents, records, and other information relevant to the claim for benefits;
- a description of any voluntary review procedures, internal appeals and the external review process, including information on how to initiate an appeal and applicable time limits;
- if the determination was based on an internal rule, guideline, protocol, or other similar criterion, a statement that such a rule, guideline, protocol, or criterion was relied upon in making the denial, along with either a copy of the specific rule, guideline, protocol, or criterion, or a statement that a copy will be provided to the Claimant free of charge upon request.
- a discussion of the decision to deny the claim;
- disclosure of the availability of, and the contact information for, the Employee Benefits Security Administration any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793; and
- a statement describing voluntary alternative dispute resolution options that may be available by contacting the U.S. Department of Labor, and the right to bring a civil legal action under ERISA.

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

## STATUTE OF LIMITATIONS AND EXHAUSTION OF ADMINISTRATIVE REMEDIES

All claims for Benefits must be submitted by the claims filing deadline specified under Section 3. This requirement may be waived by the Plan if, through no fault of the Participant, the claim is filed after the deadline but is filed as soon as practicable and within a reasonable time period, given the particular circumstances.

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

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

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

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

## **APPENDIX B**

### **HIPAA PRIVACY AND SECURITY**

#### **A. Use and Disclosure of Protected Health Information (PHI)**

The Plan will use and/or disclose protected health information (“PHI”) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto (“HIPAA”), which are hereby incorporated by reference. For example, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

The following terms are defined for purposes of this subsection:

*Protected Health Information* (“PHI”) is individually identifiable health information, whether oral or recorded in any form or medium, which is collected from an individual, and which:

- is created or received by the Plan;
- relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
  - a. that identifies the individual; or,
  - b. with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and,
- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. PHI excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. § 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as employer.

*Electronic Protected Health Information* (“e-PHI”) is PHI that is transmitted by electronic media or maintained in any electronic medium.

*Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

*Payment* includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for the coverage and provision of plan benefits or to obtain or provide reimbursement for the provision of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual’s claim);
- coordination of benefits;

- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- risk adjusting amounts due based on enrollee health status (not including genetic information) and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review; and,
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

*Health Care Operations* include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities that do not involve consideration of genetic information relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:

- a. management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or,
- b. customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and,
- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

*Summary Health Information* is information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under the Plan; and (2) from which the information described at 45 C.F.R. §164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

*Unsecured PHI* is PHI that is not secured through the use of technology or methodology specified by the Secretary of Health and Human Services.

**B. The Plan Will Use and Disclose PHI Consistent with HIPAA's Requirements and as Permitted by Authorization of the Plan Participant**

The Plan will use and disclose PHI consistent with the rules and requirements under HIPAA. To the extent required by HIPAA, the Plan shall obtain a written authorization from the individual who is the subject of the PHI for certain uses and disclosures of PHI.

**C. Disclosures to the Plan Sponsor**

The Plan will not disclose PHI to the Plan Sponsor unless it receives a certification from the Plan Sponsor that the Plan Documents have been amended to incorporate the provisions set forth in D and E, below. Notwithstanding the foregoing, the Plan may disclose to the Plan Sponsor the following:

- The Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:
  - a. Obtaining premium bids from health plans for providing health insurance coverage under the group health plan; or
  - b. Modifying, amending, or terminating the group health plan.
- The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the group health plan, or is enrolled in or has disenrolled from a particular coverage option offered by the Plan.

#### **D. Plan Sponsor Covenants Regarding PHI**

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor through a written contractual agreement in accordance with 45 CFR § 164.314;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- not use or disclose genetic information for underwriting purposes;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware, including breaches of Unsecured PHI as required by 45 CFR §164.410, and any other Security Incident of which it becomes aware;
- make PHI available in paper and/or electronic format to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

#### **E. With Respect to e-PHI, the Plan Sponsor Agrees to the Following Conditions**

The Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Plan, in accordance with HIPAA security rules;
- Ensure that the adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the



information as part of its a written contractual agreement in accordance with 45 CFR § 164.314;

- Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, Security Incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI, as well as any probable compromise of Unsecured PHI of which it becomes aware; and,
- Upon request from the Plan, Plan Sponsor agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to Plan Sponsor.
- Notwithstanding the foregoing, these limitations shall not apply to Enrollment, Disenrollment, and Summary Health Information provided to Plan Sponsor pursuant to 45 C.F.R. § 164.504(f)(1)(ii) or (iii); of Electronic PHI released pursuant to an Authorization that complies with 45 C.F.R. § 164.508; or in other circumstances as permitted by the HIPAA regulations.

#### **F. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained**

The Plan Sponsor shall permit only those individuals listed below to have access to PHI in order to carry out their duties with respect to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. In the event that the individuals listed below do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor will ensure that the adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures.

The following employees, classes of employees or other persons under the Plan Sponsor's control (or acting on behalf of Plan Sponsor) may have access to PHI:

- Plan Administrator;
- Human Resources Benefits Manager;
- Retiree Benefits Administrator; and
- Other persons designated by the Privacy Officer, Security Officer, or Plan Administrator.

#### **G. Limitations of PHI Access and Disclosure**

The persons described in Section F may only have access to and use and disclose PHI to the extent necessary to perform plan administration functions that the Plan Sponsor performs for the Plan.

## **H. Noncompliance Issues**

If the persons described in Section F do not comply with the HIPAA's and the Plan's privacy rules, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

## **I. Participant Notice**

The Plan shall be operated in accordance with the Notice of Privacy Practices, written in accordance with 45 CFR § 164.502, which shall be distributed to Plan participants and which may be amended from time to time by the Plan Administrator or insurance company providing benefits.

## **J. Health Plan Policies and Procedures**

In addition to the policies and procedures set forth in the Participant Notice, the Plan has established the policies and procedures to safeguard the privacy of PHI and comply with HIPAA's requirements. The Plan Administrator may amend such policies and procedures from time to time, as it deems appropriate.

## **K. Policy and Procedure for Notification of Breach of Unsecured Protected Health Information**

The Plan and its contractors will strive to prevent breaches of Unsecured PHI electronically or otherwise, and maintain privacy and security measures to protect the confidentiality of PHI. Pursuant to HIPAA and Regulations promulgated thereunder, and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the Plan will notify individuals if there is a probable compromise of Unsecured PHI.

### **Background and Purpose:**

Pursuant to HIPAA and Regulations promulgated thereunder, and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), the Plan will notify individuals when Unsecured PHI has been acquired, accessed, used or disclosed by an unauthorized person, when a confirmed breach of the security of the system does not fall within a statutory exception or there is a low probability that the PHI has been compromised.

### **Policy:**

Confirmed breaches of the security or privacy of Unsecured PHI will invoke certain actions to determine the probability that the PHI has been compromised based on a risk assessment and, under specific circumstances, notification of the breach will be made to the affected individual(s).

### **Procedure for Notification:**

- The Plan has implemented reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI and PI in its possession.

- The Plan has implemented reasonable systems for the discovery and reporting of a breach of PHI or PI. A “breach” of PHI is the unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of the PHI.
- When a breach has been reported, an investigation into the breach will be conducted.
- The investigation and steps taken will be thoroughly documented. If the conclusion of the investigation is that no breach occurred, no further action is necessary, but the investigation and conclusion will be thoroughly documented.
- If it is confirmed that a breach of security or confidentiality has occurred and has resulted in the unauthorized disclosure of PHI, the following risk assessment steps will be taken:
  - a. Determine whether or not the information breached was Unsecured. Unsecured PHI includes information not secured through encryption or destruction, and is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the Secretary of HHS in guidance issued under Section 13402(h)(2) of Public Law 111-5.
  - b. Determine the reasonable likelihood that such information was accessed by an unauthorized person.
  - c. Determine the probability that the PHI has been compromised based on a risk assessment of at least the following factors: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.
- The risk assessment will be documented thoroughly, including the actions taken, the conclusions of the assessment and the basis for the determination that there was or was not a low probability that the PHI was compromised.
- If it is determined that the information breached was secured and there is no reasonable likelihood that the secured information was rendered usable, readable or viewable by an unauthorized person, no further action is necessary, but the determination and conclusion will be documented.
- If it is determined that the information breached was Unsecured, but the circumstance of the breach falls within one of the exceptions to HIPAA (45 CFR § 164.402), so notification is not required, such determination will be documented.
- If it is determined that the breach of the security of the system demonstrates that there is more than a low probability that the PHI was compromised, the Plan will as soon as possible, but no later than sixty (60) days after the discovery of the breach, notify the individual(s) whose information was disclosed as a result of the breach, and the determination and conclusion will be documented.
- If it is determined that the information breached was Unsecured and notification is required, an analysis of the requirements for notification of the State in which the individuals reside will be conducted and documented.
- If notification to law enforcement or another regulatory body or agency is required under State law, such notification will be made to the regulatory body or agency in accordance with State law.

- If State law requires notification to the individual, notification will be made in accordance with State law.
- Notification to the individual may be delayed if a law enforcement agency determines that the notification will impede a criminal investigation and the notification will be made after law enforcement determines it will not compromise its investigation.
- Notification of a breach to affected individuals will be in plain language and include at a minimum:
  - a. a brief description of what happened, including the date of the breach and discovery of the breach; a description of the type of Unsecured PHI or other personal information that was involved in the breach;
  - b. any steps individuals should take to protect themselves from potential harm resulting from the breach;
  - c. a description of the investigation into the breach, mitigation of harm to individuals, and protection against further breaches; and
  - d. contact procedures, which will include a toll-free telephone number, an e-mail address, website or postal address.
- The notification must include any additional information required by applicable State law.
- If the breach involves more than 500 residents of a state or jurisdiction, notice will be provided to the media and to the Secretary of the Department of Health and Human Services (“HHS”) contemporaneously.
- A log of any and all breaches of Unsecured PHI of less than 500 individuals will be maintained and reported to the Secretary of HHS on an annual basis.
- Business Associates and vendors, through their contracts and/or Business Associate Agreements with the Plan will be required to provide notification of a breach to the Plan so that affected individuals can be notified, as necessary. Business Associates must provide all available information without delay.
- Documentation will be maintained of each individual notified, each notification provided to HHS and any other notification to the Secretary of HHS as required by law.

## **APPENDIX C**

### **COBRA RIGHTS**

This Section explains COBRA continuation coverage, when it may become available to you and your spouse, and what you need to do to protect your right to get it. When you have a right to elect COBRA, you will be provided with additional information.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and your spouse when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this Exhibit or contact the Plan Administrator.

#### **What is COBRA continuation coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Participants can become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

A spouse will become a qualified beneficiary if he or she loses coverage under the Plan. Domestic partners are not eligible for COBRA unless they are a tax dependent of the retiree.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the RF, and that bankruptcy results in the loss of coverage of any eligible RF retiree covered under the Plan, the eligible RF retiree will become a qualified beneficiary. The eligible RF retiree’s spouse will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

#### **When is COBRA continuation coverage available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The RF must notify the Plan Administrator of the commencement of a proceeding in bankruptcy with respect to the employer.

When a spouse eligibility for coverage due to divorce or death of the eligible RF retiree, the RF retiree or must notify Human Resources within sixty (60) days after the qualifying event occurs.

#### **How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. RF retirees may elect COBRA continuation coverage on behalf of their spouse.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for a maximum of 36 months of coverage.

**If you have questions**

Questions concerning COBRA continuation coverage rights should be addressed to Human Resources. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://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](http://www.HealthCare.gov).

**Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of you and your spouse. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**APPENDIX D**  
**ERISA GENERAL INFORMATION**

**Formal Plan Name, Plan Number and Plan Type:**

Plan No.: 502

Plan Name: Research Foundation of the City University of New York Retiree HRA Plan, under the Research Foundation of The City University of New York Welfare Benefits Plan

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

**Employer/Plan Sponsor/Plan Administrator:**

Research Foundation of The City University of New York  
230 W. 41<sup>st</sup> Street, Floor 7  
New York, New York 10036  
Telephone: (212) 417-8601

**Plan Year:**

The Plan year runs from January 1 to December 31.

**Employer Identification Number:**

13-1988190

**Agent for Service of Legal Process:**

Research Foundation of The City University of New York  
230 W. 41<sup>st</sup> Street, Floor 7  
New York, New York 10036  
Telephone: (212) 417-8601

You may also serve legal process to the Plan Administrator.

**Discretionary Authority:**

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

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

## **Type of Funding, Administration and Source of Contributions:**

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

## **Future of the Plan:**

Although the RF expects to maintain the Plan indefinitely, it has the right to modify or terminate the HRA benefit at any time for any reason, including the right to change the classes of retirees eligible for participation, the amount of the reimbursement or to reduce or eliminate any reimbursement. Participants have no vested rights to benefits under the Plan. As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 series) (should it become necessary for the Plan to file a Form 5500), filed by the Plan with the U.S. Department of Labor.
- Obtain upon written request to the Plan Administrator copies of documents governing the administration of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) (should it become necessary for the Plan to file a Form 5500) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Action by Plan Fiduciaries:**

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

### **Enforce Your Rights:**

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider



your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

#### Assistance with Your Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

#### Maternity and Newborn Infant Coverage Statement:

Under Federal law, a group health plans offering maternity or newborn infant coverage may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not in excess of the above periods. This requirement does not prevent an attending physician or other provider, in consultation with the mother, from discharging the mother or newborn child prior to the expiration of the applicable minimum period.