

2024 Benefits Handbook

POSTDOCTORAL EMPLOYEES



About the Research Foundation for SUNY

The Research Foundation for The State University of New York (RF) is the largest comprehensive university-connected research foundation in the country. It exists to serve the State University of New York (SUNY) by providing essential administrative services that enable SUNY faculty to focus their efforts on the education of students and the performance of life-changing research across a wide range of disciplines including medicine, engineering, physical sciences, energy, computer science, and social sciences. The RF works with the academic and business leadership of SUNY campuses to support research and discovery through administration of sponsored projects and technology transfer and management of intellectual property for public benefit and economic growth. The RF is a private non-profit education corporation that is tax-exempt under Internal Revenue Code (IRC) Section 501(c) (3). To learn more about the RF, visit www.rfsuny.org.

About the Benefits Handbook

With respect to the welfare benefits that are subject to the Employee Retirement Income Security Act of 1974 (ERISA), this handbook, in combination with handbooks and certificates from the insurance companies, constitutes the ERISA plan and summary plan description. The Research Foundation for the State University of New York Retirement Plan and The Research Foundation for the State University of New York Optional Retirement Plan have separate plan documents, which shall govern in the event of a discrepancy between this handbook and those plan documents.

Insurance contracts and plan documents are on file at the RF Office of Human Resources and are available for viewing during normal business hours. Copies will be provided upon request with a reasonable copying charge.

Certain retired employees, graduate student employees, regular employees and fellows may participate in some of the plans described herein. The terms of their participation are described in separate benefit handbooks or summary plan descriptions.

Benefits at a Glance

BENEFIT	COVERAGE WAITING PERIOD	ELIGIBILITY	BREAK IN SERVICE	WHEN COVERAGE ENDS	COVERAGE COST
Paid Family Leave	26 weeks if 20+ hours/week, OR 175 days worked if less than 20 hours/week.	Anticipated to work 26 weeks if 20+ hours/week OR 175 days worked if less than 20 hours/week.	28 days	Coverage ends the day your employment ends.	You pay for this benefit with after-tax dollars.
Voluntary Short-Term Disability	28 days	Same as Dental Care, but limited to salaried employees working at least 50% of full time, with an annual salary of at least \$15,000.	28 days	Coverage ends the day your employment ends.	You pay for this benefit with after-tax dollars.
Long-Term Disability	Coverage begins on the first day following one year of full-time service. Benefits begin on the first day following 180 consecutive days of a certified total disability.	You are eligible if you are a full-time employee.	Prior to meeting the one-year waiting period, if you incur a break in service of four months or more, you must meet a new waiting period. After meeting the one-year waiting period, if you become ineligible but return to eligible full-time employment within one year, coverage is reinstated on the day you return. If you return after a one-year break in service, you must meet a new waiting period.	Coverage ends on the last day of full-time employment.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
Basic Life and Accidental Death and Dismemberment Insurance	Six months	Same as Dental Care (Active Employees)	Same as Dental Care	Coverage ends the day your employment ends.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
Optional Life and Accidental Death and Dismemberment Insurance	Six months	Same as Dental Care (Active Employees)	Same as Dental Care	Coverage ends the day your employment ends.	You pay for this benefit through biweekly payroll deductions.
Basic Retirement Plan	One-year waiting period; vesting is immediate. Refer to <i>Retirement</i> on page 42 for detailed information.	Eligible You are eligible if you are an employee in active pay status working at least 50% of full time on a postdoctoral appointment. Ineligible Refer to <i>Retirement</i> on page 42 for detailed information.	Refer to <i>Retirement</i> on page 42 for detailed information.	Contributions end when you are no longer on the payroll. Refer to <i>Retirement</i> on page 42 for detailed information.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.

Benefits at a Glance

BENEFIT	COVERAGE WAITING PERIOD	ELIGIBILITY	BREAK IN SERVICE	WHEN COVERAGE ENDS	COVERAGE COST
Optional Retirement Plan	None	All employees except full-time SUNY students appointed in an RF student title.	N/A	Contributions end when you are no longer on the payroll or choose not to make further contributions.	You pay for this benefit through pre-tax or Roth (post-tax) salary deduction.
Unemployment Insurance	Coverage is effective immediately if you meet Department of Labor criteria. A seven-day waiting period must be met following application for unemployment insurance benefits. Refer to <i>Continuing Benefits</i> on page 55 for detailed information.	You are eligible if you are an employee who involuntarily leaves the RF and meets the Department of Labor eligibility requirements.	N/A	Benefits end when you are no longer unemployed or when 26 weeks elapse from the start of benefits, whichever comes first. (Sometimes the federal government allows additional weeks.)	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
Pretax Premium Payment	Same as benefit for which premium is paid	Same as benefit for which premium is paid	N/A	Coverage ends when your employment ends, or when your coverage under the benefit for which the premium is paid ends.	This plan allows you to pay for certain benefits on a pretax basis.
Dependent Care Flexible Spending Account	Six months	Eligible You are eligible if you are a salaried, non-student employee working at least 50% of full time. Ineligible You are not eligible if you are an hourly, full-time SUNY student appointed in an RF student title or a summer employee.	Same as Dental Care	Coverage ends when your employment ends, or at the end of the benefit plan year if you make no election for the following plan year.	You pay for this benefit through pretax salary deduction. The RF pays a subsidy based on your full-time equivalent salary.
Health Care Flexible Spending Account	Six months	Same as Dependent Care Flexible Spending Account	Same as Dental Care	Coverage ends when your employment ends, or at the end of the benefit plan year if you make no election for the following plan year.	You pay for this benefit through pretax salary deduction.
RF Ride Commuter Transit Benefit	None	All employees	N/A	Coverage ends when your employment ends, or when you choose to stop participating.	You pay for this benefit through pretax or after-tax salary deduction.
Wellness Plan	Same as Health Care (Active Employees)	Same as Health Care (Active Employees)	Same as Health Care (Active Employees)	Coverage ends when your employment with the RF ends.	The RF pays the full cost of this benefit.
Pet Insurance	None	All employees	N/A	Coverage ends when you choose to stop participating.	You pay for this benefit through payroll deduction.

Enrollment Guidelines

Through Employee Self Service (www.rfsuny.org/selfservice), you can enroll, update your coverages, and/or change your beneficiaries, dependents and contact information online. Retirement contracts, however, must be managed through TIAA.

If you have questions about how to log on to Employee Self Service, or how to enroll or make changes after logging on, please refer to the Employee Self Service Guide. You will find the guide, along with all paper enrollment forms, on the RF Benefits website (www.rfsuny.org/benefits).

If you do not enroll online, submit your completed enrollment form(s) to your campus RF benefits administrator. You also may contact your campus benefits administrator for the forms needed.

Guidelines at a Glance

COVERAGE	ENROLLMENT REQUIRED?	EMPLOYEE SELF SERVICE OR PAPER ENROLLMENT FORM?
Health Care Dental Care Vision Care	Yes, even if you are electing to decline coverage.	You can use Employee Self Service to enroll during your initial 60 days of eligible employment, marriage or birth/adoption of a child, and annually during Open Enrollment. Enrollment at any other time must be done using the RF Benefits Enrollment form.
Basic Life and AD&D Coverage	No, coverage is automatic.	Coverage is automatic, so you will not have to enroll, but you may use Employee Self Service to designate or change beneficiaries.
Optional Life and AD&D Coverage	Yes	You can use Employee Self Service to enroll during your initial 60 days of eligible employment. You also can use Employee Self Service to designate or change beneficiaries. At any other time, coverage and beneficiary changes must be done using the RF Benefits Enrollment form. Evidence of insurability is also required for coverage increases and late enrollments.
Optional Dependent Life and AD&D Coverage	Yes	You can use Employee Self Service to enroll during your initial 60 days of eligible employment. At any other time, coverage changes must be done using the RF Benefits Enrollment form and Optional Dependent Life Enrollment form. Evidence of insurability is required for dependent or spouse coverage greater than \$20,000 and for coverage changes.
New York State Short-Term Disability	No, coverage is automatic.	Coverage is automatic, so you will not have to enroll.
Voluntary Short-Term Disability	Yes	You can use Employee Self Service to enroll during your initial 60 days of eligible employment. At any other time, coverage changes must be done using the RF Benefits Enrollment form and Voluntary Short-Term Disability Enrollment form. Evidence of insurability is also required for coverage increases and late enrollments.

- A child of your domestic partner who:
 - Meets the plans' eligibility requirements,
 - Resides in your household,
 - Has a gross income for the calendar year that is less than the personal exemption amount,
 - Receives 51 percent or more of their support from you and
 - Is not a qualifying child dependent of any other taxpayer.

If two family members work for the RF, both can have employee-only coverage or one can be covered as the dependent of the other. You cannot be covered as both an employee of the RF and as a dependent of another RF employee. If both mother and father are RF employees, their dependent children may be covered as dependents of either the mother or the father, but not both.

Special Rules for Domestic Partners

Many federal laws and protections apply to spouses of employees. A domestic partner does not have these protections under federal law unless that person is also a legal spouse. Therefore, federal laws and protections, such as COBRA, Medicare, pretax payment for benefits and flexible spending account benefits under Internal Revenue Code Section 125, special enrollment rights for changes in family status, spousal protections under ERISA and the Internal Revenue Code, exclusions from income for employer-provided benefits under the Internal Revenue Code and other federal laws relating to employee benefits, do not apply to domestic partners in the same way they apply to spouses (except in those limited cases where the domestic partner may qualify as the employee's dependent for tax purposes (i.e., a "qualifying relative" under Internal Revenue Code Section 152(d)).

The RF extends to domestic partners certain types of benefits, such as health, dental and vision coverage, as well as certain types of optional coverage, such as dependent life insurance. In many cases, the extension of benefits to a domestic partner results in the employee having additional amounts includable in income for tax purposes. In addition, the RF offers continuation coverage to covered domestic partners of any gender under substantially the same conditions as it does for spouses.

Coverage of your domestic partner under the RF Health Care plan does not delay the enrollment period for Medicare in the same manner as it would for a spouse of an active employee. Consequently, your domestic partner should enroll for Medicare as soon as he or she is eligible. In most circumstances, the RF Health Care plan is the secondary payer (after Medicare) for domestic partners who are eligible for Medicare, even if not enrolled in Medicare. In addition, late enrollment in Medicare Parts B and D can result in the permanent increase in the required premiums for these programs.

This handbook does not attempt to describe every implication of coverage of the domestic partners of RF employees. You should consult your legal and tax advisors for more information.

Adding Dependents

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

If you add a dependent after 60 days from the day he or she becomes eligible, coverage will begin on the first day of the fifth pay period from the date your campus Benefits Office receives the new enrollment form unless a special enrollment right applies. (Refer to *Special Enrollment Rights* on page 17.) If a special enrollment right does not apply, then the dependent portion of the contribution would be taken on an after-tax basis for the remainder of the calendar year.

The RF is required by law to permit employees subject to a qualified medical child support order to enroll dependent children in a Health Care plan without regard to late enrollment restrictions. You may request a copy of the procedure used by the RF for determining what constitutes a qualified medical child support order.

How You and the RF Share the Cost Enrollment

The RF pays the majority of the total cost for individual and dependent coverage. For the Traditional PPO plan, the RF contributes 85 percent of the cost for individual health coverage and 70 percent of the cost for dependent health coverage. The RF's contribution for the Deductible PPO equals the dollar amount contributed toward the Traditional PPO plan. The RF's contribution for the HMO plans is the minimum of the dollar amount contributed toward the Traditional PPO Plan or 85 percent of the cost for individual health coverage and 70 percent of the cost for dependent health coverage for the plan. The employee contribution will comply with the Federal Poverty Guidelines in accordance with the Affordable Care Act. Under the Dental Care plan, the RF pays 90 percent of the cost for individual dental coverage and 75 percent of dependent dental coverage. The RF pays 100 percent of the cost for the regular Vision plan and the RF's contribution on the Vision Plan Plus is limited to the amount it pays for the regular Vision plan. You pay the balance through biweekly payroll deductions.

You pay your share of your coverage in the form of biweekly contributions from your paycheck. For more information about plan premiums, refer to the *Benefits Bulletin*, which is available on the RF Benefits website.

Initial Double Deductions

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

When to Enroll in Medicare Part B

If you are an active employee who becomes eligible for Medicare Part B while covered by the RF Health Care plan, you should not enroll for Part B until three months before you retire. Since you'll have continuous coverage with the RF as an active employee, you won't be penalized by Medicare for joining the program late. This rule does not apply to domestic partners.

If you wish to participate in the Health Care plan, you must enroll within 60 days of your RF employment or when you become eligible. Enrollment in the plan is not automatic. To enroll, log on to Employee Self Service (see page 8). If you do not have Internet access, you may complete, sign and submit an RF Benefits Enrollment form to your campus Benefits Office.

Once you enroll, your enrollment will remain in effect until you revoke it during an Open Enrollment period or under the circumstances described in the Research Foundation for the State University of New York Benefits Plan.

Coverage Options

When enrolling for Health Care coverage (PPO or HMO), you may choose one of the following coverage levels or you may waive coverage:

- Employee only,
- Employee and spouse,
- Employee and child(ren) or
- Family.

When enrolling for Dental Care and Vision Care coverage, you may choose one of the following coverage levels or you may waive coverage:

- Employee only or
- Family.

Waiving Coverage

You may waive Health Care plan coverage when you are employed or become eligible by selecting this option when enrolling through Employee Self Service.

You may change from waiver of coverage to coverage any time during the calendar year, but you must wait five pay periods in active employment for coverage to begin unless you have a qualifying event. (Refer to *Changing Your Coverage* on page 16 for more information.)

To pay the premium for coverage on a pretax basis, you must satisfy the requirements described under *Changing Your Coverage* on page 16. For more details, see *Flexible Benefits Program* on page 64. Otherwise, your cost of coverage will be deducted from your pay on an after-tax basis.

When Coverage Begins

Coverage begins on day 43 from your date of employment or eligibility unless you have a break in service. If you are not actively at work on the day you complete the waiting period, your coverage under the Health, Dental and Vision Care plans begins on the day you return to work. This exception does not apply if the reason you are not at work is due to a medical condition. Also, your dependent's coverage cannot begin before your coverage begins.

Break in Service

If you incur a break in service of any number of days before you satisfy the 42-day waiting period, you will need to satisfy a new waiting period before coverage takes effect. If you've already satisfied the 42-day waiting period and you incur a break in service of more than 28 days, you will need to satisfy a new waiting period.

Open Enrollment

Open Enrollment occurs each year in November. During this time you may enroll if you have not previously done so, drop coverage, change your coverage option or level, and/or switch between pretax and after-tax deductions. Changes take effect January 1 of the following year.

Enroll online through Employee Self Service (see page 8). If you do not have Internet access, enrollment forms are available from your campus Benefits Office. Necessary enrollment forms must be submitted to your campus Benefits Office. Completed forms should not be sent directly to the claims administrator.

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

Late Enrollment

Health Care (PPO and HMO)

If you delay enrollment more than 60 days after you become eligible, you must wait an additional five pay periods in active employment to be covered (unless you have a special enrollment right or qualifying event). Your coverage will start on the first day of the fifth pay period following the day your campus Benefits Office receives the completed RF Benefits Enrollment form, or online enrollment through Employee Self Service. Your deduction for health coverage will be taken on an after-tax basis for the remainder of the calendar year.

Example of Late Health Care Plan Enrollment 2023

Appointment/eligibility date:	January 8
42-day waiting period ends:	February 19
60-day enrollment period:	January 8 – March 7
Enrollment received:	March 21
Date of coverage:	May 20

Dental and Vision Care

If you delay enrollment in the Dental and Vision Care plans beyond 60 days from your date of eligibility and you have met the six-month waiting period, your coverage becomes effective on the day your campus Benefits Office receives the completed RF Benefits Enrollment form or online enrollment via Employee Self Service. Your deductions for dental coverage and/or the Vision Plan Plus (if applicable) will be taken on an after-tax basis for the remainder of the calendar year.

Changing Your Coverage

Health Care, Dental Care and Vision Care

Pretax Plan Deductions

If your health and/or dental and/or vision benefit premium contributions are being deducted from your pay on a pretax basis, then you may only change your coverage level, coverage option (e.g., PPO to HMO) and pretax deduction during Open Enrollment unless you have a special enrollment right or other qualifying event.

If you add dependents without a qualifying event, the employee portion of the premium will remain pretax and the dependent portion will be an after-tax deduction until the next plan year.

You may not change your dependent coverage pretax deduction to an individual pretax deduction during the year unless you have a qualifying event. Refer to the definition and list of qualifying events below.

To make changes, you must submit a new RF Benefits Enrollment form to your campus Benefits Office within 60 days of the event.

After-tax Plan Deductions

Dependents who are domestic partners are not eligible for pretax Health Care or Dental Care plan deductions under federal law unless they are “qualifying relatives” under Section 152(d) of the Internal Revenue Code. Your contribution toward their coverage will be on an after-tax basis.

If your Health Care or Dental Care plan deductions are being taken on an after-tax basis, you may change your coverage level anytime during the year, but new Health Care plan coverage is subject to a five-pay-period wait unless you have a qualifying event. If you have a qualifying event, the change is effective retroactively to the date of the event if the new enrollment is received by your campus Benefits Office within 60 days of the event.

Vision Care

If you did not enroll for the regular Vision Care plan during Open Enrollment, you can enroll in the plan anytime during the year. To do so, you must complete and submit a new RF Benefits Enrollment form to your campus Benefits Office. Your new coverage will become effective on the day your campus Benefits Office receives your enrollment.

If you enrolled in the regular Vision Care plan during Open Enrollment, you may only change to the Vision Plan Plus during the year if you experience a qualifying event. If the change involves a newly eligible dependent (for example, as a result of marriage), dependent coverage is effective on the date the dependent becomes eligible, provided a new enrollment is completed within 60 days of this date.

Qualifying Events

A qualifying event is a change in your or your dependent’s status that permits a change to be made in pretax health insurance elections outside of the annual Open Enrollment period. The change in status must result in a gain or loss of coverage or coverage options. The election change must be consistent with the change in status, and must be made within 60 days of the event.

Qualifying events include:

- Qualification for special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). See *Special Enrollment Rights* on page 17.
- A change in status that affects your, your spouse’s or dependents’ coverage, including a change in:
 - Legal marital status because of marriage, death of a spouse, divorce, legal separation or annulment;
 - Number of dependents because of birth, adoption, placement for adoption or death;
 - Employment status (termination or commencement of employment) by you, your spouse or dependent;
 - Work schedule (reduction or increase in hours of employment) for you, your spouse or dependent because of a switch between part time and full time, or commencement of or return from an unpaid leave of absence that results in acquiring or losing eligibility for health insurance;

- Dependents' status (an event that causes your dependent to satisfy or cease to satisfy the requirements for coverage because of attainment of age or any similar circumstances as provided by the plan); or
- Residence or worksite (for you, your spouse or dependent).
- Receipt by the plan of a court order, such as a qualified medical child support order under Section 609 of ERISA.
- Your, your spouse's or dependents' qualification (or loss of qualification) for a State Children's Health Insurance Program (S-CHIP), Medicare, Medicaid or other coverage sponsored by a governmental or educational institution.
- A significant cost change or a reduction or curtailment of the coverage available during the year. In such a case, you may elect coverage under another option providing similar coverage, or you may drop coverage if no similar option is available. If a coverage option is added or significantly improved or the cost of a coverage option has significantly decreased during the year, eligible employees (including those who have not previously elected coverage) may change their elections to enroll in the new, improved or decreased cost option.
- A change in the health coverage available to you, your spouse or dependents through another employer and either that employer plan has a different period of coverage (a different open enrollment period) or has rules allowing changes in election similar to the rules contained in this section.
- Eligibility for a special enrollment period to enroll in a qualified health plan through the health insurance marketplace as defined under the Affordable Care Act.

Requests for enrollment changes are processed in accordance with IRS regulations by your campus Benefits Office. These requests are subject to review by the RF Human Resources Office, which may require additional written documentation.

Special Enrollment Rights

Apart from qualifying events, special enrollment rights allow you to make changes to your medical (PPO or HMO) coverage (but not Dental Care, Vision Care or Health Care Flexible Spending Accounts), outside of your initial enrollment period or the Open Enrollment period in three specific circumstances: 1. you gain a dependent, 2. you or a dependent loses coverage under another plan, and 3. you or a dependent becomes eligible for assistance through a State Children's Health Insurance Program. The following describes these specific circumstances, which are based on rules enacted by the Health Insurance Portability and Accountability Act (HIPAA), in more detail. (The term "dependent" includes a spouse or domestic partner.)

Gaining a Dependent

If you gain a dependent through marriage (e.g., your new spouse and any eligible stepchildren), birth, adoption or placement for adoption, you may enroll the new dependents — and yourself if you are not already enrolled — in the Health Care plan by complying with the plan's procedures for other enrollments. In the case where a child is born, adopted or placed for adoption, your spouse also may be enrolled during such a special enrollment period. You also may change from one Health Care plan coverage option to another (for example, changing from HMO to PPO coverage) when you add a dependent under a special enrollment. The special enrollment period for dependents is the 60-day period that begins on the date of the marriage, birth, adoption or placement for adoption, as applicable.

In the case of marriage, coverage is effective the date the completed request for enrollment is received by the plan. In the case of a dependent's birth, coverage is effective the date of the birth. In the case of adoption or placement for adoption, coverage is effective the date of such adoption or placement.

Losing Other Medical Coverage

If you waived coverage for yourself or for an eligible dependent because you or the dependent had other medical coverage (including coverage from another employer, COBRA coverage, Medicare or Medicaid), you may enroll in the RF Health Care plan in certain circumstances including, but not limited to, the following:

- The other coverage was COBRA continuation coverage, and the coverage period was exhausted;
- The other employer terminates the coverage or terminates contributions for that coverage;
- You or your dependent loses eligibility for that coverage for reasons including termination of employment, reduction in work hours, legal separation, divorce, death or reaching the maximum age to be eligible as a dependent;
- You or your dependent no longer lives or works inside the plan's service area, and no other benefit package is available;
- You incur a claim that would meet or exceed the lifetime limit on all benefits under the plan; or
- You or your dependent loses coverage because the plan no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

Losing coverage for not paying premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact) would not qualify an individual for a special enrollment.

You must enroll within 60 days after the other coverage ends. The application must be made under the same application rules that apply to other enrollments. If elected, coverage begins on the first day of the calendar month that begins after the date that the completed request is received by the plan.

Becoming Eligible Under a State Children's Health Insurance Program

If you are eligible for the RF Health Care plan, but you are unable to afford the premiums, you may qualify for premium assistance from the State of New York. If you are not currently enrolled in the plan, you may request a special enrollment within 60 days of being determined eligible for this premium assistance.

Some states, including New York, use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office, dial 877-KIDS NOW (877-543-7669) or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay health plan premiums.

For more information about Medicaid and CHIP premium assistance, contact the New York State Department of Health at 800-541-2831 or visit www.health.ny.gov/health_care/medicaid/.

Patient Protection and Affordable Care Act (ACA)

The Patient Protection and Affordable Care Act (ACA) requires the RF to offer full-time employees health insurance that meets minimum value and affordability standards. All RF health plans satisfy the ACA's requirements for providing "minimum essential coverage" and for affordability.

The ACA defines full-time as working an average of 30 hours per week. To determine full-time eligibility under the ACA, the RF will use the safe harbor method for tracking hours worked on an ongoing basis.

- Measurement Period (October 3 through October 2): Measure hours worked for all employees to determine eligibility under the ACA.
- Administrative Period (October 3 through December 31): Offer coverage to employees who are deemed full-time under the ACA.
- Stability Period (January 1 through December 31): Time period during which employees deemed full time under the ACA must continue to be offered coverage regardless of hours worked.

The RF is also subject to reporting requirements under the ACA. These include filing form 1095-C and form 1094-B with the IRS. These forms are issued to employees by January 31 of each year.

Your Health Care Plan Options

PPO Plans

The RF offers two PPO plans through Anthem Blue Cross: the Traditional PPO and the Deductible PPO. The RF also offers the Graduate Student and Postdoctoral Employee Health Plan through Anthem Blue Cross. In a PPO plan, hospitals, physicians and other health care providers agree to join the plan's provider network. These in-network providers agree to charge reduced fees to plan participants, and the plan pays a higher percentage of the cost of care received from these providers. The plan gives you the flexibility to visit any providers you choose, but visiting in-network providers can save you money and the time associated with filing claims for reimbursement. For most types of care received in-network, you pay only a copayment at the time you receive services (within plan limits).

Identification Card

Once you have enrolled in a PPO plan, you will receive a PPO membership identification card (ID card). It enables you to receive benefits nationally and internationally. Show your membership card to any Anthem Blue Cross participating physician or hospital. The PPO physician or hospital can verify your membership eligibility and coverage. When you visit a PPO doctor or hospital, you will have no claim forms to file.

From time to time a replacement card may be issued by Anthem Blue Cross.

Choosing a Provider

In-Network Providers

Under the Anthem Blue Cross plans, most services obtained from in-network providers will cost you a fixed copayment. Under the Deductible PPO option, a deductible (\$500) and 10 percent coinsurance apply to most in-network services other than office visits, which generally will cost you a \$30 copayment. Certain types of preventive care, such as well-child care and routine newborn care, are provided at no cost to you. Also, when you visit in-network providers, you will have no claim forms to file and the plan will cover your care at a higher rate than if you visit an out-of-network provider.

Anthem Blue Cross

You can find in-network Anthem Blue Cross providers using the following telephone numbers:

- For Central and Western New York and outside New York state, call 800-810-BLUE (800-810-2583).
- For Eastern New York, call 800-342-9816.

You also may visit www.anthem.com and click on "Menu," then "Find a Doctor." Enter your ZIP code and/or other information to find providers that fit your search criteria.

Contact Anthem Blue Cross

800-342-9816

www.anthem.com

In Case of Emergency

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

Out-of-Network Providers

Under the Anthem Blue Cross plan, obtaining care from a provider outside the plan's network requires an annual deductible and 20 percent coinsurance for most services. Under the Deductible PPO plan, a separate deductible and 40 percent coinsurance applies for out-of-network services. Both plans place limits on your out-of-pocket expenses for allowable charges. You complete a claim form for reimbursement of allowable charges.

Physician Office Visits

Under either PPO plan, when you or your covered dependent(s) visit(s) an in-network physician, you will pay a copayment unless the visit is for preventive care as described in the following section.

Preventive Care

The following types of preventive care services are fully covered by the plan when received from an in-network provider. No copayment will be required.

- Routine adult care (exam and related tests)
- Routine mammography screening
- Routine bone density screening
- Routine annual Pap smear and pelvic exam
- Adult immunizations
- Colorectal cancer screening (age 50 and over)
- BRCA mutation counseling related to genetic testing
- Nutritional dietary counseling (for those with obesity and adults with risk factors)
- Smoking/tobacco use cessation counseling
- Women's preventive services

Approved Clinical Trials

For diagnosed employees who qualify, certain clinical trials and in-network treatments are covered. Out-of-network services are only covered when an in-network provider is unavailable.

Plan Limits

There are no lifetime dollar limits. Please refer to the Certificate of coverage for limits on medical care, medical test devices, procedures and preauthorization.

Contact Express Scripts

800-251-7690

www.express-scripts.com

Prescription Drug Coverage

This plan is designed to cover most medications that require a physician's written prescription. Prescription drugs may be obtained either through mail order or at a retail pharmacy. When you fill a prescription, whether through mail order or at a retail pharmacy, you will pay a copayment. Additional information can be found in the Prescription Drug Benefits for PPO Members booklet, which is available on the RF Benefits website (www.rfsuny.org/benefits).

Identification Card for Anthem Blue Cross Enrollees (Traditional and Deductible)

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

Graduate Student and Postdoc Anthem Plan enrollees

Present your Anthem Blue Cross identification card to the pharmacist at a participating pharmacy when a prescription is filled.

This ID card contains your group and member numbers and serves as verification of your enrollment in the plan.

Choosing a Pharmacy

Participating Retail Pharmacy. Your ID card can be used at a network of thousands of participating pharmacies that will provide you with prescription drugs at a discounted price. At a participating pharmacy, you present your ID card, pay the copayment (see page 22) and brand-name differential, if applicable, and receive your prescription. You can find a local pharmacy at www.express-scripts.com.

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

Nonparticipating Retail Pharmacy. If you fill a prescription at a pharmacy that does not participate in the plan's network, the plan will pay only the discounted cost

of the drug that a participating pharmacy would have charged. You will be responsible for paying the difference between the discounted price and the actual retail price. At a nonparticipating pharmacy, you pay for prescriptions when you receive them and obtain reimbursement from Express Scripts for allowable expenses. To be reimbursed, you and your pharmacist must complete a reimbursement form and submit it to Express Scripts.

How to Request Reimbursement When Using a Nonparticipating Pharmacy

1. Obtain an Express Scripts reimbursement form from either your campus Benefits Office or directly from Express Scripts.
2. Complete and sign the Member/Subscriber/Patient Information on the front side of the form.
3. Have the prescription filled, pay the full retail price and request a receipt.
4. Have the pharmacist complete and sign the Pharmacy Information section of the form.
5. Tape the original receipt to the claim form. Do not use staples or paper clips.
6. Make copies for your records and mail the reimbursement form and original receipt to: Express Scripts, ATTN: Commercial Claims, P.O. Box 14711, Lexington, KY 40512-4711. You also may fax your claim form to 608-741-5475.

After deducting a copayment (and the brand-name differential, if any), Express Scripts will reimburse you for up to a 30-day supply of the drug at the discounted price that a participating pharmacy would have charged.

Mail Order. Through the mail-order service, you can get up to a 90-day supply of a generic drug for the cost of a 30-day supply from a retail pharmacy. You can get a 90-day supply of a brand-name drug for the cost of a 60-day supply at a retail pharmacy. Shipping is free, making mail order a convenient way to save time and money.

If you are prescribed a long-term medication and would like to use the mail-order service, but need to begin taking the drug immediately, ask your physician for two prescriptions: one for a 14-day or 30-day supply that can be filled at a local pharmacy, and one for up to a 90-day supply that can be ordered through the mail.

Express Scripts Welcome Kit

For additional information about your prescription drug coverage, refer to the welcome kit you will receive from Express Scripts. This kit, in conjunction with your Research Foundation Benefits Handbook, constitutes the ERISA plan and summary plan description (SPD).

Categories of Prescription Drugs

There are three categories of covered drugs with three different copayments: generic drugs, preferred brand-name drugs and nonpreferred brand-name drugs.

Generic Drugs. You will pay the lowest copayment for generic drugs. Generics are equivalent to their brand-name counterparts, and are ensured by the Food and Drug Administration to be safe and effective. However, generics cost 30 to 70 percent less than brand-name drugs.

Preferred Brand-Name Drugs. These are drugs for which generic equivalents are not available. They have been in the market for a time and are widely accepted. Express Scripts has arranged a significant discount on these drugs. They cost more than generics, but less than nonpreferred brand-name drugs.

You may obtain a list of preferred brand-name drugs by registering at www.express-scripts.com or by calling 800-251-7690.

Nonpreferred Brand-Name Drugs. These drugs have the highest copayment for the traditional and deductible PPO plans. Fertility treatments are not covered under the UMR plan. Generally, these are high-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available. If a physician prescribes a brand-name drug when a generic equivalent is available, you must pay the difference in cost in addition to a copayment.

Annual Out-of-Pocket Maximum

For Anthem Blue Cross traditional plan there is an annual out-of-pocket maximum of \$1,320 for individuals and \$2,640 per family on a calendar-year basis for covered drugs.

For the Anthem Blue Cross Deductible and Graduate Student and Postdoc Plan there is an annual out-of-pocket maximum of \$1,270 for individuals and \$2,540 per family on a calendar-year basis for covered drugs.

Specialty Medication

Specialty medication prescriptions must be filled through the Express Scripts mail-order specialty pharmacy. This type of medication usually requires injection or infusion and special handling, including temperature control.

Patients needing specialty medication require continued treatment for long-term and often complicated diseases and associated conditions. The specialty pharmacy can support these needs with a specially trained team of pharmacists and registered nurses. Call 800-803-2523 to find out more about this program.

If you submit a prescription for a specialty medication to a retail pharmacy, the pharmacy will instruct you to instead submit the prescription to the Express Scripts mail-order specialty pharmacy.

Medically Necessary Self-Injectables

Insulin and other diabetic supplies that are prescribed by a physician are covered by your Prescription Drug coverage as described in this section. Other medically necessary self-injectables and syringes are covered as part of your Health Care plan coverage. Generally, you will pay a 20 percent coinsurance after meeting your medical benefit plan year deductible.

Prescription Drug Copayments*

	ANTHEM BLUE CROSS		OPTIONAL ANTHEM BLUE CROSS DEDUCTIBLE PLAN	
	AT RETAIL PHARMACY (30-DAY SUPPLY)	MAIL ORDER (UP TO 90-DAY SUPPLY)	AT RETAIL PHARMACY (30-DAY SUPPLY)	MAIL ORDER (UP TO 90-DAY SUPPLY)
Generic Drugs	\$10	\$10	\$5	\$5
Preferred Brand-Name Drugs	\$25	\$50	\$25	\$50
Nonpreferred Brand-Name Drugs	\$45	\$90	\$45	\$90

* In accordance with the federal Affordable Care Act, the out-of-pocket limit on covered drugs under this plan is \$1,320 for individuals and \$2,640 per family on a calendar-year basis.

Drugs and Supplies Not Covered

Some drugs and supplies are not covered under either the mail-order or retail pharmacy programs. You can find the list of excluded drugs using your member log on at www.express-scripts.com.

Quantity/Duration Limits

Quantity/duration limits are cycles that limit the amount of the drug covered per prescription or for a specific period of time. Covered drugs that have these limits are marked in the formulary (list of covered drugs) on the Express Scripts website.

How to File a Claim

If you pay in full at the pharmacy and wish to file a claim for reimbursement, your prescription drug claim will be treated as a *post-service claim*, as described on page 23. Refer to *Your Rights Under State and Federal Laws* on page 73 for details.

If You Are Diagnosed With End Stage Renal Disease

To avoid the potential of medical providers billing you for the balance of outpatient dialysis charges that are not covered by the RF Health Care plan, you should enroll in Medicare Part B when first eligible. For information about Medicare eligibility, enrollment and Medicare's end stage renal disease (ESRD) benefits, contact your local Social Security Office. For details about ESRD benefits under the RF Health Care plan, refer to the plan document.

HMOs

You may enroll in a Health Maintenance Organization (HMO) if one is offered by the RF in your geographic area. In this type of plan, you receive health care from physicians or other providers who are part of the HMO, unless you are referred by the HMO to a physician or provider who is not part of the HMO. Typically, you are charged a copayment for office visits and for filling prescriptions.

If you need care while you are outside your HMO's service area, only emergency and limited care will be available to you, although some HMOs have reciprocal agreements with other HMOs outside their service area.

Before enrolling in an HMO, thoroughly review the coverage provisions of the plan. Although HMOs provide hospitalization coverage and a comprehensive plan of medical and surgical care, some provisions differ from those established for the RF PPOs. If you are interested in HMO coverage, your campus Benefits Office can give you information about HMOs in your area.

Identification Card

If you enroll in an HMO, you will receive an identification card that you must present whenever you receive health care.

Preventive Care

The HMOs fully cover preventive care services when received from an in-network provider. For a partial list, see *Preventive Care* on page 20.

Prescription Drug Coverage

HMOs provide prescription drug coverage, but may require that prescriptions be filled at a specific pharmacy. You will be charged a copayment when you fill a prescription. For information about prescription drug coverage, refer to your HMO certificate.

Contact your HMO

Refer to *Contacts* on page 10.

HMO Handbook

The HMO will provide you with an HMO handbook and Certificate of coverage. These documents, in conjunction with your Research Foundation Benefits Handbook, constitute the ERISA plan and summary plan description (SPD).

Claims Procedure

Each benefit provider (insurer, HMO or third-party claims administrator, as applicable) will follow claims procedures that satisfy the requirements specified in Department of Labor regulations summarized in this section. For purposes of this procedure, the person who is responsible for making a claims decision is referred to as the "claims administrator."

If you have specific questions about coverage, contact your local HMO.

Urgent Care Claims

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

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

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

A "post-service claim" is any claim that is not a "pre-service claim." In other words, approval is not required before obtaining medical care.

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

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

Requirements for Notification of an Adverse Benefit Determination

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

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

Earn Cash for Good Health

Participants in the Virgin Pulse wellness program can earn up to \$100 each quarter for performing healthy behaviors. For more information, refer to page 68.

Appeal of an Adverse Determination

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

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the plan or amend or eliminate benefits under the plan for any reason.

Medical Decision Support by Aight Solutions

The RF provides a valuable free service to RF employees enrolled in an RF Health Care plan and their covered dependents. Medical Ally through Aight Solutions helps RF employees by providing the most recent research and information on any medical condition.

The pace of innovation and discovery in the medical field has increased dramatically in recent years, and it is virtually impossible for any physician to keep track of it all. This is where Medical Ally is so helpful. You receive free of charge via express delivery to your home or via email the latest information on any condition. You can then discuss your concerns with your doctor to seek new treatments and possibly avoid unnecessary surgery.

In fact, there is a special program in place to help patients avoid five major surgeries:

- Low back,
- Hip replacement,
- Knee replacement,
- Hysterectomy and
- Weight loss (obesity).

If your physician has recommended any of the elective surgeries, follow these three steps to receive a \$400 gift card*:

1. Call Medical Ally at 888-361-3944 if your physician has recommended surgery as an option OR at least 30 days prior to a scheduled surgery to determine if you're eligible. Be sure to have information about your condition available.
2. Review the personalized materials you receive and participate in follow-up consultations with your dedicated, physician-led ConsumerMedical team. They will answer your questions, walk you through the tools and resources available at www.mymedicalally.aight.com and provide additional information to help you make an informed decision.
3. Complete a brief telephone survey with your Medical Ally team.

**\$400 gift card may be considered taxable income. Consult your tax advisor.*

Even if you're not considering surgery, the service can be very helpful in providing information on less serious conditions, like insomnia and stress. More information is available on the Wellness page of the RF Benefits website (www.rfsuny.org/benefits).

By Phone

RF employees enrolled in an RF Health Care plan and their covered dependents can call Medical Ally at 888-361-3944 from 8:30 a.m. to 5:00 p.m. EST, Monday through Friday.

ConsumerMedical Website

RF employees enrolled in an RF Health Care plan and their covered dependents can access Medical Ally services at www.mymedicalally.alight.com.

Note: To access services, you will need to register the first time you use the site. Select the "Register Now" link on the Medical Ally home page. In the Company field on the registration page, enter "Research Foundation."

Contact Medical Ally

888-361-3944

www.mymedicalally.alight.com

Dental Care

The Dental Care plan, which is offered through Delta Dental, covers preventive care, treatment of teeth affected by injury or decay, and replacement of missing teeth. In this plan, you have the freedom to visit any licensed dentist, but your costs are usually lowest when you see a dentist in the Delta Dental network.

When you visit a Delta Dental dentist and present your Delta Dental identification card, you will pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from the plan. Nonparticipating providers will submit a claim to Delta Dental who will reimburse you according to the plan's benefits. You may have to pay for the services first.

You should receive a Delta Dental employee Information Sheet from your campus Benefits Office. The employee Information Sheet describes:

- The dental services covered under the Dental Care plan;
- Benefit levels, benefit limitations and predetermination of Delta payment; and
- Online and customer services.

How You and the RF Share the Cost

The RF contributes 90 percent of the cost for individual dental coverage and 75 percent of the cost for dependent dental coverage. You pay your share of your coverage in the form of biweekly contributions from your paycheck. For more information about plan premiums, refer to the *Benefits Bulletin* available on the RF Benefits website.

Benefits Summary

The plan will pay benefits according to the usual, customary and reasonable fees for a particular area and according to the plan's percentage of reimbursement for each type of dental service and calendar-year maximum.

Maximum Reimbursements

TYPE OF SERVICE	COVERAGE LEVEL ¹	MAXIMUM BENEFIT	
		Delta Premier Network or Nonparticipating Provider	PPO Network Provider
Preventive and Diagnostic ²	100%	Combined maximum of \$1,500 per calendar year	Combined maximum of \$2,000 per calendar year
Basic	75%		
Major and Prosthodontic	50%		
Orthodontic (for covered children up to age 26)	50%	\$2,000 lifetime limit per dependent child	\$2,000 lifetime limit per dependent child

1. Percentage of PPO maximum plan allowance paid when visiting a Delta PPO provider; or percentage of Premier maximum plan allowance paid when visiting a Delta Premier or nonparticipating provider.

2. In accordance with the Affordable Care Act, maximums do not apply to preventive and diagnostic services for dependent children to age 19.

Contact Delta Dental

800-932-0783

www.deltadentalins.com

Dental Care Information Sheet

The employee Information Sheet, in conjunction with your Research Foundation Benefits Handbook, constitutes the ERISA plan and summary plan description (SPD).

When Coverage Begins

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

Break in Service

Prior to meeting the waiting period, if you incur a break in service of 28 days or more, you must meet a new waiting period. After meeting the waiting period, if you become ineligible but return to eligible employment within one year, coverage is reinstated on the date you return.

If you return to work after a one-year break in service, you must meet a new waiting period.

Annual Deductibles

The annual deductible is the amount you pay for services before payment is made by Delta Dental. There is no deductible for preventive and diagnostic services or for orthodontics.

A covered person will become eligible for reimbursement after fulfilling the individual \$50 deductible. For families, there is a maximum \$150 family deductible for all other services except orthodontic services for dependent children. When more than three family members collectively meet the \$150 family deductible (for example, five family members at \$30 each), no additional individual deductibles need to be met for the remainder of the year.

Choosing a Dentist

Participating Dentists

Delta Dental offers access to some of the largest dentist networks in the United States. In fact, four out of five dentists nationwide are contracted Delta Dental dentists, giving you convenient access to participating dentists. To find a dentist in the Delta Dental network, visit www.deltadentalins.com to search the dentist directory by location or specialty. If you do not have Internet access, you can obtain a list of dentists in your area from your campus Benefits Office or from Delta Dental.

The RF uses the Delta Dental Premier and Delta Dental PPO networks. You can use either network, but you will have a higher annual maximum benefit and enjoy greater discounts if you use the Delta PPO network.

If you use a participating dentist, you will not have to complete a claim form. All you need to provide is the ID card you received from Delta. If you do not have the ID card with you, the claim can still be

processed automatically if you provide the dentist's office with the Social Security number of the covered employee. Reimbursement is made directly to your dentist by Delta Dental for covered fees or services according to the terms of the plan. You also may print an ID card by registering on Delta's website at www.deltadentalins.com.

Nonparticipating Dentists

You have the option of seeing a dentist who is not part of Delta's network of dentists. If you do, you must complete a claim form for reimbursement of fees according to the terms of the plan. You will be required to pay any dental fees in excess of plan allowances. Claims payments will be sent to you. You may obtain claims forms from your campus Benefits Office, or you may use your dentist's claim form. Claims should be submitted to: Delta Dental, P.O. Box 2105, Mechanicsburg, PA 17055-2105.

Delta Dental Website

Visit www.deltadentalins.com to access your benefits and eligibility, print ID cards, get information about your claims, and check out Delta Dental's oral health resources.

Extended Dental Benefits After Termination of Employment or Eligibility

If your Dental Care coverage ends after dental work has begun, charges for the following treatments will be paid if they are completed within 90 days of your eligibility or employment terminating:

- Fixed bridgework, crowns, inlays, onlays and gold restorations (treatment begins the date the tooth or teeth are first prepared);
- Full or partial removable dentures (treatment begins the date the impression is taken); and
- Root canal work (treatment begins the date the tooth is opened).

Orthodontic payments do not fall within the 90-day extended dental insurance provision. However, you may continue dental coverage by paying for an extension of benefits under COBRA. Refer to *Continuing Benefits* on page 55.

How to File a Claim

Your dental claim will be treated as a post-service claim as described on page 23. See also *Your Rights Under State and Federal Laws* on page 73 for additional information.

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the plan or amend or eliminate benefits under the plan for any reason.

Vision Care

The RF Vision Care plans are designed to provide quality vision services and products at a reasonable cost. The Vision Care plans are administered by Davis Vision, Inc., a leading national administrator of vision care programs. If you elect coverage, after you have completed a six-month waiting period, Davis Vision will send you an enrollment packet, which includes an ID card and a Directory of Vision Care Plan Doctors, which provides a list of participating providers in your area.

How You and the RF Share the Cost

The RF pays 100 percent of the cost for the regular Vision plan and the RF's contribution to the Vision Plan Plus is limited to the amount it pays for the regular Vision plan. You pay your share of your coverage in the form of biweekly contributions from your paycheck. For more information about plan premiums, refer to the Benefits Bulletin, which is available on the RF Benefits website.

When Coverage Begins

You must satisfy a six-month waiting period before coverage begins. You must enroll in Basic coverage or Vision Plan Plus if you want to participate; it is not automatic.

Break in Service

Prior to meeting the waiting period, if you incur a break in service of 28 days or more, you must meet a new waiting period. After meeting the waiting period, if you become ineligible but return to eligible employment within one year, coverage is reinstated on the date you return.

If you return to work after a one-year break in service, you must meet a new waiting period.

Contact Davis Vision

800-999-5431

www.davisvision.com

Choosing a Provider

Participating Providers

Eligibility for services and your level of reimbursement are determined by whether you go to a Davis Vision provider. Participating providers will verify your eligibility for services with Davis Vision without requiring an identification card. Nonparticipating providers will require payment from you for all charges, and will then submit a claim for reimbursement to the Davis Vision Processing Unit.

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

Basic Vision Plan

1. One eye examination and one pair of plan eyeglasses (including lenses and frames) at no cost once every 24 months. This covers plastic and glass lenses; single vision, bifocal or trifocal lenses; postcataract lenses; lens tinting; and prescription sunglasses.

OR

2. One eye examination and an initial supply of contact lenses from the plan selection once every 24 months with an employee copayment of \$25. If the chosen contact lenses are not in the plan selection, there will be a \$45 allowance toward the cost.

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

Vision Plan Plus

1. One eye examination and one pair of plan eyeglasses (including lenses and frames from the Davis Vision Exclusive Collection) at no cost every 12 months. This covers plastic and glass lenses; single vision, bifocal or trifocal lenses; postcataract lenses; lens tinting; and prescription sunglasses. If you choose frames from other than the Davis Vision Exclusive Collection, you receive a \$130 allowance, plus a 20 percent discount on any amount over the allowance.

OR

2. One eye examination and an initial supply of contact lenses (up to the \$105 allowance) at no cost once every 12 months. If contact lenses are more than the plan allowance, you receive a 15 percent discount on any amount over the allowance.

Eye examinations may include dilation of the eye to screen for potentially serious health conditions such as diabetes, hypertension and nerve damage.

Nonparticipating Providers

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

Occupational Eyeglasses

Both Vision Care plans pay for an additional pair of single vision eyeglasses a covered RF employee needs for his or her job. To take advantage of this benefit, obtain the additional eyeglasses at the same time as your regular eyeglasses. There are optional frame and lens features available subject to additional fees.

Davis Vision's Exclusive Frame Collection

Davis Vision's Exclusive Frame Collection features hundreds of frames from top designer brands, including Elizabeth Arden®, GANT®, Jill Stuart®, Steve Madden®, Perry Ellis®, Candie's®, Bongo® and Harley Davidson®. Frames are available in a wide variety of styles for men, women and children. To find the nearest Davis Vision provider who carries the Exclusive Frame Collection, visit www.davisvision.com.

Laser Vision Correction

Through the plan, you and your eligible dependents can receive laser vision correction services at discounts of up to 25 percent off a participating provider's normal charges or five percent off any advertised special. (Please note that some providers have flat fees equivalent to these discounts.) Please check with the participating provider for the discount available to you.

Benefit Restrictions

The following restrictions apply:

- Coverage is only for routine eye examinations, corrective lenses and frames. Benefits for medical treatment of eye disease or injury are provided under the RF Health Care plans.
- Nonprescription lenses are not covered.
- If you want special designer frames or lenses or no-line bifocals from participating providers, you are responsible for all costs that exceed the plan allowance.
- Specialty lenses (progressive, photosensitive) and lens coatings (antireflective, scratch resistant) are available at a discounted rate.

How to File a Claim

Participating Providers

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

Contact Davis Vision to make sure that 12 or 24 months (depending on your coverage) have elapsed since you last used the benefit. Choose a participating provider from the Directory of Vision Care Plan Doctors, contact this provider, give your Social Security number and schedule an appointment. Date of birth is required for dependents. The provider will contact Davis Vision to confirm your eligibility and enrollment and to obtain approval to proceed with services.

Nonparticipating Providers

Before scheduling an appointment with a nonparticipating provider, contact Davis Vision to make sure that 12 or 24 months (depending on your coverage) have elapsed since you last used the benefit. At the time of the exam you must pay for services and obtain a receipt. Contact Davis Vision to obtain a Direct Reimbursement Claim form. After your prescription has been filled, you also must obtain a receipt for your eyeglasses. Submit the receipts for the exam, lenses and frames together to Davis Vision for reimbursement at the same time.

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

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

Vision Care Benefit Description

You should receive a Vision Care Plan Benefit Description from your campus Benefits Office. This Davis Vision Benefit Description, in conjunction with your Research Foundation Benefits Handbook, constitutes the ERISA plan and summary plan description (SPD).

Dividing Services Between Nonparticipating and Participating Providers

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

Claims Appeal Process

Vision Care claims are treated as post-service claims as described on page 23. You may check the status of your claim payment at any time by contacting Davis Vision.

If you disagree with the amount reimbursed, you may initiate an appeal directly with Davis Vision. First, compare the payment against allowable Vision Care expenses as outlined in this handbook. If the reimbursement you received is unclear, call Davis Vision for an explanation.

Davis Vision may require you to provide additional information to substantiate your claim. You may contact your campus Benefits Office for assistance in resolving your appeal.

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the plan or amend or eliminate benefits under the plan for any reason.

Coordinating Your Benefits

The RF Health Care and Dental Care plans have rules for coordinating benefit payments when you or your covered dependents are entitled to benefits under more than one plan. (See Dental Care below.) These rules determine the order and amount of payment and are designed so that the combined payment by all plans does not exceed the actual cost of the services received. For example, if your dependent child is covered by both your plan and your spouse's plan, these rules will determine how benefits will be paid so that both plans combined do not overpay for services.

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

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

Dental Care

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

- A. The plan covering the person as an employee is primary and determines benefits before the plan covering the person as a dependent.
- B. If the person is a dependent child covered by both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year is primary. (If the parents are separated or divorced, see C below.) If both parents have the same birthday, the plan covering the parent for the longest period is primary. If the other plan does not have this rule but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.
- C. When the person is a covered dependent child of divorced or separated parents, benefits are determined in the following order:
 1. By the plan covering the parent with custody of the child.
 2. By the plan of the spouse of the custodial parent.
 3. By the plan of the noncustodial parent.

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

- D. The plan covering the person as an employee or as a dependent of an employee determines its benefits before the plan covering the person as a laid-off or retired employee or as a dependent of a laid-off or retired employee. If the other plan does not have a rule concerning laid-off or retired employees, the rules of this paragraph will not apply.
- E. If the other plan does not have rules establishing the same order as described in this section, or is a plan which is "excess" or always "secondary," the RF's plan will determine and pay its benefits in the following way:
 1. If this plan is the first to determine its benefits, it will pay without regard to coverage under the other plan.
 2. If the other plan determines its benefits first, this plan will pay any difference between what the other plan pays and the dentist's charge for the service but no more than this plan would otherwise pay according to its covered benefits.

- F. In situations not described in A through E, or when this plan is the first to determine its benefits, it will pay without regard to coverage under any other plan.
- G. When this plan is not the first to determine its benefits and there are remaining expenses which are covered by this plan, this plan will pay the difference between the other plan's benefits and this plan's benefits or the amount of remaining expenses, whichever is less.

Important Information About Your Rights Under the Plan

Women's Health and Cancer Rights Act

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

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

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

The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similar benefits. If you have any questions about this coverage, please contact the applicable benefits/claims administrator identified on page 10.

Newborns' and Mothers' Health Protection Act

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

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

Qualified Medical Child Support Order

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

Specialty Pharmacy Copay Assistance Program

The Research Foundation for SUNY is implementing a specialty pharmacy copay assistance program for PPO enrollees.

Please note that there are certain specialty pharmacy drugs that are considered non-essential health benefits under the plan and the cost of these drugs will not be applied toward satisfying the participant's out-of-pocket maximum. Although the cost of these drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the drugs will be reimbursed by the manufacturer at no cost to the participant. A listing of these drugs can be found at www.express-scripts.com.

Copays for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded copay assistance.

Disability/Income Protection

The RF provides disability, family leave and income protection benefits that replace a portion of your income when you are disabled and unable to work or you need time to care for a loved one. These benefits include Workers' Compensation, New York State Short-Term Disability Insurance, Voluntary Short-Term Disability Insurance, Paid Family Leave and Long-Term Disability Insurance.

A more complete description of these plans can be found in the certificates of insurance on the RF Benefits website, or by asking your campus Benefits Office. For insurance company contact information, refer to *Contacts* on page 10.

PLAN	WHEN BENEFITS BEGIN	WHEN BENEFITS END
Workers' Compensation	If your work-related injury or illness results in an absence from work of longer than seven consecutive days, you are eligible for income benefits on day eight. However, if the disability exceeds 14 consecutive days, the seven-day waiting period will be waived and income benefits will be paid retroactive to the first day you were unable to work.	When you are no longer disabled.
New York Short-Term Disability	There is a seven-day waiting period before these benefits begin from the first day you are unable to work because of your disability.	When you are no longer disabled, or a maximum of 26 weeks.
Voluntary Short-Term Disability	There is a seven-day waiting period before these benefits begin from the first day you are unable to work because of your disability.	When you are no longer disabled, or a maximum of 26 weeks.
Paid Family Leave	After 26 weeks if 20+ hours/week OR After 175 days worked if less than 20 hours/week	After you have received 12 weeks of benefits under the plan.
Long-Term Disability	Benefits begin 180 days after your disability begins.	The length of time benefits are paid while you are disabled depends on your age when the disability began. (Refer to the chart on page 37.)

Workers' Compensation

Workers' Compensation through Chubb Insurance Company provides partial income replacement as well as payments for medical expenses if you miss work due to an on-the-job injury or illness. It also provides death benefits for your surviving spouse and eligible dependents.

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

You have the following options regarding the use of leave accruals and Workers' Compensation benefits:

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

Coverage Continuation During a Disability

The Health, Dental and Vision Care benefits and life insurance coverage in effect when you become disabled will continue while you are receiving income replacement benefits for a total disability, subject to the terms of those plans. Refer to *Continuing Benefits* on page 55 for more information.

How to File a Claim

If you are accidentally injured at work or experience a work-related illness, immediately report the incident to your supervisor who should notify your campus Benefits Office. Your campus Benefits Office will report claims to the insurance company.

Claims Appeal

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

If within 45 days of filing your claim you do not receive benefits and do not receive a notice of rejection (form DB-451), promptly contact your campus location.

Sick Leave Credit

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

New York State Short-Term Disability

In accordance with New York state law, this plan pays a benefit for up to 26 weeks within a 52-week period (after the later of a seven-day waiting period or of sick leave being exhausted) if you are unable to work because of an off-the-job illness or injury.

Benefits are 50 percent of your average weekly salary, up to the maximum benefit allowed under the New York State Disability Benefits Law. The RF pays the premium for this coverage, so benefits paid to you are taxable.

Benefits under this plan will continue until your physician approves your return to work, up to 26 weeks. However, you may only supplement disability payments with leave accruals (or charge sick leave) through the end of your appointment. (Medical care claims should be submitted to your health insurance carrier.) If you are eligible for leave under the Family and Medical Leave Act (FMLA), the period of time you are out for that leave runs concurrently with the time period under New York State Short-Term Disability.

To maintain your income level prior to disability, you may receive a New York State Short-Term Disability weekly benefit and charge partial vacation leave accruals, provided you remain employed by the RF.

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

Coverage Continuation During a Disability

The Health, Dental and Vision Care benefits and Basic Life insurance coverage in effect when you became disabled will be continued for the period of time during which partial income replacement is received through New York State Short-Term Disability insurance, subject to the terms of those plans. You may elect to continue your Optional Life insurance (if applicable) by paying the full, biweekly premium. Refer to *Continuing Benefits* on page 55 for more information.

Contact Chubb Insurance Company

- Call your campus Benefits Office
www.wcb.ny.gov (Click on "Workers")

How to File a Claim

If your disability absence will exceed seven calendar days, contact your campus Benefits Office to get the documents and information necessary to obtain disability income. You and your physician should complete a New York State Disability Claim form (DB-450) and file it with your campus Benefits Office.

Claims Appeal

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

If within 45 days of filing your claim you do not receive benefits and do not receive a notice of rejection (form DB-451), promptly contact any office of the Workers' Compensation Board.

Voluntary Short-Term Disability

The RF offers eligible employees the option to purchase Voluntary Short-Term Disability coverage through The Standard Insurance Company (The Standard) to supplement benefits provided under the New York State Short-Term Disability Benefits Law.

If you are eligible for this plan, you may purchase a weekly benefit in \$100 increments not to exceed the lesser of \$2,000 or 60 percent of your salary. All available sick leave benefits must be exhausted before benefits are payable under this plan. The benefit is offset by the benefits provided under New York State Short-Term Disability, but the benefit will never be less than \$25 a week. The rates for the coverage reflect this offset. The benefit also may be subject to other offsets, which are described in detail in the Certificate of Coverage. Since coverage is purchased on an after-tax basis, benefits under this plan are not subject to taxation.

Eligibility

This program is available to all postdoctoral, non-student, salaried employees who have been with the RF for at least 28 days and whose annual salary is at least \$15,000. Employees must also be actively at work when the coverage goes into effect and be working at least 50 percent of full time to be eligible for the plan. If you enroll for the plan within your initial eligibility period, you are guaranteed coverage without medical examinations or questions and will not be subject to any pre-existing condition exclusions. Late enrollees will be subject to pre-existing condition exclusions.

When Coverage Ends

Coverage under this plan ends on your last day of employment or eligibility.

How to Enroll

Contact your campus Benefits Office for an enrollment kit, or enroll using Employee Self Service (see page 8).

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the plan for any reason.

Contact The Standard

800-426-4332

www.standard.com

Paid Family Leave

New York Paid Family Leave (PFL) provides job protection and income replacement to eligible employees who need to be away from work for the following reasons:

- To take care of a seriously ill family member (spouse, domestic partner, child, parent, parent-in-law, grandparent, grandchild, sibling);
- To bond with a newborn, adopted or foster child in the first 12 months after birth or placement; or
- To attend to family issues related to a qualifying military deployment.

When practicable, you must provide 30 days notice when the leave is foreseeable.

The New York PFL benefit is 67 percent of your average weekly wage (AWW), not to exceed 67 percent of the New York State AWW, which is currently \$1,718.15, for a maximum of 12 weeks.

You may use appropriate accruals while on leave and should discuss this option with your campus Human Resources representative.

Eligibility

If you work 20 or more hours per week, you are eligible for coverage after 26 consecutive weeks of employment. If you work less than 20 hours per week, you are eligible after completing 175 days worked. You must work in New York State to be eligible for this benefit.

Waiver Options

If your appointment meets (or is expected to meet at the time of hire) the eligibility criteria, you cannot opt out of the program and payroll deductions. In rare circumstances, you may opt out of the program if you will never meet the eligibility criteria. If you do not believe you have met, or will ever meet, the eligibility criteria listed above, then you may submit a waiver form to opt out of the program and payroll deductions. Waivers will be reviewed and approved by the campus Human Resources Department. If you opt out of payroll deductions and subsequently meet the eligibility criteria, then payroll deductions that were missed will need to be paid retroactive to your date of hire. The waiver form is located at <https://www.ny.gov/sites/ny.gov/files/atoms/files/PFLWaiver.pdf>.

Your Cost for the Program

The state has mandated that all employees will pay for this coverage through payroll deduction at a rate which is currently .373 percent of weekly earnings and will be capped at \$333.25 annually.

Coordinating With Other Programs

PFL and FMLA

The federal Family and Medical Leave Act (FMLA) provides job-protected leave for many of the same reasons as PFL. Because the new law shares many of the same requirements and definitions as the FMLA, in most cases the two leave of absence programs will be applied concurrently, not one after the other.

Changes to FMLA

The RF uses a look back method for determining FMLA availability. For those who are eligible, this means that the RF will look back over the last 12 months prior to the effective date of an FMLA request. Any FMLA used during that period will be deducted when determining the balance available for the current request. Eligible employees can take intermittent FMLA leave for the birth or placement of a child.

PFL and Disability

PFL will never run concurrently with New York State mandated disability benefits (DBL), which provide a benefit when you need to miss work because of your own disabling illness or injury. PFL only comes into play when you need to miss work to care for someone else. Eligible employees can use a maximum of 26 weeks of PFL and disability in a 52-week period.

To Apply for Benefits

Contact your campus Human Resources Office

Long-Term Disability

Long-Term Disability (LTD) insurance through The Standard replaces 60 percent of your regular monthly salary, up to a maximum of \$7,500 per month, if a certified total disability prevents you from working for more than 180 continuous days. For purposes of the plan, your monthly salary is one-twelfth of your projected annual salary at the time you become unable to work because of the disability, prior to any voluntary deductions or deferrals, such as for retirement or health insurance plans. Overtime and other forms of compensation are not included in regular monthly salary.

The length of time benefits are paid while you are totally disabled depends on your age when the disability began, as shown in the following table:

AGE WHEN DISABILITY BEGAN	MAXIMUM BENEFIT PERIOD/AGE WHEN BENEFITS END*
59 or younger	to age 65
60 through 64	five years
65 through 68	to age 70
69 or older	one year

** Benefits will not be paid for more than 24 months if disability is due to alcoholism and/or drug abuse.*

Eligibility

Full-time RF employees (scheduled to work 37.5 or 40 hours per week), excluding summer, graduate and undergraduate student employees, are eligible. Once you become eligible, you are automatically enrolled in the plan at no cost to you.

When Coverage Begins

Coverage begins automatically on the first day following one year of continuous full-time service.

Break in Service

Prior to meeting the one-year waiting period, if you incur a break in service of four months or more, you must meet a new waiting period.

After meeting the one-year waiting period, if you become ineligible but return to eligible full-time employment within one year, coverage is reinstated on the day you return.

If you return after a one-year break in service, you must meet a new waiting period.

Contact The Standard

800-426-4332

www.standard.com

What Is a Total Disability?

During the period before benefits begin under the LTD plan, and for the following 24 months, total disability is defined as the inability to perform the material duties of your regular occupation. After that period, you are considered disabled only if you are unable to perform the material duties of any occupation for which you are reasonably qualified by education, training or experience.

You must be under the regular care of a physician, other than yourself or a member of your family. Benefits will not be paid if the total disability is caused by commission of a felony, an act of war or by an intentionally self-inflicted injury. If the disability is due to alcoholism or drug addiction, you will be required to participate in rehabilitation, and benefits will be limited to 24 months unless you are confined to a hospital.

Benefit Reductions

Your LTD benefits are reduced by any income benefits you receive from Voluntary Short-Term Disability, Workers' Compensation, retirement plans, sick leave or other wages, and actual or estimated Social Security. You must notify The Standard if you receive any income benefits in addition to your Long-Term Disability benefits.

Benefit reductions based on estimated Social Security benefits will continue until The Standard receives a final written decision from the Social Security Administration regarding your application for Social Security benefits. The Standard can assist you with your application and any appeals, and will make adjustments to your benefits, if needed, when it receives the final written decision.

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

Work Incentive Benefit

The Standard will not offset earnings from the first 12 months of rehabilitative employment until the sum of: 1. the monthly benefit prior to other income benefit offsets and 2. earnings from rehabilitative employment exceeds 100 percent of your covered monthly earnings. If that sum exceeds 100 percent of covered monthly earnings, your benefit amount will be reduced until the sum of 1. and 2. equals 100 percent.

Coverage Continuation During a Disability

The Health, Dental and Vision Care benefits and life insurance coverage in effect at the time you became disabled will be continued based on your date of employment. Refer to *Long-Term Disability* on page 56 for more information.

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the plan or amend or eliminate benefits under the plan for any reason.

How to File a Claim

If your disability is expected to last more than six months, you will receive information and an LTD application from the RF Office of Human Resources. If you do not receive this information by the fourth month of your disability and you expect to be disabled for more than six months, contact your campus Benefits Office.

You must promptly complete the application when you receive it and send it to The Standard. You will receive notice of the plan's decision within a reasonable period of time, not to exceed 45 days after receipt of your claim by The Standard, unless you receive notice within that first 45-day period that an extension of not more than an additional 30 days is necessary due to matters beyond the control of the plan. If, prior to the expiration of the first 30-day extension, a decision cannot be made within the extension period, the decision period may be extended for an additional 30 days, provided that the notice of extension is made before the end of the initial 30-day extension period and explains the circumstances requiring the extension and the date the plan expects to render a decision, the standards on which entitlement is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will have at least 45 days to provide any required information.

Claims Appeal

If your request is denied or you are not satisfied with the response, you may ask for a review. Write directly to The Standard within 60 days of receiving your answer. You or your duly authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. For this purpose, information will be considered relevant if it was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination without regard to whether such document, record or other information was relied upon in making the determination; provides any guidance or statement of policy pertaining to the denied benefit; or demonstrates consistency in the application of the policy or standard.

You are encouraged to submit issues and comments to The Standard. You will receive a decision in writing on the review within 45 days.

If special circumstances require a delay on a request or question, The Standard will notify you before the end of the initial 45-day determination period. The maximum extension period for the determination is an additional 30 days, allowing for a maximum of 75 days. The notice will contain the elements described above, such as the reasons for the delay and when you can expect a decision.

Retirement Contributions During a Disability

If you are vested in the Basic Retirement plan at the time you become disabled, The Standard will make contributions to your annuity contract and/or mutual funds while you are receiving LTD payments. The contribution will be allocated to TIAA in the same proportion as when your disability began. You may change your allocation at any time by calling TIAA or using their website (www.tiaa.org/rfsuny). For more information, refer to *Continuing Benefits* on page 55.

Life Insurance

The RF's life insurance benefits for active employees offer important financial protection by helping you provide for your dependents if something were to happen to you.

Basic Life and Accidental Death and Dismemberment Insurance

Basic Life and Accidental Death and Dismemberment Insurance (Basic Life) pays a \$50,000 benefit to your beneficiary upon your death from any cause. Upon becoming eligible, you will automatically be enrolled in this plan at no cost to you. The RF pays the entire cost of this coverage.

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

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

Eligibility

You are eligible for Basic and Optional Life if you are working at least 50 percent of full time on a postdoctoral appointment and have completed six months of service.

How to Enroll

Once you are eligible, enrollment in Basic Life is automatic.

Break in Service

Prior to meeting the waiting period, if you incur a break in service of 28 days or more, you must meet a new waiting period. After meeting the waiting period, if you become ineligible but return to eligible employment within one year, coverage is reinstated on the date you return.

If you return to work after a one-year break in service, you must meet a new waiting period.

Contact Securian Life Insurance Company

877-491-5265

www.securian.com

Basic Life Summary Plan Description

The Basic Life and Accidental Death and Dismemberment Insurance plan is subject to ERISA. The Certificate of Coverage, together with this Research Foundation Benefits Handbook, constitutes the plan and the summary plan description (SPD) for these benefits.

Optional Life and Accidental Death and Dismemberment Insurance

You can purchase additional coverage over and above the Basic Life amount through the Optional Life and Accidental Death and Dismemberment Insurance plan (Optional Life). If you elect coverage for yourself within your initial eligibility period (60 days after your date of hire or date of eligible employment), you will not need to provide proof of good health. Premiums for this coverage are paid on an after-tax basis through payroll deduction.

During the 2022 open enrollment, you have a one-time opportunity to elect or increase your voluntary term life insurance equal to 1 X earnings without answering health questions.

Optional Life benefits are paid to your beneficiary upon your death. You indicate the amount of optional coverage you wish to purchase when you enroll online or complete the RF Benefits Enrollment form.

Employee Coverage

Your Optional Life coverage can equal one, two, three, four, five, six, seven or eight times your annual salary, rounded to the next higher \$1,000 not to exceed \$500,000. Therefore, the combined maximum coverage limit for both Basic and Optional Life is \$550,000 per employee.

Your Optional Life benefits are reduced, beginning at age 70, in the same way as they are for the Basic Life benefit.

Spouse/Domestic Partner Coverage

You may purchase Optional Life coverage for your spouse/domestic partner. (If you are eligible for Optional Life as an employee, you cannot be covered as a spouse/domestic partner.) Premiums are paid on an after-tax basis through payroll deduction.

Coverage amounts for a spouse/domestic partner are as follows:

- \$10,000, • \$60,000,
- \$20,000, • \$80,000 or
- \$40,000, • \$100,000.

Proof of good health is required for amounts of \$40,000 or higher and for any amount if you elect coverage later than 60 days after completing your waiting period, getting married or establishing a domestic partnership. Domestic partners must meet the eligibility requirements listed in the Health Care section of this handbook. Coverage purchased for a spouse or domestic partner cannot exceed the amount of your employee coverage. Spouse/domestic partner coverage is subject to the Hospitalization/Confinement Provision.

Child Coverage

You may purchase Optional Life coverage for your eligible dependent children. If both parents are RF employees, the child can be covered by only one parent. (If you are eligible for Optional Life as an employee, you cannot be covered as a dependent child.) One premium provides coverage for any number of dependent children. Premiums are paid on an after-tax basis through payroll deduction.

Coverage amounts for eligible dependent children are as follows:

- \$2,000, • \$6,000, • \$10,000.
- \$4,000, • \$8,000 or

Proof of good health is never required for child coverage, but this coverage can only be elected during an employee's or child's initial eligibility period, during a special enrollment period, or within 31 days of a qualified status change. Child coverage is subject to the Hospitalization/Confinement Provision.

Eligibility

You are eligible for Optional Life if you are working at least 50 percent of full time on a postdoctoral appointment. If you are not actively working due to sickness or injury on the date coverage (or any coverage increase) is supposed to take effect, the coverage (or increase) will be delayed until you return to active work.

How to Enroll

Enrollment in Optional Life (for employee or dependent) is not automatic. You or your spouse/domestic partner must enroll within 60 days after initial eligibility. Otherwise, a Statement of Health must be completed for the insurance company's review. The insurance company will either approve or deny your request for coverage.

Hospitalization/Confinement Provision

If a dependent is hospitalized or confined on the date coverage would otherwise become effective, the effective date will be delayed until the dependent is released from the hospital/confinement. This provision does not apply to a newborn child.

Break in Service

Prior to meeting the waiting period, if you incur a break in service of 28 days or more, you must meet a new waiting period. After meeting the waiting period, if you become ineligible but return to eligible employment within one year, coverage is reinstated on the date you return. If you return to work after a one-year break in service, you must meet a new waiting period.

About AD&D

Accidental Death and Dismemberment (AD&D) benefits are provided in addition to your Basic Life and Optional Life coverage. Your covered dependents also are eligible for AD&D.

AD&D pays a benefit of the same dollar amount as Basic Life and Optional Life coverage. For example, if you have \$200,000 in Basic Life and Optional Life coverage, that amount (the “principal amount”) is also paid for AD&D benefits. Payment will be made to your beneficiary. Benefits apply only if dismemberment or death results from an accident that occurs while the individual is insured. The dismemberment or death must occur within 365 days of the accident.

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

- Half the principal amount of the insurance will be paid to you for a total and permanent loss of one hand, foot or sight in one eye; or
- The full principal amount of insurance will be paid for the loss of two or more of the above.

Additional amounts (up to \$10,000) are paid if accidental death occurs when seat belts or seat belts and airbags were in use at the time of the accident.

AD&D Coverage Exclusions

In no event will an AD&D benefit be paid if the covered person’s death or dismemberment is caused directly or indirectly by, results from, or where there is a contribution from, any of the following:

- Self-inflicted injury or self destruction, whether sane or insane;
- Suicide or attempted suicide, whether sane or insane;
- The covered person’s participation in or attempt to commit a crime, assault, felony or any illegal activity, regardless of any legal proceedings or the absence of any legal proceedings;
- Bodily or mental infirmity, illness or disease;
- The use of alcohol, drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected, unless taken upon the advice of a licensed physician in the verifiable prescribed manner and dosage;
- Motor vehicle collision or accident where the covered person is the operator of the motor vehicle and his or her blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings or the absence of any legal proceedings;

- Travel in or descent from any aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight on a licensed passenger aircraft carrier;
- War or any act of war, whether declared or undeclared; or
- Service in the armed forces or auxiliary units, except as provided under the Reserve-National Guard benefit.

Accelerated Death Benefit

If you have a life expectancy of 12 months or less, you can request a full or partial accelerated death benefit from your Basic Life and Optional Life coverage. Similarly, if your insured spouse/domestic partner or child has a life expectancy of 12 months or less, you can request an accelerated death benefit from the dependent’s coverage.

To qualify for an accelerated benefit, you or your covered dependent must:

- Have not assigned ownership rights under the coverage,
- Not have an irrevocable beneficiary and
- Be terminally ill (life expectancy of 12 months or less).

An accelerated benefit will be made available on a voluntary basis only. An accelerated benefit under this supplement is not intended to cause an involuntary reduction of the death benefit ultimately payable to the named beneficiary. Therefore, payment of the death benefit cannot be accelerated under this supplement if the covered person:

- Is required by law to use this option to meet the claims of creditors, whether in bankruptcy or otherwise; or
- Is required by a government agency to use this option in order to apply for, obtain or keep a government benefit or entitlement.

Partial Accelerated Benefit

If you qualify, you may choose a partial accelerated benefit. If a partial benefit is chosen, the covered person’s coverage will remain in force minus the amount that was accelerated.

Full Accelerated Benefit

If a full benefit is paid, the covered person’s coverage will end. If your employee life coverage ends due to taking a full benefit, then any coverage on your dependents will also end at that time, though they will have the right to convert to an individual policy as described in the *If Your Coverage Ends (Policy Conversion)* section on page 41.

Designating Your Beneficiaries

When you enroll via Employee Self Service or complete the RF Benefits Enrollment form for Basic Life and AD&D insurance at the beginning of employment or eligibility, you must designate a primary beneficiary (complete Part E) and, if you wish, a contingent beneficiary. You also may name more than one primary and contingent beneficiary. The beneficiaries will receive a benefit payment upon your death. The contingent beneficiary will receive the benefit if your primary beneficiary is deceased.

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

If you name more than one beneficiary, you must specify in fractions or percentages (rather than dollar amounts) the portion payable to each beneficiary. If you do not specify portions, each beneficiary will share equally in the benefit. Refer to How Benefits Are Paid for information and a schedule of payments to your designated beneficiary(ies). You can also designate a beneficiary using Employee Self Service (see page 8).

Changing Your Beneficiaries

You may change your beneficiary designation at any time by using Employee Self Service, or by completing a new RF Benefits Enrollment form and submitting it to your campus Benefits Office. The effective date of the change will be the day you signed the form but will not affect any payment made by Securian Life before receiving notice of your change.

How Benefits Are Paid

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

- Payment will be made to the primary beneficiary(ies) in the manner indicated when you enrolled.
- If no primary beneficiary is living, benefits are paid to the contingent beneficiaries.
- If the beneficiary is a minor, application for benefits must be made by the court-appointed guardian of the minor's property. Securian will require a notarized copy of the guardianship appointment prior to payment of the benefit.
- If you do not name a beneficiary, or if there is no eligible beneficiary, benefits will be paid in the following order of priority:
 1. Your lawful spouse, if living;
 2. Your natural or legally adopted child(ren) in equal shares, if living;
 3. Your parents in equal shares, if living;
 4. Your brothers and sisters in equal shares, if living;
 5. The personal representative of your estate.

Filing a Claim

Basic Life and Optional Life

In the event of your death, your survivors should contact your campus Benefits Office, which will provide assistance in the claims process. Securian will review and approve claims.

AD&D

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

Accelerated Death Benefit

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

Claims Appeal

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

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

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

If a written notice of denial of a claim is received, the claimant may file a written request with the claims administrator that it conduct a full and fair review of the denial of the claim for benefits. A written request for a review of a denied claim must be made within 60 days after the receipt of the written notice of denial of the claim. The written request for review should state why the claimant believes the claim should not have been denied, and should describe any documents, data or other information that may have a bearing on the claim. A claimant shall have the right to review pertinent documents affecting his or her claim and to submit additional information or comments. A claimant also shall have the right to be represented.

Securian shall deliver to the claimant a written decision on the claim within 60 days after the receipt of the request for review. The period for delivering this decision may be extended for up to an additional 60 days, if necessary, provided Securian notifies the claimant of the extension within the initial 60-day period. The decision shall:

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

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

If Your Coverage Ends (Policy Conversion)

If coverage ends for you or an insured spouse/domestic partner or child because of loss of eligibility under the group policy, coverage may be continued for up to 12 months by paying premiums directly to Securian. At the end of the 12-month continuation period, the covered person may convert coverage to an individual life insurance policy. Refer to your Certificate of Insurance, or contact Securian at 877-491-5265 for more information regarding continuation options, including portability and conversion.

Right to Amend or Terminate the Plan

The Plan Sponsor reserves the right, at any time, to amend or terminate the plan or amend or eliminate benefits under the plan for any reason.

Certificate of Insurance

Securian's Certificate of Insurance, which provides details about the RF's Group Life and AD&D Insurance plan, is available on the RF Benefits website (www.rfsuny.org/benefits), or from your campus Benefits Office.

Retirement

The RF retirement plans are designed to provide you with income during your retirement. In the Basic Retirement plan, the RF contributes an amount equal to a percentage of your annual earnings. You do not contribute to this plan. The Optional Retirement plan assists you in saving additional funds for your retirement years by allowing you to contribute a portion of your pay to the plan on a pre-tax or Roth after-tax basis. The Deferred Compensation plan allows employees with certain job titles and earnings to supplement their retirement savings by deferring a portion of their compensation.

Online Account Management

You can make changes to your Basic and Optional Retirement accounts at www.tiaa.org/rfsuny. First-time users will need to set up an online account by clicking "Register for Access."

On the website, you can change your default investment in the Basic or Optional Retirement plan even before you start your contributions through payroll deductions or you start receiving RF contributions. You also can select a beneficiary and change your investment options under the Basic or Optional Retirement plan at any time without having to complete a form.

Contact TIAA

800-842-2252

www.tiaa.org/rfsuny

Basic Retirement Plan

The Research Foundation for the State University of New York Retirement Plan (Basic Retirement plan) is a defined contribution plan designed to satisfy the requirements of Section 401(a) of the Internal Revenue Code (IRC). The RF contracts with TIAA to provide services under this plan. TIAA serves employees in the academic, medical, research and cultural fields with financial products and services.

Eligibility

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

- Full-time SUNY students employed in a specific RF student title; however, student service as an RF employee will be considered toward the waiting period if the student is subsequently appointed as a postdoctoral RF employee, and before incurring five consecutive one-year breaks in service;
- Leased employees; and
- Persons engaged as independent contractors.

Research Foundation Contributions

After you complete the one-year waiting period, the RF will make contributions to your Basic Retirement plan account. These contribution amounts will be equal to a percentage of your annual earnings (as described under Contribution Rate below). According to IRS rules, the RF may make contributions on up to a certain dollar limit of annual earnings (\$345,000 in 2024), adjusted annually by the IRS for inflation.

In addition, Section 415 of the Internal Revenue Code limits the total annual contribution that can be made to a retirement plan to the lesser of a certain dollar limit (\$69,000 in 2024) or 100 percent of your compensation.

Finally, the IRS requires that contributions do not discriminate in favor of highly compensated employees. If your contributions are affected by the nondiscrimination rules, you will be notified.

Contribution Rate

Contributions will be made according to the criteria below:

- **Tier 1** (*Hired before January 1, 1981*) — 12 percent of the first \$16,500 of annual earnings and 15 percent of annual earnings exceeding \$16,500.
- **Tier 2** (*Hired on or after January 1, 1981, and before July 1, 1992*) — 12 percent of annual earnings.
- **Tier 3** (*Hired on or after July 1, 1992, and before July 1, 1994*) — Nine percent of the first \$16,500 of annual earnings and 12 percent of annual earnings exceeding \$16,500.
- **Tier 4** (*Hired on or after July 1, 1994, and before January 1, 2018*) — Eight percent of earnings until you complete seven years of RF eligible service, and 10 percent of earnings thereafter. The first year of eligible service must include 975/1,000 hours of service, with at least one of those hours in a postdoctoral appointment. Each subsequent anniversary year in which you are appointed for one hour or more of eligible non-student service will count as one year of service. An anniversary year in which you do not work at least one hour of service will result in elimination of previously credited service. When you have completed seven years of service according to these rules, contributions will increase to 10 percent. Contributions will continue at 10 percent as long as you remain active in Tier 4.
- **Tier 5** (*Hired on or after January 1, 2018*) — Seven percent of annual earnings.

You will receive notification once you reach the hours requirement for the one-year waiting period. This notification will also inform you of the default investment funds and beneficiary. TIAA will send your contract information directly to you. If you decide you want something other than these default options, you can visit www.tiaa.org/rfsuny prior to your first contribution and enroll in the investment funds of your choice and/or name your beneficiary. Once you have an online account and/or receive your account information, you can redistribute your balance and direct future contributions to any fund offered by the plan and change your beneficiary.

Your W-2 Tax Statement

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

Acceptance of Eligible Rollover Distributions

You may roll over into the Basic Retirement plan an eligible distribution from another employer's eligible retirement plan, your Individual Retirement Account or an individual retirement annuity (other than after-tax contributions or designated Roth contributions). You must request a direct rollover from the distributing plan or make an indirect rollover within 60 days of receipt of the eligible rollover distribution. Contact TIAA for more information.

Directing Your Investment

Once you have begun your participation in the plan, contributions will be invested in a target retirement date fund that is designed for your age and an estimated retirement age of 65. Your beneficiary will be your estate unless you name another beneficiary. You can redirect the investment of contributions at any time and may divide your contributions among the funds offered in any whole percentage.

Go to www.tiaa.org/rfsuny or call TIAA at 800-842-2252. If you do not enroll with TIAA, your default investment will be a target retirement date fund that is designed for your age and an estimated retirement age of 65. Your beneficiary will be your estate.

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

Note: If you received your contract prior to January 1, 2007, then your contract is not a group retirement annuity (GRA) contract. It is an individual Retirement Annuity (RA) contract. This impacts your options at termination. Refer to *Other Payment Options From Annuity Contracts* on page 46 for more information.

Investment Options

A listing of funds available for investment can be obtained from TIAA, or go to www.tiaa.org/rfsuny.

Transferring Funds

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

Changing Your Name, Address or Beneficiary

You may change your name, address or beneficiary on your contracts by contacting TIAA. All personal information except name changes can be made online. Refer to *Selecting Your Beneficiary* on page 48 for restrictions on naming a beneficiary if you are married. Also see *Contacts* on page 10.

Quarterly Accumulation Statements and Annual Illustration

After you have vested, TIAA will send you statements indicating premiums remitted during the previous quarter and the total accumulation of your contract(s). You also can view this information online at www.tiaa.org/rfsuny and may choose to receive statements electronically by providing TIAA with an email address.

Vesting

Vesting refers to your ownership of your account. You are considered fully vested as soon as you become a participant in the plan by completing the one-year waiting period.

Employment Service Credit

Under certain circumstances, the RF recognizes employment with other organizations in meeting service requirements for participation and vesting in its retirement plan. This does not affect your contribution tier. Continuous, non-student employment with an eligible employer immediately preceding your RF appointment will be considered for qualified service credit. In order to be qualified service, your employment must have terminated no more than one year before your RF appointment and must have been with:

- An accredited college or university in the United States, including State University of New York; or

- A private, nonprofit research organization incorporated in the United States under Section 501(c)(3) of the Internal Revenue Code. The primary function of this organization must be research.

For dates of hire on or after April 1, 2000, SUNY service immediately preceding employment with the RF will be disregarded if it disadvantages an employee with a longer period of qualified service from another institution. Service with the other institution must have ended within 12 months prior to RF employment.

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

Request for Retirement Credit Based on Other Employment Service

To have your prior qualified service considered toward your retirement waiting period, complete and sign Part I of a Request for Retirement Service Credit form and have it certified by your former employer. The form is available from your campus Benefits Office. Once your prior employer completes the form, return it to your campus Benefits Office. If your request is approved by the RF, you will receive a year of service credit toward the retirement waiting period for each anniversary year you worked at least 1,000 hours (for a 40-hour workweek) of qualified service (975 hours for a 37.5-hour workweek).

Note: Forms not submitted timely may have an impact on contributions that can be remitted based on IRS regulations.

Employees are only credited with prior service if they submit an application for Prior Service Credit within the following time periods:

- For employees hired on or after January 1, 2019, an application for Prior Service Credit must have been submitted no later than six months from the Employee's Employment Commencement Date.
- For employees hired prior to January 1, 2019, an application for Prior Service Credit must have been submitted no later than September 30, 2019.
- Terminated employees are not permitted to submit an application for Prior Service Credit.
- For employees with Summer Appointments, submission of the Prior Service Credit application is accepted. Credit will be processed based on current appointment date.

When You Leave the Research Foundation

Before You Satisfy the Waiting Period

If you have not met the waiting period and leave RF employment, you will incur a break in service if you are credited with less than 500 hours of service in an anniversary year. If you have five consecutive one-year breaks in service, you will lose all past service credit toward the waiting period. You will begin a new waiting period if you return to eligible employment. If you return to employment before incurring five consecutive one-year breaks in service, you will retain all past service credit.

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

After You Are Vested

Once you are vested, your benefits cannot be taken away. The funds in your contracts continue to share TIAA earnings/losses, even if no further contributions are made. However, if your total balance is more than \$1,000 but no more than \$7,000, the plan will request that TIAA roll over your balance to an Individual Retirement Account (IRA) with Bancorp, unless within the time specified by TIAA, you elect a cash payment or a direct rollover to another retirement plan or IRA of your choosing. If your total balance is \$1,000 or less, TIAA will pay this amount to you upon your termination unless within the time specified by TIAA you elect a cash payment or a direct rollover to another retirement plan or IRA. If you return to eligible RF employment at some future date, you will immediately return to plan participation without a waiting period. Contributions will be invested according to your most recent fund allocation. If your contracts were settled (cashed out or annuitized), the default investment will be a target retirement date fund appropriate for your age, but you can change the investment at any time.

Certified Disability

If you are unable to work because of a medically certified disability and are no longer on the RF payroll, you will continue to be credited with hours of service based on the percent of effort you were working at the time you became disabled for the rest of your disability period. These hours will be counted, if needed, to ensure that you are credited with a maximum of 1,000 hours (or 975 hours for a 37.5-hour workweek) in that year.

Military Leave

Retirement contributions cease when you go off the payroll while on military leave. If you return to active

employment following military leave, military service qualifying under the Uniformed Services Employment and Re-employment Rights Act (USERRA) will be credited toward eligibility and vesting service. Retroactive contributions will be made to the Basic Retirement plan for the period of military service.

Family and Medical Leave (FMLA)

If you are on an approved leave of absence under the Family and Medical Leave Act, you will be credited with up to 501 hours of service in one anniversary year, if needed, to prevent a break in service.

How Benefits Are Paid

TIAA will provide you with assistance in selecting distribution option(s) in settlement of annuity contracts and mutual fund accounts.

The normal retirement age is 65; however, you can receive a distribution at any age following termination from employment with the RF. The RF provides your termination data electronically and does not require authorization unless your paperwork is received by TIAA before our electronic submission. Retirement funds can be collected in one of the forms specified provided you meet the criteria shown in the following payment options. Income from each TIAA and CREF contract may begin on multiple dates using any combination of payout options, provided at least \$10,000 of accumulation is specified for each starting date and option you choose. The time period selected for a fixed-period option cannot exceed your life expectancy based on TIAA tables.

Benefits Payments From Mutual Funds

Balances in mutual funds may either be withdrawn in full at retirement, withdrawn periodically or converted to an annuity. Mutual funds withdrawn at termination of employment but before age 59½ have tax implications as described later in this section.

Normal Form of Payment From Annuity Contracts

If you are married on the date you commence to receive payments under the Basic Retirement plan, the payment will be in the form of a two-life annuity with your spouse as the second annuitant unless your spouse consents to another payment form in writing during the 180 days preceding the date annuity benefits begin. This consent can be revoked only during the same 180-day period. It cannot be revoked after benefits begin.

Annuity Payment Options

A quarterly illustration from TIAA provides an estimate of the single-life annuity income you will receive based on certain factors and assumptions, such as future earnings and retirement age. Upon request, TIAA will prepare a personal estimate of annuity income based on your specifications (for example, age at retirement and projected salary increases). The TIAA website has many tools to help you obtain these types of estimates.

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

A Single-Life Annuity pays you an income for as long as you live. All payments stop at your death. Payments will not be made to a beneficiary unless you select a guaranteed period. With a guaranteed period feature, if you die before the end of the guaranteed period you selected (10, 15 or 20 years), payments will continue to your beneficiary for the remainder of the guaranteed period. The guaranteed period may not exceed your life expectancy.

A Two-Life Annuity pays you and your annuity partner income for as long as either of you live. Payments may be continued to a different beneficiary by electing a guaranteed period feature. With a guaranteed period feature, if you and/or your annuity partner die before the end of the guaranteed period you selected (10, 15 or 20 years), payments will continue to your beneficiary for the remainder of the guaranteed period. The guaranteed period may not exceed your joint life expectancy.

The payment amount continuing after your death or the death of your annuity partner depends on which of the following benefit payment options is chosen:

- **Full benefit to survivor:** The benefit payment does not change at the death of the first person.
- **Two-thirds benefit to survivor:** The benefit payment is reduced to two-thirds of the original amount at either your death or the death of your annuity partner.
- **Half-benefit to second annuitant:** The benefit payment to you (the former employee) is never reduced. The benefit payment to your annuity partner is reduced to one-half the original amount at your death.

Other Payment Options From Annuity Contracts

Refer to *Making a Cash Withdrawal and Tax Implications* on page 47 for more information.

A Cash Option allows you to receive your accumulations from your TIAA Real Estate Account, any mutual funds and any CREF accounts in one or more lump-sum

payments. This may include systematic withdrawals where you design your own periodic payment plan. If your contributions are being made to a GRA contract, then you also have the option to cash out your TIAA Traditional Annuity within 120 days of your termination of employment (a surrender charge of 2.5 percent applies). After 120 days have elapsed since your termination of employment, this payment option under a GRA contract is no longer available. This option pertaining to the TIAA Traditional Annuity is not available under the Retirement Annuity (RA) contract.

The TIAA Transfer Payout Annuity (TPA) Option allows you to receive your TIAA Traditional Annuity accumulation in 10 annual installments over a nine-year period, if you are terminated from RF employment. After your death, any remaining balance will be paid to your beneficiary. While you are actively employed by the RF, you may transfer your TPA to other funds offered in the RF plans.

The Retirement Transition Benefit allows you to receive a cash payment of up to 10 percent of your TIAA or CREF accumulations at the time you start annuity income.

The TIAA Interest Only Option allows you to receive interest income payments from your TIAA Traditional Annuity, while leaving the principal amount intact, if you are terminated from RF employment. This option may be discontinued only by converting to another annuity option or to the Minimum Distribution Option (MDO). Refer to When Distribution Must Begin below.

The Minimum Distribution Option (MDO) is available to participants who are at least age 73. It allows you to collect the minimum amount required under IRS regulations, while delaying selection of a lifetime annuity income. You must begin receiving income by April 1 following the calendar year in which you turn age 73 (or 75 if you reach age 74 after 2032). Refer to When Distribution Must Begin below.

Full and partial cash withdrawals, systematic withdrawals and the TIAA TPA Option may require authorization by your campus Benefits Office in order to confirm that your employment has ended.

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

When Distribution Must Begin

Federal tax law requires that the plan commence retirement income distributions by April 1 of the calendar year following the later of:

- The calendar year in which you reach age 73 or
- The calendar year in which you terminate RF employment.

Failure to do so will result in tax penalties. **Therefore, if you do not voluntarily take the minimum required distribution, the RF will instruct TIAA to make the distribution to you in order to avoid these penalties.** This is regardless of distributions you may be taking from other retirement plans you have.

TIAA can assist you in determining your minimum required distribution amount. The required IRS minimum income can be collected using the MDO described in this section.

If you are planning to receive periodic distributions to satisfy the minimum distribution requirement, you may wish to consider beginning required distributions by December 31 of the year you attain age 73 to avoid receiving two taxable distributions in the calendar year following attainment of age 73.

If you choose to receive two taxable distributions in the same calendar year, you **must** do so using the MDO.

Benefits If You Die Before Taking an Annuity

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

Normally, your entire balance must be distributed to your beneficiary by December 31 of the tenth calendar year after your death or, if your beneficiary is not an individual, December 31 of the fifth calendar year after your death. If elected, death benefits may be payable over the life expectancy of the beneficiary, if the distribution of benefits begins no later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 73 had you lived. Note, however, that the life expectancy option is no longer available for deaths occurring after 2019, unless the beneficiary is your spouse, a child who has not reached the age of majority (as defined by the IRS), a chronically ill individual (as defined by tax laws) or disabled (also as defined by tax laws). The death distribution laws are complex. We encourage you to consult a qualified tax advisor to learn more about them.

Both spouses and non-spouse beneficiaries have the right to roll over eligible rollover distributions made at your death. A surviving spouse has the same rollover options that the participant would have had, as described elsewhere in this handbook. In addition, if a surviving spouse chooses to do a rollover to an IRA, he or she may treat the IRA as his or her own or as an inherited IRA. The

only rollover option for a payment made from the plan to a non-spouse beneficiary is a direct rollover to an inherited IRA. There are differences in the manner in which minimum required distributions must be taken from a regular and an inherited IRA. Please consult with your tax advisor for more information.

If you die after all funds have been annuitized, any additional payments will be determined by the annuity option you selected at retirement and tax laws may limit the time during which you must receive distributions in this case.. There is no death benefit if you are not vested.

Making a Cash Withdrawal and Tax Implications

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

Cash distributions are subject to ordinary income taxes and may be subject to an additional early withdrawal tax penalty. TIAA must withhold 20 percent from any benefit paid to you over a period of fewer than 10 years (including lump sums) and send it to the IRS, unless you instruct TIAA to make a direct rollover to another qualified plan or an individual retirement annuity/account. The IRS will apply the amount toward income taxes due.

If you receive a distribution from the plan before you reach age 59½ and you do not roll over the distribution, the taxable portion of your distribution is subject to a 10 percent penalty tax in addition to any federal income taxes unless an exception applies.

This 10 percent tax penalty will generally apply to cash withdrawals made before age 59½ unless you have medical expenses exceeding the tax-deductible limit or you become disabled, die or end employment after age 55 and request periodic payments over a period of at least 10 years. There is no tax penalty applied to payments made to children or to a divorced spouse in accordance with a qualified domestic relations order.

For example, a participant can take a cash distribution of his or her account balance without the additional 10 percent penalty if he or she separates from service after attaining age 55. The distribution will be taxable, but will not have the additional penalty. With an age 59½ withdrawal, the participant may have separated from service at age 40 and left his or her money in the plan. In order to avoid the 10 percent penalty, he or she would have to wait until age 59½ to take a cash distribution of the account balance.

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

Rollover to Another Qualified Retirement Plan or Traditional IRA

The RF's plans permit rollovers after termination of employment. When you become eligible for a distribution, you will receive a tax notice that describes your rollover options. The distribution must be an "eligible rollover distribution" and the recipient must be an "eligible retirement plan." Any payment from the plan is eligible for rollover, except:

- Certain payments spread over a period of at least 10 years or over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary);
- Required minimum distributions after age 73 (or after death);
- Hardship distributions;
- Corrective distributions of contributions that exceed tax law limitations; and
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends).

A properly completed rollover will not be taxed in the year the distribution is made. If, however, you take a distribution, and then do not roll the funds over into another eligible retirement plan or to a traditional IRA account within 60 days of receipt, the IRS will consider the distribution a lump-sum withdrawal and will tax the amount you received.

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

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

Phased Retirement Program

Service in a postdoctoral position does not count towards eligibility for phased retirement.

Selecting Your Beneficiary

Spousal Rights

You may not choose the single life annuity option or designate an annuity partner unless your spouse consents in writing during the 180 days preceding the date benefits begin. If you are married and die before annuity benefit payments begin or before your mutual fund balances are distributed, your spouse is automatically designated as your beneficiary.

Your spouse can waive his or her rights to this preretirement death benefit once you have reached age 35 or at any age after your employment ends.

Benefits If You Become Divorced or Separated

In the event that a judgment, decree or court order establishes the rights of your former spouse to your benefits under the plan, and where there is a qualified domestic relations order, payments will be made by TIAA in accordance with that order. A court order may preempt the usual requirement that your spouse be considered your primary beneficiary for a portion of the accumulation. A copy of the plan's procedures for determining whether a judgment, decree or order is a "qualified domestic relations order" (QDRO) can be obtained from TIAA.

Federal Insurance

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

How to File a Claim

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

The extension notice will indicate the special circumstances requiring the extension and the date by which the Plan Administrator expects to make its decision.

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

- Specific reasons for denial;

- Specific reference to plan provisions on which the denial is based;
- A description of and reason for needing any additional material required to consider the claim; and
- An explanation of the review procedure, the applicable time limits and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA, following a denial of a claim following a review.

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

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

- Request, in writing, a review of his or her claim by the Plan Administrator – if the adverse decision was by written notification, the request must be made within 60 days following receipt of notification;
- Review and receive copies of all documents, records and other information relevant to the denial (no charge will be made for the copies requested); and
- Submit written comments, documents, records and other information relating to the claim.

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

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

Send written requests to:

Plan Administrator
 Research Foundation for the State University of New York
 Post Office Box 9,
 Albany, NY 12201-0009

Voluntary Termination of the Plan

An employer who participates in this plan may voluntarily withdraw from the plan at any time. When this happens, the following occurs:

- **Notice is provided.** The employer withdrawing from the plan provides notice to the appropriate parties of its intention to withdraw from the plan. This notice must

be provided at least thirty (30) days before the effective date of the withdrawal.

- **Procedures are established.** The employer withdrawing from the plan works with the appropriate parties to agree on the procedures for an orderly withdrawal process. Such procedures may include a spin-off or transfer option.
- **Costs are paid.** The employer withdrawing from the plan must pay all reasonable costs associated with the withdrawal and transfer.
- **Participant contributions.** The employees of the withdrawing employer will no longer be eligible to accrue additional plan benefits on any compensation paid on or after the effective date of the withdrawal. For employees who have accrued, but unpaid, contributions as of the effective date of the withdrawal:
 - The employer withdrawing from the plan will contribute the amounts to the plan or the spin-off plan.
 - These contributions will be made promptly after the effective date of the withdrawal, unless the accounts are transferred to a qualified plan maintained by the withdrawing employer.

Optional Retirement Plan

The Optional Retirement plan is a defined contribution plan operating under Section 403(b) of the IRC, under which employees of tax-exempt organizations can enter into salary reduction agreements with their employers. Under the agreement, a portion of your compensation is deducted from your pay on a pre-tax, or, if you so designate, on a Roth after-tax basis and contributed to an annuity contract or mutual fund custodial account administered by TIAA rather than being paid directly to you. Your contributions may be invested in the way you instruct or they will be invested in the plan's default option as described in the *How to Enroll* section below. Pre-tax amounts, together with any earnings, are not subject to state or federal income tax until you or your beneficiary starts receiving benefits. Roth after-tax contributions are subject to state and federal income tax at the time of contribution. However, they are not subject to state or federal tax when you or your beneficiary starts receiving benefits, provided you keep these contributions in the Optional Retirement Plan for the period required by law.

Plan Contributions Are a Percentage of Your Salary

When you enroll in the Optional Retirement plan, you will indicate your salary reductions as a percentage of your salary, **not** as a dollar amount.

Eligibility

If you are an active non-student employee of the RF (including employees who are paid on an hourly basis), you are eligible to participate in the Optional Retirement plan regardless of hours worked. There is no waiting period, and you do not have to be a vested participant in the Basic Retirement plan.

How to Enroll

To participate in the Optional Retirement plan, log on to Employee Self Service, or if you prefer, complete the Salary Reduction Agreement. This form indicates the **percentage** of salary you would like to contribute and lets you stipulate when the contributions should begin. **Once you have begun your participation in the plan, contributions will be invested in a target retirement date fund that is designed for your age and an estimated retirement age of 65. Your beneficiary will be your estate unless you name another beneficiary. You can redirect the investment of contributions at any time and may divide your contributions among the funds offered in any whole percentage. If you do not enroll with TIAA, your default investment will be a target retirement date fund that is designed for your age and an estimated retirement age of 65. Your beneficiary will be your estate.**

If you decide to invest in other funds offered by the plan or if you would like to designate your beneficiary, you can enroll at www.tiaa.org/rfsuny. Remember, if you enroll through the TIAA website, you will still need to choose your election percentage either by logging on to Employee Self Service or by returning a completed Salary Reduction Agreement to your campus Benefits Office. You can download a Salary Reduction Agreement from the TIAA website or from the RF Benefits website (www.rfsuny.org/benefits). Click "Postdoctoral Employees," "Retirement," then "Optional Retirement" and click the link on the right side of the page.

If your initial contribution reaches TIAA before you select different investments, you can always go online or contact TIAA to transfer this balance and set up investments of your choice.

Your Contributions

IRS Maximum Salary Reduction Allowance

The IRS places limitations on the amount of your salary that may be placed in a tax-deferred annuity or mutual fund custodial account. Under Section 402(g) of the IRC, the contribution limit for 2024 is \$23,000, up to 100 percent of compensation (Section IRC 415).

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

Catch-up Contributions

If you are at least age 50 by the end of the plan year (December 31) and otherwise make the full salary reduction contribution available to you under the Optional Retirement plan, you may make an additional salary reduction contribution to the plan of up to \$7,500 in 2024. In future years, the catch-up limit may be adjusted by the IRS for changes in the cost of living.

Changing Your Salary Reduction Agreement

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

A new Salary Reduction Agreement is required if you return to employment or wish to start your contributions again after your final wages have been paid.

You can make changes or stop your contributions via Employee Self Service or by submitting a new Salary Reduction Agreement to your campus Benefits Office and there is no limit to the number of changes you can make.

Contributions During a Leave of Absence

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

Acceptance of Eligible Rollover Distributions

You may roll over into the Optional Retirement plan an eligible distribution from another employer's eligible retirement plan, your Individual Retirement Account or an individual retirement annuity. However, employee after-tax contributions (which differ from Roth after-tax

contributions) are not eligible for roll over. You must request a direct rollover from the distributing plan or make an indirect rollover within 60 days of receipt of the eligible rollover distribution. Contact TIAA for more information.

Normal Retirement Age

Under the Optional Retirement plan, normal retirement is age 65.

Vesting

All contributions to the Optional Retirement plan are immediately vested; however, funds can be withdrawn only under limited circumstances. Refer to *Making a Cash Withdrawal and Tax Implications* on page 47.

If You Have an Outside Business

If you meet all three of the following criteria, you must report outside business retirement plan contributions to the RF:

1. You contribute to the RF's Optional Retirement plan.
2. You own a controlling interest (over 50 percent) of an outside for-profit business.
3. You make contributions to a qualified retirement plan or simplified employee pension (SEP-IRA) plan under the outside business.

Failure to report such contributions could result in your exceeding contribution limitations under Internal Revenue Code Section 415.

Retirement Savings Credit ("Saver's Credit")

If you participate in the Optional Retirement plan, you may be eligible for income tax credit if your adjusted gross income does not exceed the following amounts in 2024:

- \$76,500 for Married Filing Jointly;
- \$57,375 for Head of Household; or
- \$38,250 for Single, Married Filing Separately, qualifying widow(er) with dependent child or taxpayers who are age 18 or over before the end of their taxable year, other than full-time students or persons claimed as dependents on another taxpayer's return.

The amount of the credit that can be claimed varies with your filing status, adjusted gross income and retirement contributions. Refer to IRS publication 571 or consult with your tax professional to see if you qualify.

Directing Your Investment

You can redirect the investment of contributions at any time and may divide your contributions among the funds offered in any whole percentage. Go to www.tiaa.org/rfsuny and click on "Log in" or call TIAA at 800-842-2252.

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

Investment Funds

A listing of funds available for investment can be obtained from TIAA, or go to www.tiaa.org/rfsuny.

Transferring Funds

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

Changing Your Name, Address or Beneficiary

You may change your address or beneficiary on your accounts at www.tiaa.org/rfsuny or by contacting TIAA. Name changes require you to complete a form and return it to TIAA. If you are married, see *Selecting Your Beneficiary* on page 48.

Quarterly Accumulation Statements

Until you settle your contracts, TIAA will continue to send you quarterly statements showing your accumulations. You can also view this information at www.tiaa.org/rfsuny, and may choose to receive statements electronically by providing TIAA with an email address.

Federal Insurance

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

Group Supplemental Retirement Annuity (GSRA) Loan Option

If you own a GSRA contract, TIAA offers a loan provision. If you are married, your spouse must consent to the loan. Effective January 1, 2015, you may not be in the process of repaying more than three loans at any time unless the loans were approved prior to this policy change.

You may borrow up to 45 percent of the funds remitted through the RF to your TIAA GSRA contract. The minimum loan is \$1,000; the maximum is \$50,000. The loan amount you request may be reduced by any outstanding loans under this option. Repayments are made quarterly over a five-year period except when the loan is used to purchase a principal residence. In that case, the repayment period may be up to 10 years. The term of the loan cannot extend beyond April 1 of the year in which you attain age 73.

The loan is offered at a fixed rate of interest. The principal and interest are paid back to the your account account based on your investment allocation for contributions. If there is not an allocation on file, the repayment is paid to the default investment option.

You will be charged a one-time origination fee of \$75 for a general purpose loan and \$125 for a primary residence loan. There is a \$25 annual maintenance fee. The fee covers the cost to initiate the loan and maintain the loan on the your behalf. If you fail to make a loan payment, the outstanding loan balance, plus the interest on that payment, will be subject to ordinary income taxes and may be subject to the tax penalties applied to early withdrawals.

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

You are responsible for paying your loan's interest rate, as well as the fees associated with generating your loan. This includes (but is not limited to) the brokerage fees associated with your loan including sales charges, as well as purchase, withdrawal and redemption fees for certain investments.

Hardship Withdrawals

You may request a hardship withdrawal through TIAA if you have an immediate and heavy financial need and a distribution is necessary to satisfy that need, under the standards described below. A hardship distribution is includable in income for tax purposes, subject to a 10 percent early distribution tax if you are not yet age 59½, and may not be rolled over. You may increase the amount of your hardship distribution request by an amount necessary to pay taxes or penalties reasonably anticipated

to result from the distribution. You may not repay a hardship distribution to your account.

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

- Unreimbursed medical expenses incurred by you, your spouse or dependents;
- Purchase (excluding mortgage payments) of your principal residence;
- Payment of tuition and related fees, and room and board expenses for the next 12 months of postsecondary education for yourself, your spouse or dependents;
- Payment of amounts necessary to prevent eviction from your principal residence, or foreclosure of your principal residence;
- Funeral expenses;
- Repairs to your principal residence from a "casualty loss" as defined in Section 165 of the IRS tax code; or
- Losses incurred as a result of a federally declared disaster if your home was in the disaster area.

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

- The distribution does not exceed the financial need plus anticipated taxes and penalties,
- You have obtained all distributions available from the Optional Retirement plan; and
- You certify to TIAA that you have insufficient cash or other liquid assets reasonably available to satisfy the need.

TIAA may require specific documentation to complete the hardship withdrawal. Contact TIAA for applicable forms.

Taxes

Retirement distributions from TIAA contracts are normally subject to ordinary income taxes. Refer to *Making a Cash Withdrawal and Tax Implications* on page 47. A 10 percent tax penalty will generally apply to cash withdrawals made before age 59½ unless you have medical expenses exceeding the tax-deductible limit, become disabled, die or end employment at age 55 or older.

For example, a participant can take a cash distribution of his or her account balance without the additional 10 percent penalty if he or she separates from service after attaining age 55. The distribution will be taxable but will not have the additional penalty. With an age 59½ withdrawal, the participant may have separated from service at age 40 and left his or her money in the plan. In order to avoid the 10 percent penalty, he or she would have to wait until age 59½ to take a cash distribution of the account balance.

Spousal Rights

Refer to *Spousal Rights* on page 48. In addition, your spouse must consent in writing to any TIAA GSRA loan, as described on page 52.

Your Retirement Benefits If You Become Divorced or Separated

Refer to *Benefits If You Become Divorced or Separated* on page 48.

After You Leave the Research Foundation

The funds in your TIAA accounts and mutual funds continue to share in earnings/losses after you leave the RF even if no additional contributions are made. You have the same investment options available to you and can make changes as you did while employed. However, if your total balance does not exceed \$7,000, the plan will request that TIAA roll over your balance to an Individual Retirement Account (IRA) with Millennium Trust, unless within the time prescribed by TIAA you elect a cash payment or a direct rollover to another retirement plan or IRA of your choosing.

GSRA

Funds contributed to a GSRA during your employment with the RF will continue to be available to you for loans (up to a maximum of three), subject to IRS regulations. No future contributions may be made to your GSRA unless you are employed by a TIAA participating institution or rehired by the RF.

TDA

No further contributions will be made to your TDA accounts under any circumstances.

How Benefits Are Paid

Payment options from TIAA contracts and mutual funds are explained under *How Benefits Are Paid* for the Basic Retirement plan on page 45, but please note the following differences:

- If you have contributed under a TDA deduction, then the payment options are the same as the options of an individual retirement annuity. Therefore, in this case, you cannot withdraw funds from a TIAA Traditional Annuity in a lump sum.
- If you have contributed under a Supplemental Retirement Annuity (SRA) deduction, you do not have any restrictions when withdrawing from the TIAA Traditional Annuity. Also, the fixed-period option allows you to receive income from your GSRA contract over a fixed number of years — from 5 to 30, not to exceed your life expectancy — from all annuity accounts. If you die during that period, payments will continue to your beneficiary.

Note: The TIAA Interest Only Option is not available for GSRA contracts.

Minimum Distribution Requirements

The minimum distribution requirements for retirement funds from TIAA are the same for the Basic and Optional Retirement plans. Refer to *When Distribution Must Begin* on page 46.

Qualified Distributions from Roth Accounts

With the Roth option, your after-tax Roth contributions also accumulate tax deferred, but may be taken tax free in a qualified distribution.

A qualified distribution is one that occurs at least five years after the year of your first Roth contribution and is made either on or after attainment of age 59½, on account of disability, or on or after death.

Required minimum distributions are not required for Roth accounts during your lifetime, but will be required after your death in a manner similar to pre-tax deferral accounts.

In addition, you can elect to convert your pre-tax contribution accounts to a Roth account. You will be taxed on the converted amount but future earnings may be distributed free to you in a qualified distributions. Please contact TIAA to learn how to request a conversion of your pre-tax to Roth accounts.

Benefits If You Die

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

Your entire balance must normally be distributed to your beneficiary by December 31 of the tenth calendar year after your death. If elected, death benefits may be payable over the life expectancy of a designated beneficiary if the distribution of benefits begins no later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 73, had you lived. Note, however, that for deaths occurring after 2019, your beneficiaries cannot elect the life expectancy distribution option unless the beneficiary is your spouse, your child who has not reached the age of majority (as defined by the Treasury regulations, chronically ill or disabled or no more than 10 years younger than you. if your beneficiary is not an individual (e.g., your estate, then distributions must be completed by the end of

the year containing the fifth anniversary of your death.

Both spouses and non-spouse beneficiaries have the right to roll over eligible rollover distributions made at your death. A surviving spouse has the same rollover options that the participant would have had, as described elsewhere in this handbook. In addition, if a surviving spouse chooses to do a rollover to an IRA, he or she may treat the IRA as his or her own or as an inherited IRA. The only rollover option for a payment made from the plan to a non-spouse beneficiary, or to a surviving spouse, is a direct rollover to an inherited IRA. There are differences in the manner in which minimum required distributions must be taken from a regular and an inherited IRA. Please consult with your tax advisor for more information.

If you die after all funds have been annuitized, any additional payments will be determined by the annuity option you selected at retirement if it is available to your beneficiary.

Making Cash Withdrawals

GSRA Contracts

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

- You are employed by the RF and have attained age 59½,
- You have terminated RF employment at any age,
- You encounter financial hardship, as defined by the IRS, *Note: Only the principal may be withdrawn.*
- You become disabled as defined by the IRS or
- You die. *Note: Your beneficiary may make withdrawals.*

How to File a Claim

Please refer to *How to File a Claim* on page 48.

Amendment and Termination

While it is expected that this plan will continue indefinitely, the Research Foundation reserves the right to amend, otherwise modify or terminate the plan, or to discontinue any further contributions or payments under the plan, by resolution of its Board. In the event of a termination of the plan or complete discontinuance of salary reduction contributions, the Research Foundation will notify all participants of the termination. As of the date of complete or partial termination, all accumulation accounts will be nonforfeitable to the extent that benefits are accrued.

Deferred Compensation Plan

The RF's Deferred Compensation plan allows eligible employees to supplement their retirement savings with pretax, biweekly contributions as defined under Section 457(b) of the Internal Revenue Code. This plan allows those eligible employees who already contribute the maximum amount allowed by the Optional Retirement plan to save even more on a pretax basis, up to an additional \$23,000 in 2024 (subject to annual adjustment by the IRS). This plan also has a catch-up provision, allowing additional contributions based on underutilized amounts in prior eligible years and only if you are within three years of the normal retirement age chosen on your initial agreement. To ensure the accuracy of the catch-up amount, contact your campus Benefits Office for a calculation. Then, submit your Voluntary Deferral form to your campus Benefits Office. However, this is an "unfunded" plan, meaning that although plan participants reduce their salary and put that money aside in accounts with their names, these funds are part of the RF's general assets and, as such, are subject to the claims of RF's creditors. The RF has no obligation to set aside any funds for the purpose of making any benefit payments under this plan, and plan participants do not have any rights to any unpaid amounts that are greater than those of an unsecured creditor.

Eligibility

Participation in the plan is limited to postdoctoral, active employees who:

- Are "highly compensated employees" as defined by the IRS (annual salary of at least \$155,000 in 2024, adjusted annually by the IRS for changes in the cost of living) and
- Perform services in one of the following job categories established by the RF:
 - Project Employees in one of the following titles: Clinical Investigator, Co-Principal Investigator, Principal Investigator, Principal Medical Practice Plan Administrator, Principal Nursing Administrator, Project Administrative Officer, Agency Administrative Officer, Senior Clinical Investigator, or
 - Administrative Employees in titles assigned to one of the following grades: E.7 (e.g., Director, Assistant Vice President), E.8 (e.g., Vice President), E.9 (e.g., Senior Vice President) or E.0 (Officers of the Employer).

If you qualify and are interested in participating, you should request an Informational Handout, Plan Summary and Enrollment form from your campus Benefits Office.

Continuing Benefits

There are several situations when you are no longer on the payroll but could still be receiving benefits. This section provides rules on continuing benefits following ending your employment, disability or leave of absence.

If Your Employment Ends

Death of an Active or Disabled Employee

Health, Dental and Vision Care coverage will continue for your covered dependents for six months following your death.

If you had not met the eligibility requirements for Retiree Health Care, coverage beyond the first six months is available to your dependents under COBRA (refer to page 59); however, your COBRA benefits continuation period runs concurrently to the first six months.

Termination

If you terminate employment, voluntarily or involuntarily, you are eligible to continue Health, Dental and Vision Care coverage under COBRA. There also are extended Dental Care benefits after termination of employment or eligibility described on page 26.

Health insurance also can be continued on a direct-payment basis with the carrier. If you are interested, contact Anthem Blue Cross or your HMO. You also may be eligible for partially subsidized coverage under a health insurance marketplace created under the Affordable Care Act. Visit www.healthcare.gov for additional information.

Basic and Optional Life

You may convert your Basic Life and Optional Life coverage to an individual whole-life policy by contacting Securian Life within 31 days from the date your employment ends. You also may be eligible to continue your Optional Life coverage with a lower cost term policy. Refer to *If Your Coverage Ends (Policy Conversion)* on page 41.

New York State Unemployment Insurance

The RF provides unemployment insurance compensation for up to 26 weeks through the New York State Department of Labor (DOL). From time to time the federal government authorizes an additional period of benefits.

Eligibility

New York State Unemployment Insurance benefits are available to eligible employees (as determined by the New York State Department of Labor) who involuntarily terminate employment with the RF. You may apply for benefits immediately following termination of employment.

When Benefits Begin and End

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

Compensation

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

How to File a Claim

When you terminate employment, you will receive a DOL Record of Employment form that includes your exact date of termination. You can file your claim for unemployment insurance benefits online at www.labor.ny.gov/unemploymentassistance.shtm or call 888-209-8124 (New York state residents) or 877-358-5306 (out-of-state residents). The DOL will review your claim and make a determination on your benefit eligibility based on the New York State Unemployment Insurance Benefits Law. If you meet the DOL's eligibility rules, benefits will begin as described above. You will be notified by the DOL if you are not eligible for benefits. You have the right to appeal a claim in accordance with DOL guidelines.

If You Become Disabled

New York State Short-Term Disability or Workers' Compensation

Health, Dental and Vision Care Coverage Continuation

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

If you receive income replacement through Workers' Compensation for a total disability caused by a work-related illness or injury sustained during RF employment, the RF will continue the benefits in effect at the time of your disability, either for the period of the total disability or up to age 65, whichever comes first.

Retirement Contributions Continuation

If you are participating in the RF Basic Retirement plan, the RF will continue to make retirement contributions but only as long as you remain on the payroll receiving a paycheck. Refer to the Disability/Income Protection section and Retirement section of this handbook for additional information.

Long-Term Disability

Health, Dental and Vision Care Coverage Continuation

When you become totally disabled within the meaning of the LTD contract, the Health, Dental and Vision Care coverage you have in effect at the time your disability begins will continue at no cost while you are receiving LTD payments for up to one year. The period for which you are eligible for COBRA continuation coverage runs concurrently with the periods of extended coverage indicated.

Retirement Contributions Continuation

If you participate in the RF Basic Retirement plan when you become totally disabled, First Reliance Standard will continue contributions to your retirement contract at the same rate as before the disability based on your annual salary at the time of your disability. Contributions continue for as long as you receive LTD benefits. The contributions credited toward your retirement account are allocated in the same proportion as when your disability began. You may change your allocation at any time by calling TIAA directly.

How Medicare Affects Your Health Insurance Benefits

You must enroll in Medicare Part A (hospital) and Part B (medical/surgical) if you have received Social Security disability benefits for two years or longer.

If You Are Not Eligible for Long-Term Disability Benefits

Health, Dental and Vision Care Coverage Continuation

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

IF YOU	THEN
Have at least one year, but less than 10 years, of full-time service (or the equivalent in part-time service, at 50 percent or more of full-time effort) at the time of disability	Benefits will continue for one year beyond the time New York State Short-Term Disability benefits cease. Note: After one year, benefits may be continued for a limited period under COBRA, if you pay the full premium.
Have 10 or more consecutive years of full-time service (or the equivalent in part-time service, at 50 percent or more of full-time effort) at the time of disability	Health insurance benefits will continue for the duration of the total disability while you remain covered by Original Medicare Parts A and B until you reach age 65.
Are no longer receiving a Social Security disability benefit	Health insurance benefits will continue as a retiree if you met the age and service requirements when the disability began and pay the required premium.

Basic Life Coverage Continuation

Basic Life and AD&D coverage in effect at the time of your disability will continue as long as you are collecting New York State Short-Term Disability, Workers' Compensation, LTD or Social Security Disability benefits for a total disability within the meaning of the applicable statute or contract. You must continue to submit proof of disability to the life insurance carrier. Coverage is subject to the following limits. If you become disabled:

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

Optional Life Coverage Continuation

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

If You Take a Leave of Absence

Leave of Absence Without Pay

While on an approved leave of absence for up to one year, you may continue Health, Dental and Vision Care benefits and Basic Life and Optional Life coverage by paying the full premium (employee plus employer share) directly to the RF. If you do not return to work after the leave of absence, you will be able to continue your benefits under COBRA rules. The leave of absence and COBRA periods run concurrently.

Family and Medical Leave

During periods of approved leave under the federal Family and Medical Leave Act (FMLA), you may continue Health, Dental and Vision Care coverage if you pay the same share of the premium as an active employee. Please contact your campus Benefits Office to obtain the forms you must complete for this continuation and refer to your Employee Handbook for details about FMLA.

You also may continue Basic Life and Optional Life insurance during FMLA leave by paying the full premium.

After Your Family and Medical Leave Period Ends

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

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

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

If you have questions about continuing your benefits while on FMLA leave, contact your campus Benefits Office. Refer to COBRA on the following page for additional information on continuing your benefits.

Paid Family Leave

During periods of approved leave under the New York State Paid Family Leave Program, you may continue Health, Dental and Vision Care coverage if you pay the same share of the premium as an active employee. Please contact your campus Benefits Office to obtain the forms you must complete for this continuation and refer to your Employee Handbook for details about Paid Family Leave.

If you remain on leave without pay after your Paid Family Leave ends, you may be required to meet the waiting period when you return to work unless you continued your benefits by paying the entire premium for the time out beyond your Paid Family Leave.

If you choose not to return to work after your Paid Family Leave has ended, the RF can recover its share of the premium from you.

If you have questions about continuing your benefits while on Paid Family Leave, or how Paid Family Leave and FMLA coordinate, contact your campus Benefits Office.

Military Leave

Health, Dental and Vision Care Coverage Continuation

During periods of approved military leave under the Uniformed Services Employment and Re-employment Rights Act (USERRA), your Health, Dental and Vision Care coverage in effect at the time of the leave may be continued for up to 24 months. New York state continuation laws allow an additional 12 months for health coverage only, with the beneficiary paying 100 percent of the premium. This extension does not apply to dental or vision benefits. You will pay the same share of the premium as an active employee during FMLA leave, the full premium after FMLA leave and up to one year from the beginning of military service, and the COBRA premium rate (100 percent of premium plus a two percent administrative fee) for the balance of the leave. Refer to COBRA for additional information regarding your coverage.

Basic Life and Optional Life Coverage Continuation

Your life insurance coverage in effect at the time of leave will continue for up to one year provided you pay the full premium.

Reinstatement of Your Benefits Upon Return From Military Leave

All benefits for which you were eligible prior to qualifying for military leave under USERRA will be reinstated without a waiting period upon your return within the time frame for retaining your position under USERRA. Any benefit for which you are eligible that became effective during the military leave will become effective upon your return to RF employment. You will be credited with time toward retirement plan vesting during the period of qualifying military service. You must return to RF employment and document your service and discharge as required under the law.

COBRA

COBRA continuation coverage is a continuation of one or more of the group health plan coverages you and your dependents participate in, if coverage would otherwise end because of a life event known as a "qualifying event." If you, or a member of your family, have coverage under the Health, Dental and Vision Care plans and/or the Health Care Flexible Spending Account at the time of the qualifying event, you each have an opportunity to continue coverage under any of these plans.

Qualified Beneficiary

COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under a group health plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. Although domestic partners are not qualified beneficiaries under federal law for purposes of COBRA continuation, the RF does offer continuation under the same terms as COBRA to eligible domestic partners covered under its health, dental and vision plans.

To be a qualified beneficiary, an individual must generally be covered under the group health plan on the day before the qualifying event that causes a loss of coverage (such as termination of employment, or a divorce from or death of the covered employee). However, a dependent child born to you or placed for adoption with you while you have COBRA continuation coverage has the same right to elect COBRA continuation coverage as the dependents

who were covered by the plan on the day before the event that created your COBRA rights. Electing COBRA continuation coverage for newborn or adopted children is important if, during the first 18 months of COBRA coverage following a termination of employment or reduction in hours, a second qualifying event occurs involving your death, divorce or legal separation, or entitlement to Medicare, or if the dependent child ceases to meet the definition of “dependent” under the terms of the plan. Under such circumstances, a dependent child who has elected COBRA continuation coverage has the right to continue COBRA coverage for up to 36 months from the date of the first qualifying event. You should notify the Plan Administrator within 30 days of the child’s birth or placement for adoption so that this valuable right is not lost.

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

Qualifying Events

Termination or Reduction in Hours

If you lose group health plan coverage because of a termination of employment (for reasons other than gross misconduct) or a reduction in hours, or it becomes known that you will not return from FMLA leave, you and other qualified beneficiaries who have coverage through you under RF health plans may elect to continue existing coverage for a period of time. If you had employee and spouse/domestic partner or employee and child(ren) coverage at the time of the qualifying event, you may change to employee only coverage when you elect COBRA.

Death, Divorce, Medicare Entitlement

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

Loss of Dependent Status

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

Duration of COBRA Continuation Coverage

Federal Law

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

New York State Law

New York state law requires that up to 36 months of COBRA continuation coverage be provided for insured health coverage only. This extended period does not apply to dental or vision coverage. Therefore, the following Disability Extension and Second Qualifying Event Extension sections apply only to dental and vision coverage.

Disability Extension

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

Second Qualifying Event Extension

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

Except in the case of a bankruptcy (see below), continuation coverage will not last beyond 36 months from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

Bankruptcy

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

Your Responsibilities

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

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

Paying for COBRA Continuation Coverage

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

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

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

Termination of COBRA Continuation Coverage

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

- The RF no longer provides group health coverage to any of its employees;
- The premium for your continuation coverage is not paid on time;
- After electing continuation coverage under the RF health plan, the qualified beneficiary becomes covered by another group plan, unless that plan contains any pre-existing condition exclusions or limitations that apply to the qualified beneficiary;
- You become entitled to Medicare; or
- Dental or vision coverage was extended for up to 29 months for a person disabled under Social Security rules, and there has been a final determination that the qualified beneficiary is no longer disabled.

Health Care Flexible Spending Account

As of the date of the qualifying event, if the qualified beneficiary can receive a higher benefit from the Health Care FSA than the maximum amount the plan may charge for COBRA premiums under the Health Care FSA for the remainder of the plan year, then continuation coverage must be made available for the remainder of the plan year (but not for any subsequent year). This would likely be the case if, as of the date of the qualifying event, the amount contributed to the Health Care FSA is greater than the amount of submitted reimbursable expenses for the year.

If (as of the date of the qualifying event) the maximum amount the plan may charge for COBRA premiums under the Health Care FSA for the remainder of the plan year equals or exceeds the maximum benefit that the qualified beneficiary can receive from the Health Care FSA for the remainder of the year, continuation coverage is not available. This would be the case if the qualified beneficiary already received reimbursement for expenses equal to or greater than his or her Health Care FSA account balance as of the date of the qualifying event.

Effect of Not Electing COBRA

If you do not choose continuation coverage, your Health, Dental and Vision Care coverage and your participation in the Health Care FSA will end on the date specified by the plan.

The Health Insurance Marketplace: An Alternative to COBRA

Those who lose health coverage under the RF plan have another option. The Affordable Care Act created the health insurance marketplace where those without coverage may qualify for subsidies to help them purchase coverage. Visit www.healthcare.gov for more information.

Dependent Coverage Under New York State's "Young Adult" or "Age 29" Laws

Under New York state law, an adult child (or children) may be able to continue or elect RF coverage until the adult child's 30th birthday if you or the adult child pays the full premium, provided the adult child to be covered is:

- Unmarried;
- 29 years of age or under;
- Not insured by or eligible for comprehensive (i.e., medical and hospital) health insurance through his or her own employer;
- Living, working or residing in New York state or the health insurance company's service area; and
- Not covered under Medicare.

The young adult does not have to live with a parent, be financially dependent on a parent or be a student.

Work/Life Balance

The RF realizes that it's important for employees to have a healthy work/life balance and offers a variety of leave options as well as money-saving benefits, including flexible spending accounts, a college savings program and insurance discounts.

Paid Time Off and Paid Leave

In general, salaried employees appointed to at least 50 percent of full time are eligible to accrue paid time off. Hourly employees and those appointed to less than 50 percent of full time are eligible to accrue sick paid time off. Unless there are special circumstances, an employee cannot take time unless it is already accrued.

This section describes various types of paid time off and paid leave. For additional information on eligibility and administration, refer to the Employee Handbook, which is available at www.rfsuny.org. From the main page, select the down arrow by *Information For* and select Employees. Then, click on the link to the Employee Handbook. Once there, click on the "Leave" link for more information. If you do not have Internet access, contact your campus Benefits Office to obtain a copy.

Sick Time

The primary purpose of sick time is to provide a reasonable measure of protection against loss of income due to illness or disability. The amount of sick time you accrue and are able to use depends on the date you were hired, your employment status and your position classification. Your campus Benefits Office will explain your eligibility.

Vacation and Personal Time

Subject to managerial approval, vacation time may be taken at your request. Personal time may be used for absences due to pressing personal business and other similar circumstances, e.g., personal appointments, banking and so on, that cannot be taken care of other than during normal working hours.

Your eligibility to accrue and use vacation and personal time depends on the date you were hired, your status as a full-time or part-time employee, and status as an exempt or nonexempt employee. Your campus Benefits Office will provide you with additional details on leave accrual.

Paid Family Leave

The New York State Paid Family Leave Program provides job-protected, paid leave to bond with a new child, care for a loved one with a serious health condition or to help relieve family pressures when someone is called to active military service. While you are on approved Paid Family Leave, you receive a percentage of your Average Weekly Wage, as defined by the State of New York. If you are eligible for Paid Family Leave, contact your campus Benefits Office for more information and the appropriate forms.

Holidays

Generally, RF employees observe state, federal and other customary holidays scheduled at their individual campus locations. If you are required to work on such a holiday, you will be paid for your time and given a paid day off. If employees do not use holiday time before their employment terminates, the holiday time is lost. For a list of holidays at your campus location, contact your campus Benefits Office.

Military Leave

If you are called to active military duty, you will be paid for up to 22 workdays or 30 calendar days, whichever is greater, during any one calendar year or any continuous period of ordered military service. After paid leave is exhausted, you may use accrued vacation, holiday or personal leave credit or be put on leave without pay for the period of your military duty.

You may be entitled to re-employment rights and retention of full seniority benefits for all prior service upon re-employment under the Uniformed Services Employment and Re-employment Rights Act and the New York State Military Law.

If practicable, you will need to bring your military service orders to your campus Benefits Office for review prior to commencement of the leave. Spouses of members of the armed forces who have been deployed during a period of military conflict are allowed to take 10 days unpaid leave when that employee's spouse is on leave from the armed forces.

Jury Duty

If you are called to jury duty, you will receive the necessary time off with full pay to fulfill this civic obligation. You are only eligible for this time on days you are actively serving on a jury. You should request jury duty leave from your supervisor in advance and provide him or her with the necessary documentation (jury duty voucher).

Other Types of Leave

You may be eligible for the following types of leave without pay: disability, childcare and personal.

Family and Medical Leave

You are entitled to family and medical leave in accordance with the requirements of applicable state and federal law in effect at the time the leave is granted. Please refer to the RF Employee Handbook for additional details.

Flexible Benefits Program (Pretax Health Contributions)

Under the RF's Flexible Benefits Program, you may pay your share of the health insurance premium with pretax earnings unless you are not receiving sufficient pay to do so (for example, while on unpaid leave or in retirement). This means that your contribution toward health insurance will reduce your taxable income by that amount, thereby reducing your federal and state income and Social Security taxes.

Participation in this program is automatic unless you decline this option by signing a waiver. This benefit is made available by the RF under Section 125 of the Internal Revenue Code. For domestic partner premiums to qualify for pretax payments, the domestic partner must be a tax dependent under IRC Section 152.

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

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

To change your election, enroll online using Employee Self Service, or complete a new RF Benefits Enrollment form and submit it within 60 days of the qualifying event.

Health Care and Dependent Care Flexible Spending Accounts

Under the RF's Flexible Benefits Program, you also can enroll in a Health Care or Dependent Care Flexible Spending Account. A Flexible Spending Account (FSA) is an IRS-approved, tax-free account that saves you money on eligible health care and dependent care expenses. You authorize per-pay-period deposits to your FSA from your before-tax salary. Then, as you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. If you incur both types of expenses, you can establish both accounts; however, you may not transfer money between Health Care and Dependent Care FSAs.

In accordance with federal law, the Health Care FSA maximum deposit is \$3,050 annually. The Dependent Care FSA maximum annual deposit is \$2,500 or \$5,000 (depending on your tax filing status).

Contact BVSLUD@LQDQFLDO

844-729-3539

www.inspirafinancial.com

Understanding How the Plans Work

The following documents explain how the FSAs work, and can be found on the RF Benefits website (www.rfsuny.org/benefits) by selecting "Postdoctoral Employee," and then "Flexible Spending Accounts."

- Health Care Flexible Spending Account Frequently Asked Questions
- Dependent Care Flexible Spending Account Frequently Asked Questions
- Participant Website Navigation Guide

RF Dependent Care FSA Subsidy

The RF will provide an annual subsidy to your Dependent Care FSA, ranging from \$300 to \$800 based on your full-time income. If you work part time, your salary is converted to full-time equivalent annual salary for purposes of the subsidy.

FULL-TIME SALARY	RF CONTRIBUTION*
Over \$70,000	\$300
\$60,001 – \$70,000	\$400
\$50,001 – \$60,000	\$500
\$40,001 – \$50,000	\$600
\$30,001 – \$40,000	\$700
Up to \$30,000	\$800

* The RF contribution will be added to your Dependent Care FSA in a lump sum after your account becomes effective.

Employee Eligibility

You are eligible to open either type of FSA after a six-month waiting period, if you are a salaried employee working at least 50 percent of full time. You are not eligible if you are paid hourly, a summer-only appointment, or a full-time SUNY student appointed in an RF student title.

Break in Service

If you have a break in service of 28 days or more before meeting the waiting period, you must begin a new waiting period if you return to the RF. If you have a break in service after completing the waiting period, and return to the RF within one year, you are eligible on the date you return.

Plan Administered by Inspira Financial

Inspira Financial is the company that administers the FSAs.

Enrollment

You may enroll in an FSA within 60 days of your date of hire or date of eligible employment, and must re-enroll each year during the Open Enrollment period (generally the month of November). Enrollment does not roll over from one year to the next. If you would like to enroll, log on to Employee Self Service at www.rfsuny.org/selfservice to make your annual election. If you are unable to enroll online, please contact your campus Benefits Office.

Online Account

Once your FSA coverage becomes effective, you should visit the **Inspira Financial** website, www.inspirafinancial.com, to register and create an account. Creating an account allows you to view your account balances, review account activity and submit claims online.

Eligible Expenses – Health Care FSA

The Health Care FSA can be used to pay for medical expenses not covered by your insurance plan, such as prescription and health care copays, eyeglass options not covered by the Vision Care plan, and dental and orthodontia care beyond the Dental Care plan limits. A complete list of eligible expenses can be found at www.inspirafinancial.com. The RF plan allows all expenses that are allowed by the IRS.

Eligible Expenses – Dependent Care FSA

The Dependent Care FSA can be used to pay for employment-related, daytime dependent care expenses for your dependent children or dependent relatives. This includes your dependent child under the age of 13 who lives with you for more than half the year. It also includes your spouse or other qualifying dependent who is physically or mentally incapable of self-care and lives with you for more than half the year. An “employment-related” expense is care that enables you to work or look for work. A complete list of eligible expenses can be found at www.inspirafinancial.com.

FSA Debit Cards Are Good for Three Years

The FSA debit card you will receive is good for up to three years, as long as you re-enroll in the plan. When your debit card expires, you will automatically receive a replacement within 30 days of expiration.

Deadline to Use FSA Funds

According to IRS rules, you forfeit any funds remaining in an FSA at the end of the plan year. The RF's FSA plan year ends December 31 each year; however, a grace period and run-out period help ensure you have the opportunity to maximize your FSA funds and avoid forfeiting them.

The grace period gives you an additional two months and 15 days after the end of the plan year to incur eligible expenses. Since the RF plan year ends on December 31, the grace period allows you until March 15 of the following year to incur expenses.

The run-out period extends the deadline for filing claims for expenses incurred during the plan year. The RF run-out period ends March 31.

For example, if you enroll in an FSA for the 2024 plan year, you would have until March 15, 2025 to incur expenses and until March 31, 2025 to file claims. Remember, any funds left in your FSA at the end of the plan year will be forfeited. They will not roll over into the next plan year.

Changing Your Coverage

Under some circumstances, you may make a mid-year change to your FSA election, or vary your pretax contribution amount, depending on the qualifying event and requested change.

Making a Change

You can change your FSA election(s), or vary the pretax contribution amounts you have selected during the plan year, only under limited circumstances as provided by the RF's plans and established IRS guidelines. Election changes must be consistent with the event. The RF will, in its sole discretion, review on a uniform and consistent basis the facts and circumstances of each properly completed and timely submitted mid-year election change form.

To Make a Change: Within **60 days** of a qualifying event, you must complete and submit a Benefits Enrollment Form to your campus Benefits Office, which you can find at www.rfsuny.org/benefits. Documentation supporting your election change request is required. Once your election change request is approved and processed, your existing FSA(s) elections will be stopped or modified (as appropriate). Generally, mid-year pretax election changes can only be made prospectively, no earlier than the first payroll after your election change request has been received by the RF, unless otherwise provided by law. If your FSA election change request is denied, you will

have **60 days** from the date you receive the denial to file an appeal with the RF. For more information, refer to the "Appeal Process" at the end of this section.

Appeal Process

If you have a request for a mid-year election change, FSA reimbursement claim or other similar request denied, in full or in part, you have the right to appeal the decision by sending a written request within 30 days of the denial for review to the RF.

Your appeal must state:

- The name of your employer,
- The date of the services for which your request was denied,
- A copy of the denied request,
- The denial letter you received,
- Why you think your request should not have been denied, and
- Any additional documents, information or comments you think may have a bearing on your appeal.

Your appeal will be reviewed once your request and all supporting documentation is provided. You will be notified of the results of this review within 30 business days from the receipt of your appeal. In unusual cases, such as when appeals require additional documentation, the review may take longer than 30 business days. If your appeal is approved, additional processing time is required to modify your benefit elections.

Note: Appeals are approved only if the extenuating circumstances and supporting documentation are within the regulations governing the plan.

College Savings Program

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

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

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

Program Overview

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

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

Withdrawals used by the beneficiary for qualified higher education expenses are not subject to federal or New York state income taxes.

Upromise Rewards

Upromise offers a unique opportunity to add additional credits to your account simply by registering for the rewards program and by making qualifying purchases from any of the plan's numerous nationwide partners. For additional details, call 877-NYSAVES (877-697-2837) or visit www.nysaves.org.

Contact Vanguard/Upromise

877 NYSAVES (877-697-2837)

www.nysaves.org

New York's College Savings Program Brochure

You should receive a New York's College Savings Program brochure from your campus Benefits Office. If you want to enroll, you can request an Enrollment Kit, which includes detailed information about the program, a payroll deduction authorization form and an enrollment form. You can download, complete and/or print an electronic enrollment form on the New York College Savings Program website at www.nysaves.org.

In order to enroll you must:

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

Payroll Deductions

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

Overpayments

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

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

Auto, Homeowner's and Renter's Insurance Discount Program

RF employees enjoy a discount of up to 10 percent off standard rates for personal auto and homeowner's insurance (including renter's insurance) with Liberty Mutual's Group Savings Plus program. You are responsible for paying the full cost of this coverage. Convenience fees are waived when you sign up for scheduled electronic payments.

If you are an RF employee working at least 50 percent of full time on a postdoctoral appointment, you are eligible to participate in this program. There is no waiting period. To participate in the discount program, enroll at www.libertymutual.com/rfsuny, call 800-524-9400, or visit your local Liberty Mutual office. Identify yourself as an RF employee (or provide them with the RF client number 111756). There are no payroll forms to complete.

Contact Liberty Mutual Insurance

800-524-9400

www.libertymutual.com/rfsuny

RF Ride Commuter Transit Benefit

The RF contracts with Inspira Financial to offer RF Ride. This plan can help you save money by letting you pay for eligible commuter transit expenses with pretax payroll deductions. Eligible expenses include the cost of public transportation to get you to work, such as fare cards and train, subway, ferry, bus and vanpool passes. No income tax, Social Security or Medicare tax will be withheld from the amount of your eligible expenses. Enroll at www.inspirafinancial.com or call 844-729-3539.

Contact Inspira Financial

844-729-3539

www.inspirafinancial.com

Wellness Program

By completing simple healthy behaviors, you can earn up to \$100 in cash or gift cards each quarter — \$400 for the year. The money you earn can be deposited right into your bank account, or you can use it to purchase gift cards or certain wearable devices. Any money earned is considered taxable income, so tax withholding rules will be applied as your rewards are earned.

To get started, visit join.virginpulse.com/rfsuny and complete the registration steps. Be sure to enter your name exactly as it appears on your RF direct deposit or paycheck so that the Virgin Pulse system will recognize you.

Once you're registered, you can start earning PulseCash points for exercise, steps, nutrition, sleep, and wellness challenges and quizzes. To track your activities, you can enter them yourself on the VirginPulse website, or upload information from your FitBit or apps like Endomondo and Moves.

Please note you are not eligible to earn rewards while on a leave of absence.

Contact Virgin Pulse

866-852-6898

www.virginpulse.com

To enroll:

join.virginpulse.com/rfsuny

Pet Insurance

Liberty Mutual's customized Pet Insurance delivers multiple policy options – spanning accidents, illnesses and wellness – with affordable coverage and the ability to select the percentage you'll get back from each visit up to 90%, your deductible and your annual maximum. Choose the best policy to protect your pet with coverage underwritten by a company with more than 100 years of insurance experience, and the flexibility to use any vet.

Fetch a quote at pet.libertymutual.com/rfsuny or call 844-250-9199 and reference promo code "Sunyrf" for your discount.

Contact Liberty Mutual

pet.libertymutual.com/rfsuny

International Travel

The RF provides blanket international travel assistance coverage, as well as emergency health insurance benefits, for all persons traveling overseas on official RF business.

The health insurance premium is paid in full by the RF. Generally, non-routine health care expenses up to \$200,000 per year are covered in full. Other travel assistance benefits include medical evacuation, lost document assistance, legal referrals, contact information for embassies, emergency messages to family members, translation services and more.

Employees planning to travel outside the country on RF business should obtain brochures and ID cards for these programs from their campus Benefits Office.

GeoBlue Traveler

GeoBlue Traveler provides up-front payment guarantees to hospitals and physicians worldwide for non-routine medical care for all SUNY or RF employees traveling on RF business for periods of fewer than 180 consecutive days. Accompanying eligible dependents also are covered.

GeoBlue Expatriate

GeoBlue Expatriate is available to RF employees on an international assignment for longer than 180 consecutive days as an alternative to their regular RF Health Care coverage. This program guarantees up-front payment and makes direct payments to health care providers in many foreign countries. Most health services under this plan (routine as well as emergency care) are covered at 90 percent with an annual out-of-pocket limit of \$1,000 (individual).

GeoBlue Global Assistance

The RF contracts with GeoBlue to administer Worldwide Emergency Assistance Services, including global security services for anyone other than independent contractors traveling outside the country on official RF business. Accompanying spouse and dependent children also are covered. Travel assistance benefits include a call center that provides access to numerous services 24 hours a day, 365 days a year.

Contact GeoBlue

855-282-3517

www.geo-blue.com

About Your Travel Assistance Plans

Notice of Claim

Within 20 days after a person insured under an International Travel Assistance plan receives covered services, that person (or someone on that person's behalf), must notify the insurance company in writing of the claim. Failure to give notice within the specified time frame will not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.

Within 15 days after the insurance company receives the written notice of claim from the person who received covered services, the insurance company must:

- Acknowledge receipt of the claim,
- Begin any investigation of the claim,
- Specify the information that must be provided by the person to file proof of loss (the insurance company can request additional information during the investigation, if necessary), and
- Send the person any forms the insurance company requires for filing proof of loss. If the insurance company does not send the forms within this time period, the person who received covered services can file proof of loss by giving the insurance company a letter describing the occurrence, the nature and the extent of the person's claim. The person must give the insurance company this letter within the time period for filing proof of loss.

Right to Terminate the Plan

The coverage of anyone insured under an International Travel Assistance plan will terminate if the policy for that plan is terminated. If the insurer terminates a plan's policy, then the insurer will notify the RF in writing of the termination at least 45 days in advance. In addition, a plan's policy may be terminated by the RF on any premium due date. It is the RF's responsibility to notify all insured participants if a policy is being terminated.

General Information

Summary of Plans

Plan Administrator

The president of the Research Foundation for the State University of New York is the Plan Administrator for all plans.

Research Foundation President
 Research Foundation for the State University
 of New York
 Post Office Box 9
 Albany, NY 12201-0009

The telephone number for the corporate office for benefits administration is 518-434-7101.

Agent for Service of Legal Process

The president of the Research Foundation, at the address at left, is the agent for service of legal process for all plans.

Employer Identification Number

The Research Foundation's Employer Identification Number is 14-1368361.

Plan Information

PLAN NAME	ERISA PLAN NUMBER	PLAN TYPE	TYPE OF ADMINISTRATION	FUNDING	END OF PLAN YEAR
HEALTH CARE					
Health Insurance for Postdoctoral Employees	501	Preferred provider organization (PPO - Anthem)	Group insurance contract with Anthem Blue Cross	Insured	December 31
		PPO - Optional Plan	Administrative services agreement	Self-insured*	December 31
		Prescription drug benefits	Administrative services agreement	Self-insured*	December 31
		Health maintenance organizations	Insurance contracts with various health maintenance organizations	Insured	December 31
Post-retirement Benefits Plan	515	Health and dental	Group health insurance contracts and dental administrative services agreement	Group health insured, dental self-insured*	December 31
Dental Care Plan	504	Dental benefits	Administrative services agreement with Delta Dental of New York, Inc.	Self-insured*	December 31
Vision Care Plan	508	Vision care benefits	Vision care services agreement with Davis Vision	Self-insured*	December 31
Health Care Flexible Spending Account	501	Part of the RF Flexible Benefits Plan	Administrative services agreement with Inspira Financial	Self-insured*	December 31

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

Plan Information *continued*

PLAN NAME	ERISA PLAN NUMBER	PLAN TYPE	TYPE OF ADMINISTRATION	FUNDING	END OF PLAN YEAR
International Travel Assistance	501	International assistance and medical benefits	Insurance contract with GeoBlue	Insured	December 31
LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE					
Basic and Optional Life Insurance	505	Life and AD&D insurance	Group insurance contract with Securian Life Insurance Company	Insured	December 31
DISABILITY INSURANCE					
Workers' Compensation Insurance	N/A	Disability insurance	Insurance contract with Chubb Insurance Company	Insured	June 30
New York State Short-Term Disability Insurance	N/A	Disability insurance	Insurance contract with The Standard	Insured	December 31
Long-Term Disability Insurance	506	Disability insurance	Insurance contract with The Standard	Insured	December 31
Voluntary Short-Term Disability	514	Disability insurance	Insurance contract with The Standard	Insured	December 31
RETIREMENT PLANS					
Basic Retirement Plan	001	Defined contribution	Retirement annuity and mutual fund contracts	Insured and variable accounts	December 31
Optional Retirement Plan	003	Tax-deferred annuity (TDA)	Retirement annuity contracts	Insured and variable accounts	December 31
		Group supplemental retirement annuity (GSRA)	Retirement annuity contracts	Custodial accounts	December 31
		Tax-deferred mutual funds	Mutual fund accounts	Insured and custodial accounts	December 31
OTHER BENEFITS					
New York State Unemployment Insurance	N/A	Unemployment insurance	Self-insured plan through the state of New York Department of Labor	Self-insured*	N/A
Paid Family Leave	N/A	Paid family leave insurance	Insurance contract with The Standard	Insured	December 31
Dependent Care Flexible Spending Account	N/A	Part of the RF Flexible Benefits Plan	Administrative services agreement with Inspira Financial	Self-insured*	December 31

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

Your Rights Under State and Federal Laws

Your Rights Under the Employee Retirement Income Security Act of 1974 (ERISA)

The following statement is required by federal law and regulation and applies to those benefit plans identified in the "Summary of Plans" that have an "ERISA Plan Number," indicating that the plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). The Research Foundation for the State University of New York is the Plan Administrator.

As a participant in the plans, you are entitled to certain rights and protections under ERISA, which provides that all plan participants shall be entitled to the following protections.

Right to Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- With respect to the retirement plans, obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal

retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to earn the right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.

- With respect to the group health plans, including the health, vision and dental plans, continue coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- With respect to group health plans (other than dental and vision), reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

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

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20220. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 866-444-EBSA (3272) or accessing the website at www.dol.gov/ebsa.

Your Privacy Rights Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The RF is the sponsor of group health plans that are subject to the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA privacy rules, insured health plans sponsored by the RF are covered entities. RF self-insured health plans are also covered entities. The RF and its group health plans are committed to maintaining the privacy of health information pertaining to individuals enrolled in the plan.

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

For self-insured plans, the RF provides the Notice of Privacy Practices, which is on the RF website. Each of the plans may disclose PHI to the RF to carry out the following administrative functions for the plan:

- To determine if an individual is participating in the plan;
- To modify, amend or terminate the plan;
- To obtain premium bids to provide insurance coverage for the plan, including reinsurance;
- To carry out other administrative functions of the plan such as:
 - Claims Assistance: Designated personnel may assist "covered persons" (i.e., employees of the RF who are plan participants and their covered dependents) in attaining a resolution of any issues related to obtaining payment for claims, including coverage and eligibility issues.
 - Appeal of Benefit Denials: Designated personnel may assist covered persons in appealing benefit denials of the insurer or third-party claims administrator.
 - Individual Rights Requests: Refer to *Your Rights Regarding Your PHI* on page 75 for more information.
 - Audit Functions: Designated personnel may review PHI, such as Check Registers, to confirm payment and perform other audit functions.

Designated Personnel

“Designated personnel” are RF employees who administer the group health plans. These individuals will provide the services on behalf of the plan as part of the payment and/or health care operations of the plan. As a result, it is intended and understood that any and all disclosures of PHI of plan participants by an insurer or third-party administrator to the designated personnel shall be permitted by 45 CFR §164.506(c)(1) and shall be exempt from the authorization requirement of 45 CFR §164.508.

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

With respect to the health plans identified as being self-insured in the *Summary of Plans* beginning on page 71, the RF may receive PHI in connection with its role as the final arbiter of claims that have been appealed as provided under the administrative services agreements.

With respect to PHI that the RF receives from the plan, the RF shall:

- Not further use or disclose the PHI other than as permitted or required by the plan documents or as required by law;
- Ensure that any agents, including an insurance broker or a subcontractor, to whom it provides PHI received from the plan, agree to the same restrictions and conditions that apply to the RF with respect to such information;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the RF;
- Report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for herein, of which it becomes aware;
- Make available PHI as required by 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the plan available to the Secretary for purposes of determining compliance by the plan;
- If feasible, return or destroy all PHI received from the plan that the RF still maintains in any form, and not retain copies when the PHI is no longer needed for the

purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure that adequate separation between the plan and the RF is established.

The plans will disclose PHI to the RF only upon receipt of a written certification by the RF that the plan documents have been amended to incorporate the foregoing provisions of this paragraph.

The plan will disclose, as permitted or required by the plan, PHI to only the following class of employees or other persons under the control of the RF: employees who administer the group health plans.

These employees and the designated personnel shall use and disclose only the minimum amount of PHI necessary to perform the administrative functions identified in this section.

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

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

Your Rights Regarding Your PHI

Right to inspect and copy. You have the right to inspect and receive a copy of your protected health information, except under a few unusual circumstances. If you request a copy of your protected health information, the plan may charge a fee for the costs of copying.

Right to amend. If you feel that protected health information the plan has about you is incorrect or incomplete, you may ask the plan to amend the information. To request an amendment, your request must be made in writing and should include the reason(s) why you believe the plan should amend your information. The plan will respond to your request for amendment no later than 60 days after the receipt of your request. If the plan denies your request for an amendment, the plan will provide you with a written notice that explains its reasons. You will have the right to submit a written statement disagreeing with the denial.

You also will be informed of how to file a complaint with the plan or with the Secretary of the Department of Health and Human Services.

Right to an accounting of disclosures. An accounting of disclosures is a list of certain disclosures the plan has made of your PHI. Disclosures that were made to carry out payment and health care operations, disclosures to persons involved in your care or payment for your care, disclosures that were made to you or made in accordance with your written authorization, and certain other disclosures need not be included in an accounting of disclosures.

To request an accounting of disclosures, you must submit your request in writing and must state the time period for which you are requesting an accounting of disclosures, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request will be free. If you request additional lists within 12 months, the plan will charge you for the costs of providing the list. The plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before costs are incurred. The plan will respond to your request for an accounting of disclosures within 60 days.

Right to request restrictions. You have the right to request a restriction or limitation on the protected health information the plan uses or discloses about you for treatment, payment or health care operations. The plan is not required to agree to your request. You also have the right to request a limit on the medical information the plan discloses about you to someone who is involved in your care, like a family member or friend. If the plan agrees to your request for restriction, the plan will limit the disclosure of your protected health information, unless the information is needed to provide you with emergency treatment or to comply with law.

To request restrictions on disclosures, you must make your request in writing, and you must state 1. what information you want to limit; 2. whether you want to limit its use, disclosure or both; and 3. to whom you want the limits to apply.

Right to request confidential communications. You have the right to request that the plan communicate with you in a certain way or at a certain location. For example, you have the right to request that messages not be left on an answering machine. To request confidential communications, you must make your request in writing. The plan will not ask you the reason for your request, and the plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and how payment for your health care will be handled if the plan communicates with you through this alternative method or location.

Right to receive a Notice of Privacy Practices. You have the right to receive a Notice of Privacy Practices from the plan. To obtain a copy of this notice, please contact the

Privacy Official at the Benefits/Claims Administrator listed on page 10. For self-insured plans, the RF provides the Notice of Privacy Practices, which is on the RF website.

Discrimination Is Against the Law

The RF complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The RF does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The RF:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters, and
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters, and
 - Information written in other languages.

If you need these services, contact Kathleen Caggiano-Siino by phone (518-434-7132), fax (518-434-8348), or email (kathleen.caggiano-siino@rfsuny.org).

If you believe that the RF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kathleen Caggiano-Siino
Vice President of Human Resources
PO Box 9, Albany, NY 12209
Phone: 518-434-7132
Fax: 518-434-8348
Email: kathleen.caggiano-siino@rfsuny.org.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kathleen Caggiano-Siino, Vice President of Human Resources, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20211
Phone: 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-518-434-7101.

Chinese

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-518-434-7101。

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.

Звоните 1-518-434-7101.

French Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-518-434-7101.

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-518-434-7101.

번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.

Chiamare il numero 1-518-434-7101.

Yiddish

אויפֿמערקזאָם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל.
רופט 1-518-434-7101.

Bengali

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নথি রাখায় ভাষা সহায়তা পরষিবো উপলব্ধ আছে। ফোন করুন
১-৫১৮-৪৩৪-৭১০১

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer

1-518-434-7101.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- (رقم
هاتف الصم والبكم: 1-518-434-7101).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-518-434-7101.

Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں 1-518-434-7101۔
دستیاب ہیں۔ کال کریں

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa 1-518-434-7101.

Greek

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν.
Καλέστε 1-518-434-7101.

Albanian

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-518-434-7101.

Key Terms

This section provides brief definitions of important terms used in this handbook. For health plan terms, refer to your PPO or HMO handbook. Terms that primarily relate to a specific benefit plan are indicated as such. If no specific plan is indicated, the definition may apply to several plans.

AD&D – Accidental Death and Dismemberment. Generally offered as companion coverage to a life insurance policy, AD&D coverage pays supplemental benefits in case of accidental death as well as certain non-fatal but disabling injuries.

Affordable Care Act – see PPACA.

After-tax contribution – your contribution toward a benefit will be made after taxes are taken from your paycheck. Therefore, the deduction has no impact on your taxes (see also “pretax contribution”).

Anniversary year – an anniversary year is the one-year period beginning with your date of hire or initial date of qualified service, and each anniversary of that date.

Annuitant – a person receiving retirement annuity payments.

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

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

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

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

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1986, part of which allows plan participants who leave employment to continue access to their coverage for a period of 18 or 36 months if they pay the full premium and an administrative fee. This is commonly referred to as “COBRA coverage.”

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

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

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

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

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

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

HIPAA – Health Insurance Portability and Accountability Act of 1996.

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

Leave of absence – a period of up to one year of approved time away from your job.

LTD – Long-Term Disability. A disability lasting longer than six months.

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

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

Mutual fund – an investment company that pools funds from individuals to buy securities selected to meet specific criteria and goals.

Nonforfeitable – a benefit that cannot be taken away from you (e.g., vested pension benefits).

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

Paid Family Leave – a program provided through the State of New York to provide eligible employees with up to 10 weeks of paid leave to bond with a new child, care for a sick loved one or to relieve pressure when someone is called to active military service.

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

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

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

PPACA – the Patient Protection and Affordable Care Act of 2010. Referred to in general terms as "health reform legislation."

PPO – Preferred Provider Organization. Certified health care organizations that provide hospitalization coverage, and a comprehensive plan of medical and surgical care. Participants are generally free to see any network or non-network provider or specialist without a referral from their primary physician.

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

Pretax contribution – your contribution toward a benefit will reduce your taxable income by that amount, thereby reducing your federal and state income and Social Security taxes.

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

Qualified service – RF employment or employment with an eligible prior employer. A year of qualified service is an anniversary year of eligible employment of at least 975 hours for employees working 37.5 hours per week or at least 1,000 hours for employees working 40 hours per week.

Qualifying event – a change in an employee's personal or employment status that permits a change to be made in pretax health insurance deductions outside of the annual Open Enrollment period. Also applies to COBRA.

Rollover – a tax-free transfer of assets from one eligible retirement plan to another.

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

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

Service credit – time counted toward the service requirements for participation and vesting in the RF Basic Retirement plan.

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

TIAA – a full-service financial services company and a leading provider of retirement benefits. It is the administrator for all of the RF's retirement and deferred compensation plans.

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

Vesting – an employee's right, usually earned over time, to receive retirement benefits regardless of whether or not he or she remains with the employer.

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



35 State Street
Albany, New York 12207-2826

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

This Research Foundation Benefits Handbook replaces all previous Research Foundation Benefits Handbooks and addenda.