2026 Benefits Handbook

GRADUATE STUDENTS

SUNY RF
The Research Foundation for
The State University of New York

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 (ERISA), this handbook, in combination with handbooks and certificates from the insurance companies, constitutes the ERISA plan and summary plan description.

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 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.

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BENEFIT	BENEFITS/CLAIMS ADMINISTRATOR	PHONE	WEBSITE
Health Care	Anthem Blue Cross	800-342-9816	www.anthem.com
Prescription Drug	Express Scripts	800-818-6632	www.express-scripts.com
Specialty Pharmacy	Accredo	800-803-2523	www.accredo.com
Dental Care	Delta Dental	800-932-0783	www.deltadentalins.com
Vision Care	Davis Vision	800-999-5431	www.davisvision.com
New York State Short-Term Disability	First Reliance Standard Life Insurance Company	866-752-8117	www.reliancestandard.com
Paid Family Leave	First Reliance Standard Life Insurance Company	866-752-8117	www.reliancestandard.com
Workers' Compensation	Chubb Insurance Company	Contact your campus Benefits Office	www.wcb.ny.gov (Select "Workers")
College Savings Program	Vanguard / Upromise	877-NYSAVES	www.nysaves.org
Auto, Homeowner's and Renter's Insurance Discount Program	Liberty Mutual Insurance	800-524-9400	www.libertymutual.com/rfsuny
RF Ride Commuter Transit Benefit	Inspira Financial	844-729-3539	www.inspirafinancial.com
Pet Insurance	Liberty Mutual	844-250-9199	pet.libertymutual.com/sunyrf
Unemployment Benefits	New York State Department of Labor	Contact your local unemployment office	www.labor.ny.gov (Select "Individuals")
International Travel Assistance (while working on RF programs) which includes Health Insurance and Worldwide Emergency Assistance Services	GeoBlue Traveler	855-282-3517	www.geo-blue.com

Health Care

The RF's Graduate Student Employee Health Plan (GSEHP) provides hospital, medical and prescription drug benefits to eligible graduate student employees. When you enroll in the GSEHP, you are automatically enrolled in the Dental Care and Vision Care plans.

Eligibility

You may participate in the GSHEP if you are an eligible graduate student or fellow as described below.

Graduate Student Employee

If you are a SUNY graduate student, you are eligible for the GSEHP from the first day that you are:

- Employed by the RF in an RF student title and your work coordinates with your education and training, leading to the fulfillment of academic requirements,
- Receiving an annual salary of at least $4,293 and paid biweekly through the RF payroll system,
- Appointed to a position for which funds are anticipated to be available for a period of at least one semester, and
- Employed in active pay status. (You may be eligible for coverage during the summer period even if you are not in active pay status. See *Eligibility During the Summer*.)

If you are an international SUNY graduate student, you are eligible for the plan if you hold an F-visa or J-visa and meet the eligibility requirements listed above. F-visa and J-visa holders also must purchase medical evacuation and repatriation insurance through the SUNY Health Plan for International Students.

Fellows

If you are a scholar who is receiving non-wage payments from the RF in support of academic study or fellow-initiated research, you are eligible for the GSEHP if your annual stipend is at least $4,293.

Eligibility During the Summer

You may continue GSEHP coverage during the summer period, even if you are not in active pay status, under the following circumstances:

- You were covered by the plan throughout the preceding semester,
- The RF Operations Manager at your campus certifies that you are expected to be re-appointed in the fall, and
- You pre-pay the entire employee share of the premium for the summer period.

Dependent Eligibility

The dependents listed on the next page are eligible to be included in your GSEHP coverage if you choose "individual plus one dependent" or "individual plus two or more dependents" when you enroll. At any time, the plan may require proof that a spouse or child qualifies as a dependent. 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.

For Detailed Information

This handbook is a summary outline of benefits offered to RF graduate student employees. For a detailed description of your benefits, refer to the plan's summary plan description, which is available on the RF Benefits Website.

Your eligible dependents include:

- Your spouse (including a legally married, same-sex spouse) or eligible domestic partner, and
- Your eligible children.

Your eligible children include:

- Children under age 26 who are your:
  - Biological children,
  - Stepchildren[1],
  - Foster children as defined by the health plan,
  - Children for whom you are the legal guardian,
  - Eligible children of your domestic partner[1], or
  - Children legally adopted by or placed for adoption with you or your spouse[2].
- Your unmarried children who reach the limiting age and are mentally or physically disabled before reaching the limiting age and are incapable of self-support due to the disability. The dependent must depend on you for support and maintenance as defined by the Internal Revenue Code, and you must declare the child as an income tax deduction. The plan requires periodic medical documentation.
- Your child who is an alternate recipient under a qualified medical child support order (QMCSO). You may obtain, without charge, a copy of the procedures governing QMCSO determinations from the RF Office of Sponsored Programs Administration.

[1] The child's biological parent must remain legally married to you (the covered member) or be your qualified, covered domestic partner.

[2] The child is considered "placed for adoption" if you (the covered member) intend to adopt the child, and if the child is available for adoption and has not reached the age of 18 as of the date of placement for adoption. The adoption does not have to be final for the child to be eligible for coverage, but the legal process for adoption must have commenced.

Domestic Partners

A domestic partner is a person of the same or opposite sex with whom you have been involved in a domestic partnership for at least one year, and who is:

- Your only domestic partner,
- Age 18 or older,
- Unmarried,
- Not related to you in any way that would bar marriage,
- Residing with you for at least one year and
- Financially interdependent with you.

You must provide evidence of the domestic partnership, including domestic partnership registration or a signed affidavit and proof of cohabitation. Check with your campus Benefits Office for examples of acceptable proof of cohabitation.

Unless your domestic partner qualifies as your federal tax dependent, his or her health plan benefits will be reported as after-tax benefits. This will result in additional amounts being included in your income for tax purposes.

Adding Dependents

If you gain a dependent during the year as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your new dependent in the GSEHP. If you are already enrolled in the plan, you may add coverage for your dependent. For more information, refer to *Special Enrollment Rights* on page 6.

How You and the RF Share the Cost

The RF pays 90 percent of the cost for individual coverage and 75 percent of the cost for dependent coverage for graduate student employees. Fellows pay the full cost for individual and dependent coverage. The fellowship sponsor or department may pay the cost on behalf of the fellow.

What Is a 1095-C?

IRS Form 1095-C Employer-Provided Health Insurance Offer and Coverage is an annual statement of the health insurance benefits available to you. The ACA requires applicable large employers, like the RF, to send this annual statement. If you are enrolled in the GSEHP, the RF will mail you a 1095-C form on January 31 of each year.

Am I Required to Have Health Insurance?

The Affordable Care Act requires that most people purchase health insurance for themselves and their dependents or they may pay a penalty if they do not. You have the option to evaluate and consider whether health care coverage through the national Health Insurance Marketplace (www.healthcare.gov) will better meet your health care needs. Since you are eligible for the GSEHP as a graduate student employee, it is unlikely that the Marketplace will offer you a better plan. However, you should visit the site to learn more, and decide for yourself.

Enrollment

To participate in the Graduate Student Employee Health Plan, you must enroll. When you enroll in the plan, you are also enrolled in the Dental Care and Vision Care plans.

Your coverage choices include "individual," "individual plus one dependent" or "individual plus two or more dependents." You will need to list your covered dependents. To enroll, log on to www.rfsuny.org/selfservice to access the Employee Self Service website. If you are unable to complete the enrollment process online, you may complete an enrollment form and return it to your campus Benefits Office. Enrollment forms are available at www.rfsuny.org/benefits. Click on "Graduate Student Employees." Completed paper enrollment forms should be sent to your campus Benefits Office. They should not be sent directly to the claims administrator.

When Coverage Begins

If your enrollment form is received within 45 days of when you become initially eligible for the plan, your coverage will be effective on the day you are hired or your first day of eligible employment. If you do not enroll within 45 days of becoming eligible, you will be considered a late enrollment and there will be a 30-day waiting period before coverage begins. Additionally, deductions for late enrollments will be taken on an after-tax basis for the remainder of the plan year and you may change to pre-tax deductions during the next open enrollment period. The waiting period is waived if you have a special enrollment right or other qualifying event as described in *Changing Your Coverage* below. If you enroll during the annual open enrollment period, your coverage will become effective as of the beginning of the plan year (January 1). You must be in active pay status for coverage to take effect. For more information, refer to *Eligibility* on page 3.

Open Enrollment

Open enrollment occurs each year from November 1 through November 30. During this time you may enroll if you have not previously done so, drop coverage or change your coverage option.

See Enrollment above for instructions on how to enroll. During open enrollment, you must enroll or make changes to your elections by November 30.

Changing Your Coverage

There are restrictions on when you can change your GSEHP coverage outside of the open enrollment period. If your coverage is paid for on a pretax basis, you may only make changes at other times during the year if you have a special enrollment right or other qualifying event. Generally, your benefits are paid for on a pretax basis unless you waive this arrangement; however, coverage of a domestic partner can only be deducted on an after-tax basis, unless he or she is a "qualifying relative" under section 152(d) of the Internal Revenue Code. Coverage paid for with after-tax contributions may be changed at any time during the year.

What Is a Qualifying Event?

Qualifying events are specific occurrences that enable you to make changes to your GSEHP coverage outside of the open enrollment period even if you pay for that coverage with pretax premium contributions. Changes must be made within 31 days of the qualifying event, or 60 days if qualified under the Medicaid and State Child Health Insurance Program (S-CHIP); and the changes you make must be consistent with the change resulting from the qualifying event. For example, if you get married, you may add your spouse to your coverage.

Requests for coverage 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.

Qualifying events include:

- **Qualification for special enrollment rights** — refer to *Special Enrollment Rights* for more information.
- **Change in legal marital status** — you are married, divorced, legally separated; your marriage is annulled; you add a domestic partner or end a domestic partner relationship.
- **Change in number of dependents** — you or your spouse gives birth or adopts a child; a child is placed

with you for adoption; your child or spouse or domestic partner dies.

- **Change in your or your spouse's employment status** — you leave the RF or begin work for the RF; your spouse leaves his or her employer or begins a new job.
- **Change in dependent eligibility** — your child becomes eligible or loses eligibility as defined by the plan.
- **Change in health coverage** — the cost or coverage of benefits available to you or your spouse or domestic partner through the RF or another employer changes significantly.
- **Change in work status** — you or your dependent change jobs, or begin or end a job; you or your dependent increase or decrease work hours, or switch from part-time to full-time; you or your dependent begin or return from an unpaid leave of absence that results in acquiring or losing eligibility for health insurance.
- **Change of your worksite** — or that of your spouse or domestic partner, resulting in a change of benefits offered.
- **Change due to relocation** — of your residence to outside the plan's service area.
- **Qualified medical child support order** — the plan receives a court order requiring you to provide coverage for a dependent child.
- **Change in qualification for Medicaid or S-CHIP** — you, your spouse or dependent gain or lose qualification for the State Children's Health Insurance Program (S-CHIP) or Medicaid. Refer to *Special Enrollment Rights* for more information.

Special Enrollment Rights

Apart from qualifying events, special enrollment rights allow you to make changes to your health care coverage outside of the open enrollment period in three specific circumstances: 1. you gain a dependent, 2. you or a dependent lose coverage under another plan and 3. you or a dependent become eligible for assistance through a State Children's Health Insurance Plan. The following describes these specific circumstances, which are based on rules enacted by the Health Insurance Portability and Accountability Act (HIPAA), in more detail.

Gaining a Dependent

If you gain a dependent through marriage, birth, adoption or placement for adoption, you may enroll the new dependents — and yourself if you are not already enrolled — in the GSEHP. 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 must enroll within 31 days of gaining a dependent, beginning on the date of the marriage, birth, adoption or placement for adoption, as applicable. If your enrollment is completed in 31 days, your new spouse's coverage will be effective the date of the marriage, and coverage for a child will be effective the date the child was born or, if adopted, the date the child was adopted or placed with you for adoption.

If you do not enroll the new dependent within 31 days, you generally will not be permitted to do so until the next open enrollment period unless you experience a qualifying event.

In the case of a previously un-enrolled dependent's arrival in the United States, you must enroll the dependent within 30 days of arrival. Coverage will be effective on the date the dependent arrived in the United States.

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 GSEHP 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 within the plan's service area, and no other benefit package is available; 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 31 days after the other coverage ends. The application must be made under the same application rules that apply to other enrollments. Newly elected coverage would begin on the first day of the calendar month following the date that your enrollment elections are received by the plan. For example, if your elections are received June 12, coverage would be effective July 1.

Becoming Eligible Under a State Children's Health Insurance Program

If you are eligible for the GSEHP, 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 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/.

Health Care

The RF's Graduate Student Employee Health Plan is a preferred provider organization, or PPO, plan. In a PPO plan, hospitals, physicians and other health care providers agree to join the plan's provider network. These in-network providers, which include SUNY Student Health Centers, 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).

Contact Anthem Blue Cross
800-342-9816
www.anthem.com

Identification Card

When you join the GSEHP you will receive an identification card. Present your identification card when receiving care. If you visit an in-network doctor or hospital, you will have no claim forms to file.

Choosing a Provider

Student Health Centers

Most SUNY campuses have Student Health Centers that provide registered students medical services, including appointments or walk-in service for routine primary care. Some Student Health Centers also provide urgent care and limited specialty services. You are urged to use the services of the campus Student Health Center when appropriate, and to verify the levels of care that can be obtained at the Student Health Center on the campus where you are employed. On some campuses, the Student Health Center bills patients for services not covered under the campus mandatory health fee. Some of these services may be covered by the GSEHP. Contact Anthem Blue Cross for coverage details.

Only registered students have access to a Student Health Center. Covered dependents and fellows who are not registered students do not have access to a campus Student Health Center.

In-Network Providers

Most services obtained from in-network providers will cost you a fixed 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. When you enroll in the plan, you will receive information about how to locate in-network providers. You also can obtain information at www.anthem.com.

Out-of-Network Providers

Obtaining care from outside the plan's network requires an annual deductible and 20 percent coinsurance of allowed charges for most services. You must pay for the care you receive out of network and complete a claim form to be reimbursed (up to the plan's allowable charges). There is no annual limit to the amount of copayments and coinsurance you pay for out-of-network care.

Physician Office Visits

When you or your covered dependent(s) visits 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 that are not already available without a copayment

Hospital Admission and Surgery Notification Requirement

If the GSEHP is your primary plan, you must contact 800-342-9816 five working days before being admitted to the hospital or undergoing surgery in an inpatient setting, or within two working days following an emergency admission. Failure to meet this notification requirement will result in a benefit reduction of 50 percent of allowed charges after applicable deductible or copayment. Precertification is not a guarantee that benefits will be paid. This notification requirement is designed to help ensure that you receive necessary and appropriate health care while avoiding unnecessary expenses.

Live Health Online

When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

Go to livehealthonline.com or download the app and register on your phone or tablet.

Second Opinion Program

To help you avoid inappropriate or potentially harmful surgical treatments, the GSEHP offers a voluntary second opinion program. Under this program, you pay only a $10 copayment for a qualified second opinion consultation with an in-network physician regarding a planned, elective surgical procedure. If you consult with an out-of-network physician, the visit will be subject to the plan's deductible. If you have met the deductible, the plan will pay 80 percent of the allowed charges for this consultation.

The plan also provides a benefit for second opinion consultation for a cancer diagnosis. If you consult with an in-network physician, you will pay a $10 copay (with or without a referral from your physician). If you consult with an out-of-network physician, and have a referral, you will pay a $10 copayment and the visit will not be subject to the plan's deductible. If you do not have a written referral, the plan will pay for 80 percent of the allowed charges for consulting with an out-of-network physician after you have met the deductible.

For more information about the second opinion program, call Anthem Blue Cross at 800-342-9816.

Out-of-Country Care

If you are traveling outside the United States and require medical care, the GSEHP will pay benefits based on the currency exchange rate in effect at the time services are rendered. You may be required to pay the provider at the time of service. To request reimbursement for care received outside the United States, you must submit a translation of the bill, including diagnosis, description of service, charge for each service in local currency (if not in U.S. dollars), date(s) of service, and name of country where services were rendered. True medical emergencies in hospital facilities (inpatient and outpatient) are covered the same as if the care were received from an in-network provider. The plan reserves the right to reimburse the member directly.

If you are traveling internationally on official RF business, you should contact your campus Benefits Office 30 days in advance to obtain materials for international travel emergency services offered through GeoBlue. This valuable, free service includes travel alerts, global security services, and medical care for sudden illnesses or accidents. You should also refer to *International Travel Assistance* on page 23.

Summary of Benefits

The following is a brief outline of GSEHP benefits. For a detailed description of all covered services, please refer to the plan document, which is available on the RF Benefits Website.

	IN-NETWORK	OUT-OF-NETWORK
Plan Year Deductible	Does not apply to most services	$100 per individual
Annual Out-of-Pocket Maximum* Medical Prescription Drug	$5,080 individual/$10,160 family $1,270 individual/$2,540 family	No limit
	YOUR COSTS	
Preventive Care Follows the mandates of the Affordable Care Act. Refer to your summary plan description for details.	$0	0-18 years: 20% coinsurance 18+ years: Not covered
Physician Office Visit Includes specialist visits, diagnostic X-ray, diagnostic machine tests and procedures, lab tests, pathology tests, and allergy testing performed during the physician office visit	$10 copayment	20% coinsurance after deductible
Emergency Room and Related Services for a Medical Emergency	$25 copayment per visit; copayment waived if already applied to the emergency room physician's fee	$25 copayment per visit; copayment waived if already applied to the emergency room physician's fee
Outpatient Surgical Care	$15 copayment	20% coinsurance after deductible
Urgent Care Facility	$10 copayment	20% coinsurance after deductible
Approved Clinical Trials	The plan covers routine patient costs	Only covered if an in-network provider is unavailable

** Copayments, coinsurance and amounts paid to satisfy the plan year deductible apply.*

How Claims Are Submitted

The GSEHP pays in-network providers directly for services provided to you. So, generally, you will only need to submit a claim for reimbursement when you directly pay for care received from an out-of-network provider.

Claim forms can be downloaded from www.anthem.com and should be filed within 90 days of the date charges are incurred. Claims filed later than that date may be declined or reduced. Benefits are based on the plan's provisions at the time of the charge.

There are different kinds of claims and each one has a specific timetable for either approval, payment, request for further information or denial. You also have certain rights to appeal claim denials, and the plan must meet certain requirements for notifying you about claim decisions. For more information about how claims are handled, contact the Plan Administrator or refer to the plan document, which is available on the RF Benefits Website.

What's an Annual Out-of-Pocket Maximum?

This is a cap on what you will pay for certain in-network covered services in any one year. Your copayments, coinsurance and deductible for in-network services count toward meeting this limit. Once your annual out-of-pocket maximum is met, the plan pays 100 percent of covered expenses for the remainder of the plan year.

Important Medicare Notice

Once you and/or your covered dependents are eligible for Medicare, the GSEHP will integrate with Medicare coverage, even if you or your covered dependents are not enrolled in Medicare. In many cases, the GSEHP will reduce its benefits by the actual or estimated Medicare payment. This can result in a significant decrease in plan benefit.

You and your dependents are responsible for Medicare enrollment, so it is important that you understand when you become eligible for Medicare and take appropriate action.

Generally, you, your spouse or domestic partner or other dependent becomes eligible for Medicare at age 65. You also may become eligible after receiving no less than 24 months of Social Security disability benefits, or after being diagnosed with end stage renal disease or Lou Gehrig's disease (amyotrophic lateral sclerosis or ALS) subject to certain exceptions. If the GSEHP is your primary health care coverage, Medicare regulations allow you (but not your domestic partner) to delay Medicare enrollment until this plan becomes secondary according to Medicare Secondary Payer rules. Your local Social Security Office can provide details on enrollment requirements and penalties for late enrollment.

For more information about how the GSEHP integrates with Medicare coverage, refer to the plan document, which is available on the RF Benefits Website. For more information about Medicare enrollment, contact your local Social Security Office.

Prescription Drug Coverage

If you enroll in the GSEHP, you will automatically receive Prescription Drug coverage as part of the plan. This coverage is provided through Express Scripts and is designed to cover most medications that require a physician's written prescription, including insulin and other diabetic supplies. Prescription drugs may be obtained from your campus's Student Health Center, through the Express Scripts mail-order service or from a retail pharmacy.

Contact Express Scripts
800-818-6632
www.express-scripts.com

Identification Card

The GSEHP identification card you receive from Anthem Blue Cross will serve as your identification card for prescription drug coverage. Present this card at a participating pharmacy when you fill a prescription. This ID card contains your group and member numbers and serves as verification of your enrollment in the plan.

Choosing a Pharmacy

Retail Pharmacies

For short-term or immediate prescriptions, you also may visit your local retail pharmacy. When you visit a retail pharmacy that participates in the Express Scripts network, you will pay less for your prescription than if you visit a nonparticipating pharmacy.

Participating Pharmacies — Thousands of retail pharmacies participate in the Express Scripts network. These pharmacies offer you discounted drug prices and your copayment will be lower. Simply present your ID card, pay the copayment (and brand-name differential, if applicable), and receive your prescription. You may fill up to a 30-day supply of a medication at a retail pharmacy, but you will save money by using the mail-order service to fill long-term medications. To find a local participating retail pharmacy, visit www.express-scripts.com.

Nonparticipating Pharmacies — If you have a prescription filled at a retail pharmacy that is not a part of the Express Scripts network, you must pay the full price of your prescription and request a reimbursement from Express Scripts. The plan will reimburse you up to the amount the plan would have paid at a participating pharmacy for that drug. If you choose a brand-name drug when a generic equivalent is available, you will be reimbursed up to the amount the plan would pay for the generic equivalent. For more information, refer to *How to File a Claim* on page 15.

Mail Order

Through the mail-order service, you can receive 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 less than the cost of a 60-day supply (two fills) from a retail pharmacy. Shipping is free, making the mail-order service 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.

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.

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 as safe and effective. However, generics cost 30 to 70 percent less than brand-name drugs.

Preferred brand-name drugs 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.

Nonpreferred brand-name drugs have the highest copayment. Generally, these are high-cost medications that have recently come on the market. So-called "designer" drugs also fall into this category. 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.

You may obtain a list of preferred brand-name drugs at www.express-scripts.com or by calling 800-818-6632.

Specialty Medication

Specialty medication prescriptions must be filled through the Express Scripts mail-order specialty pharmacy. This type of medication usually requires 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 when billed by a pharmacy. Generally, you will pay a 20 percent coinsurance after meeting your medical benefit plan year deductible.

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 GSEHP, 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 GSEHP, refer to the plan document.

Summary of Benefits

	YOU PAY	
	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs – Retail 30-day supply	$5 generic $25 preferred brand* $45 nonpreferred brand*	You pay the full price and submit a claim for reimbursement
Prescription Drugs – Mail Order 90-day supply	$5 generic $50 preferred brand* $90 nonpreferred brand*	N/A

** If you choose a brand-name drug when a generic equivalent is available, you will be responsible for paying the difference in cost between the generic drug and the brand-name drug in addition to the copayment.*

Copayments Waived for Certain Preventive Care Medications

Copayments are waived for medications that are mandated as covered under the preventive care provisions of the federal Affordable Care Act. For more information about these medications, contact Express Scripts at 800-818-6632.

Drugs and Supplies That Are Not Covered

The following drugs and supplies are not covered under either the mail-order or retail pharmacy programs unless specifically listed as "Covered Drugs" by the plan.

- Nonfederal legend drugs
- Contraceptive jellies, creams, foams or nonfederal legend devices
- Differin/Epiduo from age 36 and over
- Food supplements
- ACA aspirin (except for those aged 45 through 79)
- ACA iron (except for those up to age 1)
- ACA folic acid (except for females through age 50)
- ACA fluoride (except for those through age 5)
- Vitamins (except for legend prenatal vitamins)
- Mifeprex
- Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only
- Allergy sera
- Biologicals, immunization agents or vaccines
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual

- Expense due to injury or sickness that arises out of or in the course of employment
- Drugs that are not approved by the Food and Drug Administration, including any component of a compound medication

Quantity/Duration Limits

Quantity/duration limits are designed to prevent the dangers associated with the inappropriate or improper use of prescription medicines. These limits apply to drugs in the following categories:

- Antibiotics (Xiflaxan/Zyvox),
- Anti-influenza agents,
- Anti-narcoleptics,
- Cancer therapy,
- Drugs used to treat nausea and vomiting,
- Hypnotic agents (treatments for insomnia),
- Incivek/Victrelis,
- Migraine agents,
- Pain management (narcotic and non-narcotic) and
- Rheumatoid arthritis drugs.

How to File a Claim

If you do not present your ID card when filling a prescription at a participating pharmacy, or if you fill your prescription at a nonparticipating pharmacy, you will be responsible for paying the full cost of the prescription. If this happens, you must submit a claim for reimbursement to Express Scripts at the address below. A separate Express Scripts reimbursement form is required for each employee or dependent and for each pharmacy used. Reimbursement forms are available from your campus Benefits Office and from Express Scripts.

How to Request Reimbursement When Using a Nonparticipating Pharmacy

1. Obtain an Express Scripts Prescription Drug Reimbursement Form from Express Scripts or from your campus Benefits Office.
2. Complete the Member/Subscriber/Patient Information and sign the form.
3. Have your prescription filled and pay the full retail price of the drug.
4. Have the pharmacist complete and sign the Pharmacy Information portion of the form.
5. Tape the original receipt to the claim form. Do not use staples or paper clips.
6. Make a copy of the form and receipt for your records, then mail the **original** completed form and receipt to:

   Express Scripts, Inc.
   P.O. Box 631850
   Irving, TX 75063-0030
   Website: www.express-scripts.com

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

Determination of Claims and Appeals

Prescription drug claims and appeals are handled according to the same requirements described under Post-service Claims in the GSEHP plan document.

If you are initiating an appeal for Prescription Drug coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied and any additional information that may be relevant to your appeal.

For initial *administrative* reviews, this information should be mailed to:

Express Scripts, Inc.
P.O. Box 631850
Irving, TX 75063-0030
Attention: Administrative Appeals

For initial *clinical* reviews, this information should be mailed to:

Express Scripts, Inc.
P.O. Box 631850
Irving, TX 75063-0030
Attention: Clinical Appeals

Dental Care

The Dental Care plan, which is part of the GSEHP, provides you and your eligible dependents coverage for preventive services (exams and cleanings), basic services (fillings), major services (dentures and bridges) and orthodontics.

The Dental Care plan is offered through Delta Dental. 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 which will reimburse you according to the plan's benefits. You may have to pay for the services first.

Benefits Summary[1]

	IN-NETWORK	OUT-OF-NETWORK AND DELTA DENTAL PREMIER[2]
Deductible Waived for diagnostic, preventive and periodontal prophylaxis	$50 per person / $150 per family each calendar year	
Benefit Maximum[3] Diagnostic and preventive services count toward maximum	$1,000 per person each calendar year	
	YOU PAY	
Diagnostic and Preventive Services Exams, cleanings, X-rays, sealants (within plan limits)	No charge	No charge
Basic Restorative Services Fillings	25%	25%
Major Restorative Services Single crowns, inlays, onlays	50%	50%
Oral Surgery Extraction and other oral surgery procedures, including pre- and post-operative care	25%	25%
Endodontics Root canal, pulpal therapy	25%	25%
Periodontics Gum treatment	25%	25%
Temporomandibular Joint Dysfunction (TMJ) Services relating to hinging joints of the jaw	50%	50%
Prosthodontics Bridges and dentures	50%	50%

[1] Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

[2] Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

[3] Maximums do not apply to diagnostic, preventive or basic services for dependent children under age 19.

Contact Delta Dental

800-932-0783
(TTY/TDD: 888-373-3582)
www.deltadentalins.com

Choosing a Dentist

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 online dentist directory by location or specialty. (The RF uses the Delta Dental Premier and Delta Dental PPO networks.)

Delta Dental Website

Delta Dental's Online Services (www.deltadentalins.com) make getting information quick and easy. Access your benefits and eligibility, print ID cards and get information about your claims. Also, check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

Extended Dental Benefits After Termination of Employment or Eligibility

If dental work is begun before coverage ends, and it is completed within 90 days of termination of eligibility or employment, then charges for the following treatments will be paid:

- 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 *Coverage Continuation* on page 25 for more information.

How to File a Claim

Delta Dental does not require any special claim forms. Most dental offices have standard claim forms available. Participating dentists will fill out and submit your claims paperwork for you. Some nonparticipating dentists may also provide this service upon your request. If you receive services from a nonparticipating dentist who does not provide this service, you can submit your own claim directly to Delta Dental. You can print a claim form from the Delta Dental website (www.deltadentalins.com). Delta Dental shall not be obligated to pay claims submitted more than 12 months after the date of the service, unless it can be shown not to have been reasonably possible to submit the claim and the claim was submitted as soon as reasonably possible. Your dental office should be able to assist you in filling out the claim form. Mail completed claim forms to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-6999

Claim Appeals

Any dissatisfaction with adjustments made or denials of payment should be brought to Delta Dental's attention and, if not resolved to your satisfaction, to the Plan Administrator. The Plan Administrator will advise you of your rights of appeal or other recourse. Grievances, appeals and claims review requests must be submitted in writing to:

Delta Dental
One Delta Drive
Mechanicsburg, PA 17055

Vision Care

When you enroll in the GSEHP, you will automatically be enrolled in the Vision Care plan. This plan is designed to provide quality vision services and products at a reasonable cost. The Vision Care plan is administered by Davis Vision, Inc., a leading national administrator of vision care programs. In New York, Davis Vision retail locations are called Visionworks.

Contact Davis Vision
800-999-5431
www.davisvision.com

Participating Providers

Eligibility for services and your level of reimbursement is 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 one of the following benefits:

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 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 from the Davis collection with an employee copayment of $25. If contact lenses are chosen that are not in the plan selection, there will be a $105 allowance toward the cost plus 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. Upgraded frame and lens options are available with an additional employee copayment.

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 Description.

Occupational Eyeglasses

The Vision Care plan pays for an additional pair of single vision eyeglasses a covered RF employee needs for his or her job; covered dependents are not eligible for this benefit. To take advantage of this benefit, obtain the additional eyeglasses at the same time as your regular eyeglasses.

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 5 percent off any advertised special. Note that some providers have flat fees equivalent to these discounts. Please check the discount available to you with the participating provider.

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 GSEHP.
- 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 and discounts on amounts over the allowance.
- Specialty lenses (progressive, photosensitive) and lens coatings (antireflective, scratch resistant) are available at a discounted rate.

Davis Vision's Exclusive Frame Collection

Davis Vision's Exclusive Frame Collection features 222 frames from top designer brands, including Elizabeth Arden®, GANT®, Jill Stuart®, Perry Ellis®, Candie's®, Bongo® and Chelsea Morgan®. Frames are available in a wide variety of styles for men, women and children. To find the nearest Davis Vision provider that carries the Exclusive Frame Collection, visit www.davisvision.com.

How to File a Claim

Participating Providers

Contact Davis Vision to make sure that 12 months have elapsed since you last used your benefit. Choose a participating provider from the Directory of Vision Care Plan Doctors, contact this provider, give your Social Security number or employee 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.

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

Nonparticipating Providers

Before scheduling an appointment with a nonparticipating provider, contact Davis Vision to make sure that 12 months 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 by phone or online 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.

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

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. Vision Care claims are treated as post-service claims as described in the GSEHP plan document. You may contact your campus Benefits Office for assistance in resolving your appeal.

Coordination of Benefits

The GSEHP has rules for coordinating benefit payments when you or your covered dependents are covered by more than one plan. These rules determine the order and amount of payment 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.

When medical payments are available under vehicle insurance, the GSEHP will always be the secondary plan regardless of your personal injury protection coverage election with the auto carrier.

For more information about coordination of benefit rules, refer to the plan document, which is available on the RF Benefits Website.

Disability/Income Protection

The RF provides disability and income protection benefits that replace a portion of your income when you are disabled and unable to work. These benefits include New York State Short-Term Disability insurance, Workers' Compensation and Unemployment Benefits.

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. You also may contact the insurance company for each plan directly.

New York State Short-Term Disability

In accordance with New York State law, this plan pays a benefit for up to 26 weeks (after a seven-day waiting period) 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 (currently $170 per week). These benefits will continue until your physician approves your return to work, up to 26 weeks or through your current appointment, if that comes first. If you are eligible for leave under the Family 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.

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.

Contact Your Campus Benefits Office

Eligibility

Only RF employees, including graduate student employees, are eligible for this plan. Fellows are not eligible. If you were not eligible for this benefit with a previous employer, and you are a full-time employee, you will become eligible after four consecutive weeks of service. If you are a part-time employee, you are eligible after 25 regular work days.

How to Enroll

Eligible employees are automatically enrolled in this benefit. The RF pays the full cost for this coverage.

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 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 decision, 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, promptly contact any office of the Workers' Compensation Board.

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 $1,833.63 for a maximum of 12 weeks.

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.

To Apply for Benefits

Contact your campus Human Resources Office.

Using Accruals

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

Your Cost for the Program

The state has mandated that all employees will pay for this coverage through payroll deduction at a rate of .432 percent of weekly earnings and capped at $411.91 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 will be able to 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, 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 PFL and disability in a 52-week period.

Workers' Compensation

If you are unable to work because of an injury or illness directly caused by your job, Workers' Compensation will pay you up to two-thirds of your average weekly wages (up to legal limits) and cover medical expenses related to the injury or illness until your physician approves your return to work.

You would be eligible for income benefits on the eighth day of your absence from work due to a work-related injury or illness. If your 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. This plan also provides death benefits for your surviving spouse and eligible dependents.

Eligible employees are automatically enrolled in this benefit and coverage begins on the first day of work. Fellows are not eligible. The RF pays the full cost of coverage.

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 decision, 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 Benefits Office.

Unemployment Benefits

Unemployment insurance pays you a weekly benefit for up to 26 weeks if your employment with the RF is involuntarily terminated. You are automatically enrolled for this coverage and the RF pays the full cost of this benefit. Fellows are not eligible.

The benefit amount paid to you is based on your wages and a formula established by the New York Department of Labor (DOL). Your benefit will be capped by the maximum weekly benefit in effect under DOL rules at that time. Your maximum weekly benefit may be reduced by any pension benefit or other compensation you receive.

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. However, during periods of high unemployment, the DOL may extend benefits for additional weeks.

How to File a Claim

When you terminate employment, your campus Benefits Office will provide you with a record of employment form that includes your exact date of termination. You can file your claim for unemployment insurance benefits online using the DOL website or by calling the claims center at 888-209-8124 (for New York State residents) or 877-358-5306 (for 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. If you are not eligible for benefits, you will be notified by the DOL. You have the right to appeal a claim in accordance with DOL guidelines.

Contact Your Local New York State Department of Labor Unemployment Office

www.labor.ny.gov
(Select "Individuals")

Savings and Discounts

Do you commute to work? Do you need help paying for college tuition? Do you have the proper insurance to protect your home and your valuables? The RF offers a variety of benefits to help you manage and save money on all these important parts of your life outside of work. (Fellows are not eligible for these programs.)

College Savings Program

The College Savings Program allows you to set aside up to $5,000 per year ($10,000 per year if married) to pay for your own higher education expenses or for the higher education expenses of specified beneficiaries, such as a child, grandchild, other relative or friend.

Contributions can only be made to your program account by direct payroll deposits. The funds in your account are invested according to investment options that you select. The earnings on those investments, as well as withdrawals from the plan account, are free from state and federal income taxes as long as the money is used to pay for the beneficiary's qualified higher education expenses.

If you are eligible for payroll direct deposit from the RF, you are eligible to participate in the College Savings Program. The program is managed by Upromise Investments, Inc. Investment funds are managed by the Vanguard Group, Inc.

Contact College Savings Program
877 NYSAVES
(877-697-2837)
www.nysaves.org

Upromise Rewards

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

How to Enroll

If you would like to enroll, request a College Savings Program enrollment kit from your campus Benefits Office. The kit 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. Completed forms must be submitted to your campus RF Payroll Office.

When Payroll Deductions Begin

Your payroll deductions for the College Savings Program will begin the second payroll period after the RF Payroll Office receives your forms.

Overpayments

Direct deposits to your program account are made before direct deposits to your local bank. If you are overpaid and have directed funds to the College Savings Program, you will be required to reimburse the RF for the entire overpayment. Funds already deposited to the plan will remain in your plan account.

Managing Your Account

You are responsible for managing your College Savings Program account. You may retrieve funds from the account by filling out the appropriate forms and paying 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, homeowner's and renter's insurance through Liberty Mutual. You pay the full cost of this coverage, but if you sign up for scheduled electronic payments, the convenience fees normally charged for making installment payments will be waived.

To participate in the insurance discount program, call Liberty Mutual at 800-524-9400 directly and identify yourself as an RF employee (or provide them with the RF client number 111756). You also can enroll online, or in person at your local Liberty Mutual office. There are no payroll forms to complete.

Contact Liberty Mutual Insurance
800-524-9400
www.libertymutual.com/rfsuny

RF Ride Commuter Transit Benefit

RF Ride can help you save money by letting you pay for eligible public commuting expenses with pretax payroll deductions. Eligible expenses include the cost of public transportation to get you to work (e.g., 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.

To see if your expenses are eligible, visit www.inspirafinancial.com or call Inspira Financial at 844-729-3539.

Contact Inspira Financial
844-729-3539
www.inspirafinancial.com

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/sunyrf or call 844-250-9199 and reference promo code "Rfgrademp" for your discount.

Contact Liberty Mutual
pet.libertymutual.com/sunyrf

International Travel

As SUNY and the RF reach out across the globe, international travel has become an increasingly common activity for RF employees. To support these important research, education and training activities, the RF provides international travel assistance, as well as emergency health insurance benefits, for all persons traveling overseas on official RF business.

GeoBlue Traveler

GeoBlue Traveler provides up-front payment guarantees to hospitals and physicians worldwide for non-routine medical care for eligible employees traveling on RF business for periods of fewer than 180 consecutive days. Accompanying eligible dependents also are covered. Generally, non-routine health care expenses up to $200,000 per year are covered in full. The health insurance premium is paid in full by the RF.

GeoBlue also offers Worldwide Emergency Assistance Services for anyone traveling outside the country on official RF business. Accompanying spouse and dependent children also are covered.

Travel assistance benefits include medical evacuation, lost document assistance, legal referrals, contact information for embassies, emergency messages to family members, translation services and access to a call center that provides numerous services 24 hours a day, 365 days a year. The travel assistance coverage becomes effective when your international travel is scheduled.

Before You Travel

If you are planning to travel internationally on RF business, you should sign up for an online account with GeoBlue. This organization provides valuable online services to RF travelers. Visit the RF Benefits Website or your campus Benefits Office for more information.

Contact GeoBlue

855-282-3517

www.geo-blue.com

General Information

Summary of Plans

Plan Administrator

The Research Foundation president is the Plan Administrator for all plans.

Research Foundation for The State University of New York
35 State Street
Albany, NY 12207-2826

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
RF Graduate Student Employee Health Care	512	Preferred provider organization (PPO)	Administrative services agreement	Self-insured[1]	December 31
		Prescription drug benefits	Administrative services agreement	Self-insured[1]	December 31
Dental Plan	512	Dental benefits	Administrative services agreement with Delta Dental of New York, Inc.	Self-insured[1]	December 31
Vision Care Plan	512	Vision care benefits	Vision care services agreement with Davis Vision	Self-insured[1]	December 31
International Travel Assistance	N/A	International assistance and medical benefits	Insurance contract with GeoBlue	Insured	December 31
Workers' Compensation	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 First Reliance Standard	Insured	December 31
Paid Family Leave	N/A	Paid Family Leave	Insurance contract with First Reliance Standard	Insured	December 31
New York State Unemployment Insurance	N/A	Unemployment insurance Department of Labor	Self-insured plan through the State of New York	Self-insured[1]	N/A

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

Your Rights Under State and Federal Laws

Coverage Continuation

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) you and your covered dependents are entitled to elect a temporary extension of health care coverage (called "COBRA continuation coverage") when coverage under the plan would otherwise end because of a life event known as a "qualifying event." If you or a member of your family has coverage under the GSEHP (including Dental and Vision Care) at the time of the qualifying event, you each have an opportunity to continue coverage under that plan.

Other Options for Continuing Your Coverage

In addition to COBRA, you may have other options available to you to continue your health care coverage. You will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums. For more information, visit www.healthcare.gov.
You also may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan). Even if the plan generally does not accept late enrollees, you may be able to request enrollment within 30 days. For more information, contact a representative for that plan.

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 and same-sex spouses 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 and same-sex spouses 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 the GSEHP 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 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.

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 notice to the Plan Administrator not later than the last day of your COBRA election period. The affected individual must notify the RF office of Sponsored Programs Administration 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 that event.

Except in the case of a bankruptcy, 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 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 Sponsored Programs Administration 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 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 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 GSEHP, the qualified beneficiary becomes covered by another group plan, unless that plan contains any 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.

Effect of Not Electing COBRA

If you do not choose continuation coverage, your health, dental and vision care coverage will end on the date specified by the plan.

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* on page 24 that have an "ERISA Plan Number," indicating that the plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). The president of 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 group health plans, including the Health, Vision and Dental Care 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 the 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 your claim for benefits 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. 20230. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-EBSA (3272) or by 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, although the RF is not itself generally a "covered entity," the group health plans sponsored by the RF are 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.

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; or

- 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 30 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* on page 24, 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 classes 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 for Human Resources, The Research Foundation for The State University of New York, 35 State Street, Albany, NY 12207-2826.

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 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 PHI, except under a few unusual circumstances. If you request a copy of your PHI, the plan may charge a fee for the costs of copying.
- **Right to amend.** If you feel that the PHI 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.** You have the right to request 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 PHI, 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.

Notice of Rescission of Coverage

Coverage may only be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation, or due to failure to pay premiums. A 30-day advance notice is now required before coverage can be rescinded. The regulatory agencies have not yet issued model language to be used for coverage rescissions.

Newborns and Mothers Health Protection Act

Under this federal law, sometimes referred to as the "NMHPA," 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) 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, the NMHPA 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.

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) 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
Email: kathleen.caggiano-siino@rfsuny.org.

You can file a grievance in person or by mail 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 20231
Phone: 1–800–368–1019, 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

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

Bengali

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারনে, তাহলে নিঃখরচায় ভাষা সহায়তা পরষিবো উপলব্ধ আছে। ফোন করুন ১-518-434-7101।

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-.7101-434-518).

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. 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.

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").

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

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.

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.

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

HIPAA – Health Insurance Portability and Accountability Act of 1996.

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.

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 12 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.

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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.

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.

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.

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

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.

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