2024 Benefits Handbook

ACTIVE EMPLOYEES

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 of 1974 (ERISA), this handbook, in combination with handbooks and certificates from the insurance companies, constitutes the ERISA plan and summary plan description. The Research Foundation for the State University of New York Retirement Plan and The Research Foundation for the State University of New York Optional Retirement Plan have separate plan documents, which shall govern in the event of a discrepancy between this handbook and those plan documents.

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

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

Benefits at a Glance

BENEFIT	COVERAGE WAITING PERIOD	ELIGIBILITY	BREAK IN SERVICE	WHEN COVERAGE ENDS	COVERAGE COST
Optional Retirement Plan	None	All employees except full-time SUNY students appointed in an RF student title.	N/A	Contributions end when you are no longer on the payroll or choose not to make further contributions.	You pay for this benefit through pre-tax or Roth (post-tax) salary deduction.
Unemployment Insurance	Coverage is effective immediately if you meet Department of Labor criteria. A seven-day waiting period must be met following application for unemployment insurance benefits. Refer to *Continuing Benefits* on page 56 for detailed information.	You are eligible if you are an employee who involuntarily leaves the RF and meets the Department of Labor eligibility requirements.	N/A	Benefits end when you are no longer unemployed or when 26 weeks elapse from the start of benefits, whichever comes first. (Sometimes the federal government allows additional weeks.)	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
Pretax Premium Payment	Same as benefit for which premium is paid	Same as benefit for which premium is paid	N/A	Coverage ends when your employment ends, or when your coverage under the benefit for which the premium is paid ends.	This plan allows you to pay for certain benefits on a pretax basis.
Dependent Care Flexible Spending Account	Six months	Eligible You are eligible if you are a salaried, non-student employee working at least 50% of full time. Ineligible You are not eligible if you are an hourly, full-time SUNY student appointed in an RF student title or a summer employee.	Same as Dental Care	Coverage ends when your employment ends, or at the end of the benefit plan year if you make no election for the following plan year.	You pay for this benefit through pretax salary deduction. The RF pays a subsidy based on your full-time equivalent salary.
Health Care Flexible Spending Account	Six months	Same as Dependent Care Flexible Spending Account	Same as Dental Care	Coverage ends when your employment ends, or at the end of the benefit plan year if you make no election for the following plan year.	You pay for this benefit through pretax salary deduction.
RF Ride Commuter Transit Benefit	None	All employees	N/A	Coverage ends when your employment ends, or when you choose to stop participating.	You pay for this benefit through pretax or after-tax salary deduction.
Wellness Plan	Same as Health Care (Active Employees)	Same as Health Care (Active Employees)	Same as Health Care (Active Employees)	Coverage ends when your employment with the RF ends.	The RF pays the full cost of this benefit.
Pet Insurance	None	All employees	N/A	Coverage ends when you choose to stop participating.	You pay for this benefit through payroll deduction.

Enrollment Guidelines

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

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

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

Guidelines at a Glance

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

Coverage Continuation During a Disability

The Health, Dental and Vision Care benefits and life insurance coverage in effect when you become disabled will continue while you are receiving income replacement benefits for a total disability, subject to the terms of those plans. Refer to *Continuing Benefits* on page 56 for more information.

How to File a Claim

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

Claims Appeal

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

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

Sick Leave Credit

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

Contact Chubb Insurance Company

Call your campus Benefits Office

www.wcb.ny.gov (Click on "Workers")

New York State Short-Term Disability

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

Benefits are 50 percent of your average weekly salary, up to the maximum benefit allowed under the New York State Disability Benefits Law (currently $170 per week). The RF pays the premium for this coverage, so benefits paid to you are taxable.

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

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

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

Coverage Continuation During a Disability

The Health, Dental and Vision Care benefits and Basic Life insurance coverage in effect when you became disabled will be continued for the period of time during which partial income replacement is received through New York State Short-Term Disability insurance, subject to the terms of those plans. You may elect to continue your Optional Life insurance (if applicable) by paying the full, biweekly premium. Refer to *Continuing Benefits* on page 56 for more information.

How to File a Claim

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

Claims Appeal

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

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

Voluntary Short-Term Disability

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

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

Eligibility

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

When Coverage Ends

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

How to Enroll

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

Right to Amend or Terminate the Plan

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

Contact The Standard
800-426-4332
www.standard.com

Long-Term Disability

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

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

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

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

Eligibility

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

When Coverage Begins

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

Break in Service

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

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

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

Contact The Standard
800-426-4332
www.standard.com

What Is a Total Disability?

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

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

Benefit Reductions

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

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

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

Continuing Benefits

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

If Your Employment Ends

Death of an Active or Disabled Employee

Health, Dental and Vision Care coverage will continue for your covered dependents for six months following your death. If you had met all eligibility requirements for Retiree Health Care, health coverage may be continued beyond six months. The first six months of coverage is provided without charge, after which the dependent must pay the full premium. In addition, a contribution will be made to your Basic Retirement plan account based on the dollar value of your remaining sick leave, as described in *Contributions on Unused Sick Leave at Retirement* on page 45.

If you had not met the eligibility requirements for Retiree Health Care, coverage beyond the first six months is available to your dependents under COBRA (refer to page 64); however, your COBRA benefits continuation period runs concurrently to the first six months.

Termination

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

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

Basic and Optional Life

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

New York State Unemployment Insurance

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

Eligibility

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

When Benefits Begin and End

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

Break in Service

Retirements Before January 1, 2012 – Prior to meeting the eligibility criteria, if you incur a break in service of one year or more, you must meet a new service requirement.

Retirements After January 1, 2012 – You do not need to meet a new service requirement after incurring a break in service.

Payment of Health Insurance Premiums (for Retirees and Dependents Who Are Not Eligible for Medicare)

After you retire, your RF health insurance premiums will be paid as follows:

IF YOU WERE HIRED	THEN
Before January 1, 1986	The RF will pay the full premium for your coverage until you reach age 65. See page 59 for health care coverage at age 65 or older.
On or after January 1, 1986, and were eligible to retire on or before December 31, 2011	Until you reach age 65, you are responsible for the same share of the premium as an active employee (see page 14). Payment details will be provided at the time of retirement. See page 59 for health care coverage at age 65 or older.
On or after January 1, 1986, and were not eligible to retire on or before December 31, 2011	The amount you pay will vary with the number of full-time equivalent years of service you have at retirement. See the Retire Health Care Rate Tables below for more information. See page 59 for health care coverage at age 65 or older.

Health Care Rate Tables (for Retirees and Dependents Who Are Not Eligible for Medicare)

For those hired on or after January 1, 1986, but before January 1, 2012, and not eligible to retire on or before December 31, 2011.

FULL NUMBER OF YEARS OF SERVICE AT RETIREMENT	AGE OF COVERED PERSON	RETIREE CONTRIBUTION RATE	
		Individual Coverage	Spouse Coverage
10 to 14 years	Between 55 and 64 years old	40% of premium	85% of premium
15 to 19 years	Between 55 and 64 years old	25% of premium	55% of premium
20 or more years	Between 55 and 64 years old	15% of premium	30% of premium

For those hired on or after January 1, 2012.

FULL NUMBER OF YEARS OF SERVICE AT RETIREMENT	AGE OF COVERED PERSON	RETIREE CONTRIBUTION RATE	
		Individual Coverage	Spouse Coverage
10 to 14 years	Between 55 and 64 years old	80% of premium	85% of premium
15 to 19 years	Between 55 and 64 years old	40% of premium	55% of premium
20 or more years	Between 55 and 64 years old	15% of premium	30% of premium

Right to Amend or Terminate the Plan

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

If You Become Disabled

New York State Short-Term Disability or Workers' Compensation

Health, Dental and Vision Care Coverage Continuation

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

If you receive income replacement through Workers' Compensation for a total disability caused by a work-related illness or injury sustained during RF employment, the RF will continue the benefits in effect at the time of your disability, either for the period of the total disability or up to age 65, whichever comes first. At age 65, you will be eligible to continue your Health Care coverage as a retiree if you meet the eligibility criteria. Refer to *Payment of Health Insurance Premiums* on page 58.

Retirement Contributions Continuation

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

Long-Term Disability

Health, Dental and Vision Care Coverage Continuation

How your Health, Dental and Vision Care coverage continues while you are receiving LTD payments depends on a number of factors, including your date of hire, your age and the amount of full-time equivalent service you have at the time you become disabled. In each of the following situations, the period for which you are eligible for COBRA continuation coverage runs concurrently with the periods of extended coverage indicated.

When you become totally disabled within the meaning of the LTD contract, the Health, Dental and Vision Care coverage you have in effect at the time your disability begins will continue at no cost while you are receiving LTD payments for up to one year. After one year, your benefits will continue as described in the table below. (For more information about LTD benefits, refer to page 35.)

Benefits Continuation After One Year on Long-Term Disability

For Long-Term Disabilities Beginning on or After January 1, 2012.

YOUR HIRE DATE	FULL-TIME EQUIVALENT SERVICE AT THE TIME DISABILITY BEGINS	
	AT LEAST 10 YEARS	LESS THAN 10 YEARS
On or after January 1, 1986	You may continue your Health Care coverage while you are receiving LTD payments by paying for your coverage at the retiree premium rate regardless of your age. Your premium will be based on the years of service you had prior to the start of your long-term disability. **If your LTD payments end after you reach age 55**, your Health Care coverage will continue under the Retiree Health Care plan as long as you pay the premium. See page 57 for eligibility. **If your LTD payments end before you reach age 55**, you may continue your coverage in accordance with COBRA benefits continuation rules.	You may continue your Health, Dental and Vision Care coverage in accordance with COBRA benefits continuation rules.

Retirement Contributions Continuation

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

How Medicare Affects Your Health Insurance Benefits

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

If You Are Not Eligible for Long-Term Disability Benefits

Health, Dental and Vision Care Coverage Continuation

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

IF YOU	THEN
Have at least one year, but less than 10 years, of full-time service (or the equivalent in part-time service, at 50 percent or more of full-time effort) at the time of disability	Benefits will continue for one year beyond the time New York State Short-Term Disability benefits cease. Note: After one year, benefits may be continued for a limited period under COBRA, if you pay the full premium.
Have 10 or more consecutive years of full-time service (or the equivalent in part-time service, at 50 percent or more of full-time effort) at the time of disability	Health insurance benefits will continue for the duration of the total disability while you remain covered by Original Medicare Parts A and B until you reach age 65. At age 65, health insurance will continue as a retiree. See page 59 for eligibility.
Are no longer receiving a Social Security disability benefit	Health insurance benefits will continue as a retiree if you met the age and service requirements when the disability began and pay the required premium.

Basic Life Coverage Continuation

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

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

Optional Life Coverage Continuation

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

If You Take a Leave of Absence

Leave of Absence Without Pay

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

Family and Medical Leave

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

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

After Your Family and Medical Leave Period Ends

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

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

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

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

Paid Family Leave

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

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

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

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

Military Leave

Health, Dental and Vision Care Coverage Continuation

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

Basic Life and Optional Life Coverage Continuation

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

Reinstatement of Your Benefits Upon Return From Military Leave

All benefits for which you were eligible prior to qualifying for military leave under USERRA will be reinstated without a waiting period upon your return within the time frame for retaining your position under USERRA. Any benefit for which you are eligible that became effective during the military leave will become effective upon your return to RF employment. You will be credited with time toward the 10-year retiree health insurance service requirement and toward retirement plan vesting during the period of qualifying military service. You must return to RF employment and document your service and discharge as required under the law.

COBRA

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

Qualified Beneficiary

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

To be a qualified beneficiary, an individual must generally be covered under the group health plan on the day before the qualifying event that causes a loss of coverage (such as termination of employment, or a divorce from or death of the covered employee). However, a dependent child born to you or placed for adoption with you while you have COBRA continuation coverage has the same right to elect COBRA continuation coverage as the dependents who were covered by the plan on the day before the event that created your COBRA rights. Electing COBRA continuation coverage for newborn or adopted children is important if, during the first 18 months of COBRA coverage following a termination of employment or reduction in hours, a second qualifying event occurs involving your death, divorce or legal separation, or entitlement to Medicare, or if the dependent child ceases to meet the definition of "dependent" under the terms of the plan. Under such circumstances, a dependent child who has elected COBRA continuation coverage has the right to continue COBRA coverage for up to 36 months from the date of the first qualifying event. You should notify the Plan Administrator within 30 days of the child's birth or placement for adoption so that this valuable right is not lost.

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

Qualifying Events

Termination or Reduction in Hours

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

Death, Divorce, Medicare Entitlement

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

Loss of Dependent Status

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

Work/Life Balance

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

Paid Time Off and Paid Leave

In general, salaried employees appointed to at least 50 percent of full time are eligible to accrue paid time off. Hourly employees and those appointed to less than 50 percent of full time are eligible to accrue sick paid time off. Unless there are special circumstances, an employee cannot take time unless it is already accrued. Employees who are full-time SUNY students working part time and appointed in an RF student title are not eligible to receive paid time off.

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

Sick Time

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

Vacation and Personal Time

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

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

Paid Family Leave

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

Holidays

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

Military Leave

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

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

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

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

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

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

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

RF Ride Commuter Transit Benefit

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

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

Wellness Program

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

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

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

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

Contact Virgin Pulse
866-852-6898
www.virginpulse.com
To enroll:
join.virginpulse.com/rfsuny

Pet Insurance

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

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

Contact Liberty Mutual
pet.libertymutual.com/rfsuny

International Travel

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

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

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

GeoBlue Traveler

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

GeoBlue Expatriate

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

GeoBlue Global Assistance

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

Contact GeoBlue
855-282-3517
www.geo-blue.com

About Your Travel Assistance Plans

Notice of Claim

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

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

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

Right to Terminate the Plan

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

General Information

Summary of Plans

Plan Administrator

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

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

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

Agent for Service of Legal Process

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

Employer Identification Number

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

Plan Information

PLAN NAME	ERISA PLAN NUMBER	PLAN TYPE	TYPE OF ADMINISTRATION	FUNDING	END OF PLAN YEAR
HEALTH CARE					
Health Insurance for Regular Employees	501	Preferred provider organization (PPO)	Group insurance contract with Anthem Blue Cross	Insured	December 31
		Prescription drug benefits	Administrative services agreement	Self-insured*	December 31
		Health maintenance organizations	Insurance contracts with various health maintenance organizations	Insured	December 31
Post-retirement Benefits Plan	515	Health and dental	Group health insurance contracts and dental administrative services agreement	Group health insured, dental self-insured*	December 31
Post-65 Retiree Health Reimbursement Account	N/A	Health Reimbursement Account	Administrative services agreement with Alight	Self-insured*	December 31
Dental Care Plan	504	Dental benefits	Administrative services agreement with Delta Dental of New York, Inc.	Self-insured*	December 31
Vision Care Plan	508	Vision care benefits	Vision care services agreement with Davis Vision	Self-insured*	December 31
Health Care Flexible Spending Account	501	Part of the RF Flexible Benefits Plan	Administrative services agreement with Inspira Financial	Self-insured*	December 31

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

Plan Information *continued*

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

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

Your Rights Under State and Federal Laws

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

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

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

Right to Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- With respect to the retirement plans, obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to earn the right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months. The plan must provide the statement free of charge.
- With respect to the group health plans, including the health, vision and dental plans, continue coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- With respect to group health plans (other than dental and vision), reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA coverage, when your COBRA coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20230. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 866-444-EBSA (3272) or accessing the website at www.dol.gov/ebsa.

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

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

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

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

- To determine if an individual is participating in the plan;
- To modify, amend or terminate the plan;
- To obtain premium bids to provide insurance coverage for the plan, including reinsurance;
- To carry out other administrative functions of the plan such as:
  - Claims Assistance: Designated personnel may assist "covered persons" (i.e., employees of the RF who are plan participants and their covered dependents) in attaining a resolution of any issues related to obtaining payment for claims, including coverage and eligibility issues.
  - Appeal of Benefit Denials: Designated personnel may assist covered persons in appealing benefit denials of the insurer or third-party claims administrator.
  - Individual Rights Requests: Refer to *Your Rights Regarding Your PHI* on page 79 for more information.
  - Audit Functions: Designated personnel may review PHI, such as Check Registers, to confirm payment and perform other audit functions.

Designated Personnel

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

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

With respect to the health plans identified as being self-insured in the *Summary of Plans* beginning on page 75, the RF may receive PHI in connection with its role as the final arbiter of claims that have been appealed as provided under the administrative services agreements.

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

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

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

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

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

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

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

Your Rights Regarding Your PHI

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

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

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

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

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

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

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

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

Right to receive a Notice of Privacy Practices. You have the right to receive a Notice of Privacy Practices from the plan. To obtain a copy of this notice, please contact the Privacy Official at the Benefits/Claims Administrator listed on page 10. For self-insured plans, the RF provides the Notice of Privacy Practices, which is on the RF website.

Discrimination Is Against the Law

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

The RF:

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20231
Phone: 800–368–1019, 800–537–7697 (TDD).

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

Spanish

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

Chinese

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

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-518-434-7101.

French Creole

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

Korean

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

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero 1-518-434-7101.

Yiddish

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 পরিষেবা 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. For health plan terms, refer to your PPO or HMO handbook. Terms that primarily relate to a specific benefit plan are indicated as such. If no specific plan is indicated, the definition may apply to several plans.

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

Affordable Care Act – see PPACA.

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

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

Annuitant – a person receiving retirement annuity payments.

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

Alight Retiree Health Solutions (or private Medicare exchange) – an insurance marketplace through which the RF's Medicare-eligible retirees and/or their Medicare-eligible dependents age 65 and older can choose from a wide variety of health plans. Alight Retiree Health Solutions is private and is not part of the health care marketplace or public "exchanges" that were introduced as part of the Affordable Care Act.

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

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

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

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

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

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

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

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

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

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

Health Reimbursement Account (HRA) – a tax-advantaged, RF-funded account that reimburses RF retirees who participate in Alight Retiree Health Solutions for their eligible, out-of-pocket medical expenses and individual health insurance premiums.

HIPAA – Health Insurance Portability and Accountability Act of 1996.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Research Foundation for
The State University of New York

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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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