



THE RESEARCH FOUNDATION  
*The State University of New York*



# RESEARCH FOUNDATION BENEFITS HANDBOOK

---

# TABLE OF CONTENTS

<b>General Information .....</b>	<b>1</b>	Designating Your Beneficiaries.....	47
About the Research Foundation of State University of New York .....	1	How Benefits Are Paid.....	48
About the Benefits Handbook and Website .....	1	Filing a Claim .....	48
Benefits Plan Guidelines.....	2	Certificate of Insurance.....	50
Where to Get Help.....	6	<b>Retirement.....</b>	<b>51</b>
Summary of Plans .....	7	Benefits at a Glance.....	51
Your Rights Under Federal Laws.....	9	Basic Retirement Plan.....	51
<b>Health Care .....</b>	<b>15</b>	Optional Retirement Plan.....	61
Benefits at a Glance.....	15	Deferred Compensation Plan.....	67
Eligibility.....	15	<b>Continuing Benefits.....</b>	<b>69</b>
Enrollment.....	18	Continuing Benefits at a Glance .....	69
Changing Coverage.....	19	If Your Employment Ends .....	69
When Coverage Begins .....	22	If You Retire from the RF.....	71
Your Health Care Plan Options .....	23	If You Become Disabled.....	73
Dental Care .....	29	If You Take a Leave of Absence .....	76
Vision Care .....	31	COBRA.....	77
Coordinating Your Benefits .....	34	Dependent Coverage Under New York State's "Young Adult" or "Age 29" Laws .....	81
Important Information About Your Rights Under the Plan .....	35	<b>Work/Life Benefits.....</b>	<b>83</b>
<b>Disability/Income Protection.....</b>	<b>37</b>	Benefits at a Glance.....	83
Benefits at a Glance.....	37	Paid Leave .....	83
Workers' Compensation .....	38	Other Types of Leave .....	84
New York State Short-Term Disability.....	39	Flexible Benefits Program (Pretax Health Contributions).....	85
Voluntary Short-Term Disability.....	40	Health Care and Dependent Care Flexible Spending Accounts .....	85
Long-Term Disability .....	41	College Savings Program.....	86
Voluntary Long-Term Care Insurance.....	43	Auto and Homeowner's Insurance Discount Program.....	87
<b>Life Insurance.....</b>	<b>45</b>	RF Ride Commuter Transit and Parking Benefits .....	88
Benefits at a Glance.....	45	<b>International Travel Assistance.....</b>	<b>89</b>
Basic Life and Accidental Death and Dismemberment Insurance.....	45	<b>Key Terms .....</b>	<b>91</b>
Optional Life and Accidental Death and Dismemberment Insurance.....	46	<b>Index .....</b>	<b>93</b>
About AD&D .....	46		
Accelerated Death Benefit.....	47		





# GENERAL INFORMATION

---

## The Re·search Found·a·tion • *noun*

an organization of people providing services, systems and infrastructure to help each SUNY campus create a climate that supports research, scholarly and creative endeavors

# GENERAL INFORMATION

---

## About the Research Foundation of State University of New York

Celebrating 60 years of supporting SUNY research, the Research Foundation of State University of New York (RF) is the largest, most comprehensive university-connected research foundation in the country. The RF supports over \$1 billion in SUNY research activity annually and facilitates university-industry-government partnerships to accelerate the growth of sponsored program and applied research opportunities. Areas of research encompass a vast range of disciplines, including life sciences and medicine, engineering and nanotechnology, physical sciences and energy, social sciences, and computer and information sciences.

Founded in 1951 as a private, not-for-profit educational corporation, the RF works with academic and business leadership to support essential research and discovery that translate into invention, innovation, entrepreneurship, economic opportunity and public benefit. For more information visit the RF website at [www.rfsuny.org](http://www.rfsuny.org), and connect with the RF on Facebook at [www.facebook.com/rfsuny](http://www.facebook.com/rfsuny).

## About the Benefits Handbook and Website

Employee benefits represent an important part of your total compensation. Your *Research Foundation Benefits Handbook* provides a summary of each benefits plan and tells you where to find detailed information. 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. The Research Foundation of State University of New York Retirement Plan and The Research Foundation of 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.

This handbook aims to:

- Provide a comprehensive source of information about RF benefits plans and programs,
- Make your RF benefits plans and programs easier to access and understand when you need them most, and
- Help you with personal benefits and financial planning.

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.

Please retain this handbook for future reference and share it with your family. We encourage you to visit the RF Benefits Website at [www.rfsuny.org/benefits](http://www.rfsuny.org/benefits). You also can access the RF Benefits Website from the RF Home Page ([www.rfsuny.org](http://www.rfsuny.org)). Under "Working at the RF," click on "Your RF Benefits." Then, select "Regular Employees," or click on one of the "Life Events" shown to find related benefits information.

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.

## Benefits Plan Guidelines

### Guidelines At A Glance

Benefit	Coverage Waiting Period	Eligibility	Break in Service	When Coverage Ends	Coverage Cost
<b>Health Care (Active Employees)</b>	42 days Coverage begins on day 43 from date of employment or eligibility unless you incur a break in service. Refer to page 19 for late enrollment rules.	<b>Eligible</b> You are eligible if you are an employee working at least 50% of full time on a regular appointment. <b>Ineligible</b> You are not eligible if you are any of the following: <ul style="list-style-type: none"> <li>• An employee working less than 50% of full time,</li> <li>• A summer-only appointment,</li> <li>• A full-time SUNY employee or</li> <li>• A full-time SUNY student working part time in an RF student title.</li> </ul>	Prior to meeting the 42-day waiting period, if you incur a break in service of any number of days, you must meet a new waiting period.  After meeting the 42-day waiting period, if you incur a break in service of more than 28 days, you must meet a new waiting period.	Coverage ends 28 days after your employment or eligibility ends.	The RF pays 90% of the cost for individual coverage and 75% of the cost for dependent coverage; however, the RF's contribution is limited to the amount it pays for the PPO Plan.  You pay the balance through biweekly payroll deductions.
<b>Health Care (Retirees)</b>	N/A	You are eligible if you: <ul style="list-style-type: none"> <li>• Are an employee enrolled in RF Health Care benefits (PPO or HMO) at the time you retire,</li> <li>• Have a minimum of 10 years of continuous, full-time equivalent service and</li> <li>• Are at least age 55.</li> </ul>	<b>Retirements Before January 1, 2012</b> 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. Refer to Continuing Benefits on page 69.  <b>Retirements After January 1, 2012</b> You do not need to meet a new service requirement after incurring a break in service.	Refer to the <i>Retiree Benefits Handbook</i> and Continuing Benefits on page 69.	Refer to Continuing Benefits on page 69.

## Guidelines At A Glance

Benefit	Coverage Waiting Period	Eligibility	Break in Service	When Coverage Ends	Coverage Cost
<b>Dental Care</b>	<p><b>Preventive/Basic/Orthodontics</b> Coverage begins six months from the date of employment or eligibility.</p> <p><b>Major and Prosthodontic</b> Coverage begins 12 months from the date of employment or eligibility.</p> <p>Refer to page 19 for late enrollment rules.</p>	Same as Health Care (Active Employees)	<p>Prior to meeting the waiting period, if you incur a break in service of 28 days or more, you must meet a new waiting period.</p> <p>After meeting the waiting period, if you become ineligible but return to eligible employment within one year, coverage is reinstated on the date you return.</p> <p>If you return to work after a one-year break in service, you must meet a new waiting period.</p>	Coverage ends 28 days after your employment or eligibility ends.	<p>Effective January 1, 2012, the RF pays 90% of the cost for individual coverage and 75% of the cost for dependent coverage.</p> <p>You pay the balance through biweekly payroll deductions.</p>
<b>Vision Care</b>	<p>Six months</p> <p>Refer to page 19 for late enrollment rules.</p>	Same as Health Care (Active Employees)	Same as Dental Care	Same as Dental Care	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
<b>Basic Life and Accidental Death and Dismemberment Insurance</b>	<p>Six months</p> <p>Refer to page 19 for late enrollment rules.</p>	Same as Health Care (Active Employees)	Same as Dental Care	Coverage ends the day your employment ends.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
<b>Optional Life and Accidental Death and Dismemberment Insurance</b>	<p>Six months</p> <p>Refer to Life Insurance on page 46 for late enrollment rules.</p>	Same as Health Care (Active Employees)	Same as Dental Care	Coverage ends the day your employment ends.	You pay for this benefit through biweekly payroll deductions.
<b>Workers' Compensation</b>	<p>Coverage begins on your first day of active work. Income replacement benefits begin seven days after the day your disability begins.</p> <p>If your disability extends beyond 14 days, income replacement benefits will be paid retroactive to the first day of the disability.</p> <p>Refer to Disability/Income Protection on page 37 for detailed information.</p>	All employees	N/A	Coverage ends the day your employment ends.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.

## Guidelines At A Glance

Benefit	Coverage Waiting Period	Eligibility	Break in Service	When Coverage Ends	Coverage Cost
<b>New York State Short-Term Disability</b>	<p>None, if eligibility was established with a previous employer.</p> <p>If eligibility was not previously established, coverage begins</p> <ul style="list-style-type: none"> <li>• After four consecutive weeks of service for full-time employees or</li> <li>• After 25 regular work days for part-time employees.</li> </ul> <p>There is a seven-day waiting period before these benefits begin, starting with the first day you are unable to work because of your disability.</p>	All employees	N/A	Coverage will continue for four weeks after your last day of employment. If you are covered by a new employer within that time period, your RF coverage will end.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
<b>Voluntary Short-Term Disability</b>	28 days	Same as Health Care, but limited to salaried employees working at least 50% of full time, with an annual salary of at least \$15,000.	28 days	Coverage ends the day your employment ends.	You pay for this benefit with after-tax dollars.
<b>Long-Term Disability</b>	<p>Coverage begins on the first day of the month following one year of full-time service.</p> <p>Benefits begin on the first day following 180 consecutive days of a certified total disability.</p>	Full-time employees	<p>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.</p> <p>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.</p> <p>If you return after a one-year break in service, you must meet a new waiting period.</p>	Coverage ends on the last day of full-time employment.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.
<b>Basic Retirement Plan</b>	<p>One-year waiting period; vesting is immediate.</p> <p>Refer to Retirement on page 51 for detailed information.</p>	<p><b>Eligible</b> You are eligible if you are an employee in active pay status working at least 50% of full time on a regular appointment.</p> <p><b>Ineligible</b> Refer to Retirement on page 51 for detailed information.</p>	Refer to Retirement on page 51 for detailed information.	Contributions end when you are no longer on the payroll. Refer to Retirement on page 51 for detailed information.	The RF pays the full cost of coverage for this plan. You do not pay any biweekly deduction.

## Guidelines At A Glance

Benefit	Coverage Waiting Period	Eligibility	Break in Service	When Coverage Ends	Coverage Cost
<b>Optional Retirement Plan</b>	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 pretax salary reduction.
<b>Unemployment Insurance</b>	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 69 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.
<b>Voluntary Long-Term Care Insurance</b>	Six months Refer to Disability/Income Protection on page 37 for enrollment rules.	Same as Health Care (Active Employees)	N/A	Coverage ends when you stop paying the premium.	You pay the full cost of the coverage through payroll deduction or a direct payment plan with the carrier.
<b>Pretax Premium Payment</b>	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 benefits on a pretax basis.
<b>Dependent Care Flexible Spending Account</b>	Six months	<b>Eligible</b> You are eligible if you are a salaried, non-student employee working at least 50% of full time.  <b>Ineligible</b> 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 reduction. The RF pays a subsidy based on your full-time equivalent salary.
<b>Health Care Flexible Spending Account</b>	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 reduction.
<b>RF Ride Commuter Transit and Parking Benefit</b>	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 reduction.

# Where to Get Help

The RF has contracts with the following companies to insure your benefits and administer your claims, according to the terms of the plans as authorized by the RF. Contact these benefits administrators for information on service providers, claim reimbursement or pension benefits. Contact your campus Benefits Office for additional information, if you have questions on your benefits coverage, or if you need enrollment forms.

## Contact Information

Coverage	Benefits/Claims Administrator	Phone	Website
<b>Auto, Homeowner's and Renter's Insurance Discount Program</b>	Liberty Mutual Insurance	800-524-9400	<a href="http://www.libertymutual.com/lm/rfsuny">www.libertymutual.com/lm/rfsuny</a>
<b>Dental Care</b>	Delta Dental of New York, Inc.	800-932-0783	<a href="http://www.deltadentalins.com">www.deltadentalins.com</a>
<b>Health Maintenance Organizations (HMOs)</b>	Blue Choice (Rochester/Excellus) Capital District Physician's Health Plan (CDPHP) Health Insurance Plan of Greater NY (HIP) HMO Blue (BCBS of Central NY/Excellus) Independent Health Association (IHA) MVP Health Plan (All Areas) Vytra Premium Network (HIP)	800-462-0108 800-777-2273 800-447-8255 800-447-6269 800-501-3439 888-687-6277 631-694-4000	<a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> <a href="http://www.cdphp.com">www.cdphp.com</a> <a href="http://www.hipusa.com">www.hipusa.com</a> <a href="http://www.excellusbcbs.com">www.excellusbcbs.com</a> <a href="http://www.independenthealth.com">www.independenthealth.com</a> <a href="http://www.mvphealthcare.com">www.mvphealthcare.com</a> <a href="http://www.vytra.com">www.vytra.com</a>
<b>Life Insurance</b>	Prudential Insurance Company of America	800-524-0542	<a href="http://www.prudential.com">www.prudential.com</a>
<b>Long-Term Disability</b>	First Reliance Standard Life Insurance Company	877-315-0954	<a href="http://www.rsl.com">www.rsl.com</a>
<b>New York State Short-Term Disability</b>	First Reliance Standard Life Insurance Company	800-559-0954	<a href="http://www.wcb.state.ny.us/content/main/workers/workers.jsp">www.wcb.state.ny.us/content/main/workers/workers.jsp</a>
<b>Preferred Provider Organization (PPO)</b>	Empire Blue Cross: <ul style="list-style-type: none"> <li>• Member Services</li> <li>• To locate providers in Eastern New York State, including downstate</li> <li>• To locate providers in Central and Western New York State or outside New York State</li> <li>• Mental Health or Substance Abuse</li> <li>• Pre-certification</li> <li>• Personal Health Advisor</li> </ul>	800-342-9816 800-342-9816  800-810-BLUE or 800-810-2583 800-626-3643 800-982-8089 877-TALK2RN	<a href="http://www.empireblue.com">www.empireblue.com</a> <a href="http://www.empireblue.com">www.empireblue.com</a>  <a href="http://www.empireblue.com">www.empireblue.com</a>
<b>Prescription Drugs (PPO Plan)</b>	Mail Order: Medco By Mail Retail: Medco TTY service (for the hearing impaired)	800-251-7690 800-251-7690 800-759-1089	<a href="http://www.medco.com">www.medco.com</a> <a href="http://www.medco.com">www.medco.com</a>
<b>Retirement Plans</b>	TIAA-CREF	800-842-2776	<a href="http://www.tiaa-cref.org/rfsuny">www.tiaa-cref.org/rfsuny</a>
<b>Unemployment Insurance</b>	New York State Department of Labor	Contact your local unemployment office.	<a href="http://www.labor.state.ny.us/ui/ui_index.shtml">www.labor.state.ny.us/ui/ui_index.shtml</a>
<b>Vision Care</b>	Davis Vision	800-999-5431	<a href="http://www.davisvision.com">www.davisvision.com</a>
<b>Workers' Compensation</b>	Chubb Insurance Company	Contact your campus RF office.	<a href="http://www.wcb.state.ny.us/content/main/workers/workers.jsp">www.wcb.state.ny.us/content/main/workers/workers.jsp</a>

## Contact Information

Coverage	Benefits/Claims Administrator	Phone	Website
College Savings Program	Vanguard/Upromise	877-NYSAVES	<a href="http://www.nysaves.org">www.nysaves.org</a>
Consumer's Medical Resource	Medical Decision Support	888-644-1640	<a href="http://www.mymedicaldecisionsupport.com">www.mymedicaldecisionsupport.com</a>
Flexible Spending Accounts (Health Care and Dependent Care)	Fringe Benefits Management Company	800-342-8017	<a href="http://www.fbmc.com">www.fbmc.com</a>
Voluntary Long-Term Care Insurance	CNA	877-777-9072	<a href="http://www.ltcbenefits.com">www.ltcbenefits.com</a> password: trfsunyltc
International Health Insurance	GeoBlue (formerly HTH Worldwide)	855-282-3517	<a href="http://www.geo-blue.com">www.geo-blue.com</a>
International Emergency Assistance	Frontier Medex	800-537-2029	<a href="http://www.frontiermedex.com">www.frontiermedex.com</a>
RF Ride Commuter Transit and Parking Benefits	WageWorks	877-924-3967	<a href="http://www.wageworks4me.com/rfsuny">www.wageworks4me.com/rfsuny</a>
Voluntary Short-Term Disability	First Reliance Standard Life Insurance	877-315-9838	<a href="http://www.rsli.com">www.rsli.com</a>

## Summary of Plans

### Plan Administrator

The Research Foundation of State University of New York is the plan administrator for all plans.

Research Foundation of 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) 434-7080.

### Agent for Service of Legal Process

The president of the Research Foundation, at the above address, 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
<b>Health Care</b>					
<b>Health Insurance for Regular Employees</b>	501	Preferred provider organization (PPO)	Group insurance contract with Empire 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
<b>Post-retirement Benefits Plan</b>	515	Health and dental	Group health insurance contracts and dental administrative services agreement	Group health insured, dental self-insured*	December 31
<b>Dental Plan</b>	504	Dental benefits	Administrative services agreement with Delta Dental of New York, Inc.	Self-insured*	December 31
<b>Vision Care Plan</b>	508	Vision care benefits	Vision care services agreement with Davis Vision	Self-insured*	December 31
<b>Health Care Flexible Spending Account</b>	501	Part of the RF Flexible Benefits Plan	Administrative services agreement with Fringe Benefits Management Company	Self-insured*	December 31
<b>International Travel Assistance</b>	501	International assistance and medical benefits	Insurance contract with GeoBlue and international services contract with FrontierMedex	Insured	December 31
<b>Life and Accidental Death and Dismemberment (AD&amp;D) Insurance</b>					
<b>Basic and Optional Life Insurance</b>	505	Life and AD&D insurance	Group insurance contract with Prudential Insurance Company	Insured	December 31
<b>Disability Insurance</b>					
<b>Workers' Compensation Insurance</b>	N/A	Disability insurance	Insurance contract with Chubb Insurance Company	Insured	June 30
<b>New York State Short-Term Disability Insurance</b>	N/A	Disability insurance	Insurance contract with First Reliance Standard Life	Insured	June 30
<b>Long-Term Disability Insurance</b>	506	Disability insurance	Insurance contract with First Reliance Standard Life	Insured	December 31
<b>Voluntary Short-Term Disability</b>	514	Disability insurance	Insurance contract with First Reliance Standard Life	Insured	December 31

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

## Plan Information

Plan Name	ERISA Plan Number	Plan Type	Type of Administration	Funding	End of Plan Year
<b>Retirement Plans</b>					
<b>Basic Retirement Plan</b>	001	Defined contribution	Retirement annuity and mutual fund contracts issued by TIAA-CREF	Insured and variable accounts	December 31
<b>Optional Retirement Plan</b>	003	Tax-deferred annuity (TDA)	Retirement annuity contracts issued by TIAA-CREF	Insured and variable accounts	December 31
		Group supplemental retirement annuity (GSRA)	Retirement annuity contracts issued by TIAA-CREF	Custodial accounts	December 31
		Tax-deferred mutual funds	Tax-deferred custodial accounts managed by TIAA-CREF	Insured and custodial accounts	December 31
<b>Other Benefits</b>					
<b>New York State Unemployment Insurance</b>	N/A	Unemployment insurance Department of Labor	Self-insured plan through the state of New York	Self-insured*	N/A
<b>Dependent Care Flexible Spending Account</b>	N/A	Part of the RF Flexible Benefits Plan	Administrative services agreement with Fringe Benefits Management Company	Self-insured*	December 31
<b>Group Long-Term Care</b>	N/A	Long-term care	Insurance contract with CNA	Insured	May 31

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

## Your Rights Under 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 of 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. 20210. 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 accessing the website at [www.dol.gov/ebsa](http://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;
- 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 13 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 contained on pages 8 and 9, 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 Administration and Human Resources, The Research Foundation of 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. 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 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 identified on pages 6 and 7.





SECTION 2

# HEALTH CARE

---

HEALTH CARE

health care • *noun*

the field concerned with the maintenance and improvement of the health of the body or mind

# HEALTH CARE

---

## Benefits at a Glance

The RF provides the following plans to help you meet your health care needs:

- The Empire Blue Cross Preferred Provider Organization (PPO plan) or
- A Health Maintenance Organization (HMO), if available in your area.

Empire Blue Cross will provide PPO plan members with a benefit handbook. HMOs will provide their members with a handbook and a certificate of coverage.

The Health Care plan's handbook, in conjunction with this *Research Foundation Benefits Handbook*, constitutes the ERISA plan and summary plan description (SPD).

The remainder of this section provides the following information about your health, dental and vision coverage:

- Eligibility
- Enrollment
- Changing coverage
- When coverage begins
- Your plan options
- Coordinating your benefits
- Important information about your rights under the plan
- Qualified medical child support order

## Eligibility

You are eligible for the RF Health Care plan if you are an employee working at least 50 percent of full time on a regular appointment.

You are not eligible if you are any of the following:

- An employee working less than 50 percent of full time,
  - A summer-only appointment,
  - A full-time SUNY employee or
  - A full-time SUNY student working part time in an RF student title, including a graduate student or fellow.
- See the Graduate Student Employee Health Plan Handbook to determine if you might be eligible for health care benefits under that plan.

## Dependent Eligibility

The dependents listed below can be included if you choose employee and spouse, employee and child(ren), or family coverage. HMO dependent rules are similar, but you should check with your HMO for certain details.

- Your spouse, including a legally-married, same-sex spouse. (The fair market value of coverage of same-sex spouses who do not qualify as federal tax dependents, less the amount that you pay for coverage on an after-tax basis, is includable in your income as wages under the Internal Revenue Code pursuant to the federal Defense of Marriage Act. In addition, any additional contribution required for you to cover your nontraditional spouse must be paid on an after-tax basis.)
- Your children up to 26 years of age as follows:
  - Biological children,
  - Stepchildren,
  - Children for whom you are the legal guardian and
  - Children legally adopted by or placed for adoption with you or your spouse.
- Your unmarried children of any age incapable of self-support because of a mental or physical disability who become disabled before reaching the limiting age. (Plan requires periodic medical documentation.)
- Your domestic partner who is
  - Age 18 or older,
  - Unmarried and not related to you by marriage or blood in any way that would bar marriage,
  - Residing with you,
  - Financially interdependent with you, and
  - Involved in the domestic partnership for a period of not less than one year. (Documentation of the above must be approved by the RF.)
- A child of your domestic partner who:
  - Meets the plans' eligibility requirements,
  - Resides in your household,
  - Whose gross income for the calendar year is less than the personal exemption amount (\$3,800 in 2012),
  - Receives 51 percent or more of their support from you, and
  - Who is not a qualifying child dependent of any other taxpayer.

### EXCEPTION

---

If two family members work for the RF, both can have employee-only coverage; but only one can choose a higher level of coverage. You cannot be covered as an employee and as a dependent of another employee.

## SPECIAL RULES FOR SAME-SEX SPOUSES OR DOMESTIC PARTNERS

---

The federal Defense of Marriage Act (DOMA) restricts who is recognized as a “spouse” under federal law by only recognizing marriages between one man and one woman. Therefore, federal laws and protections, such as COBRA, Medicare, pretax payment for benefits and flexible spending account benefits under Internal Revenue Code Section 125, special enrollment rights for changes in family status, spousal protections, under ERISA and the Internal Revenue Code, exclusions from income for employer-provided benefits under the Internal Revenue Code and other federal laws relating to employee benefits, do not apply to same-sex spouses and domestic partners in the same way they apply to DOMA-qualified spouses (except in those limited cases where the non-DOMA spouse or domestic partner may qualify as the employee’s dependent for tax purposes (i.e., a “qualifying relative” under Internal Revenue Code Section 152(d))).

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

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

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

## ADDING DEPENDENTS

---

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

If you add a dependent after 60 days from the day he or she becomes eligible, coverage will begin on the first day of the fifth pay period from the date your campus Benefits Office receives the new enrollment form unless a special enrollment right applies. (Refer to Special Enrollment Rights on page 20.)

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

# Enrollment

Enrollment in the Health Care plan is not automatic. You must enroll at the beginning of employment or at the time you become eligible. Complete, sign and submit an RF Benefits Enrollment Form and an HMO enrollment form (if applicable) to your local campus Benefits Office.

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

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

## PAID AND UNPAID LEAVE BENEFITS

The RF realizes that it's important for employees to have a healthy work-life balance. Under the RF Leave Policy, eligible employees earn accruals for vacation, sick and personal leave, and may take other types of leave such as holiday leave, military leave and leave without pay.

For more information about leave benefits, refer to page 83.

# Coverage Options

## HEALTH (PPO PLAN), DENTAL AND VISION CARE

You may choose one of the following coverage levels or you may waive coverage:

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

## MEDICARE ELIGIBILITY AS AN ACTIVE EMPLOYEE

If you are an active employee who becomes eligible for Medicare Part B while covered by the RF Health Care plan, you should not enroll for Part B until three months before you retire. Since you'll have continuous coverage with the RF as an active employee, you won't be penalized by Medicare for joining the program late. This rule does not apply to domestic partners nor to same-sex spouses

## WAIVING COVERAGE

You may waive Health Care plan coverage at the time of employment or eligibility by checking the "I decline coverage" box in Part B of the RF Benefits Enrollment Form.

You may change from waiver of coverage to coverage any time during the calendar year, but you must wait five pay periods in active employment for coverage to begin unless you have a qualifying event. (Refer to Changing Coverage on page 19 for more information.)

To pay the premium for coverage on a pretax basis, you must satisfy the requirements described under Making Changes During the Year on page 20. For more details, see the Basis for Changing Elections section of the Flexible Benefits Plan. Otherwise, your cost of coverage will be deducted from your pay on an after-tax basis.

## Late Enrollment

### HEALTH CARE (PPO PLAN AND HMO)

---

If you delay enrollment more than 60 days after you become eligible, you must wait an additional five pay periods in active employment to be covered (unless you have a special enrollment right or qualifying event). Your coverage will start on the first day of the fifth pay period following the day your local campus Benefits Office receives the completed RF Benefits Enrollment Form.

#### **Example of Late Health Care Plan Enrollment 2012**

Appointment/eligibility date: January 6

42-day waiting period: February 17

60-day enrollment period: January 6– March 7

Enrollment received: March 16

Date of coverage: May 22

### DENTAL AND VISION CARE

---

If you delay enrollment in the Dental and Vision Care plans beyond 60 days from your date of eligibility and you have met the six-month waiting period, your coverage becomes effective on the day your campus Benefits Office receives the completed RF Benefits Enrollment Form.

## Changing Coverage

### Open Enrollment

Each year the RF schedules an open enrollment period to allow you to make changes to your Health Care or Dental Care coverage not usually permitted during the calendar year.

You may do the following only during open enrollment:

**(Exception:** Special enrollment rights may apply when enrolling dependents; see Special Enrollment Rights on page 20 or Qualifying Events on page 21 for more information.)

- Change from one Health Care coverage option to another, for example, changing from HMO to PPO coverage;
- Change your coverage level on a pretax basis;
- Change from pretax coverage to waiver of coverage; or
- Change from pretax to after-tax deductions or from after-tax to pretax deductions.

Other changes you make during open enrollment are subject to the same rules that apply during the calendar year. For example, when you add dependents more than 60 days after they become eligible, late enrollment rules apply unless you have a special enrollment right.

### IF YOU MAKE NO CHANGES DURING OPEN ENROLLMENT

---

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

## Making Changes During the Year

### HEALTH CARE AND DENTAL CARE

---

#### ***Pretax Health Care and Dental Care Plan Deductions***

If your health and/or dental benefit premium contributions are being deducted from pay on a pretax basis, then a change of coverage level, coverage option (e.g., PPO to HMO) and pretax deduction may only be made at open enrollment unless you have a special enrollment right or other qualifying event. If you add dependents without a qualifying event, the employee portion of the premium will remain pretax and the dependent portion will be an after-tax deduction until the next plan year. You must complete and submit a new RF Benefits Enrollment Form to your campus Benefits Office. (If you have HMO coverage, you must complete an additional enrollment form.)

You may not change your dependent coverage pretax deduction to an individual pretax deduction during the year unless you have a qualifying event. Refer to the definition and list of qualifying events on page 21.

#### ***After-tax Health Care and Dental Care Plan Deductions***

Dependents who are same-sex spouses are not eligible for pretax Health Care or Dental Care plan deductions under federal law unless they are “qualifying relatives” under section 152(d) of the Internal Revenue Code. Your contribution toward their coverage will be on an after-tax basis. If your Health Care or Dental Care plan deductions are being taken on an after-tax basis, you may change your coverage level anytime during the year, but new Health Care plan coverage is subject to a five-pay-period wait unless you have a qualifying event. If you have a qualifying event, the change is effective the first day of the next pay period following receipt of the newly completed enrollment form by your campus Benefits Office.

### VISION CARE

---

If you wish to change your coverage level, you must complete and submit a new RF Benefits Enrollment Form to your campus Benefits Office. You may change coverage any time during the year. Your new coverage will become effective on the day your campus Benefits Office receives your completed form.

If the change involves a newly eligible dependent (for example, as a result of marriage), dependent coverage becomes effective on the date the dependent became eligible, provided a new enrollment form is completed within 60 days of this date.

## Special Enrollment Rights

You normally may enroll for Health Care plan benefits during either your initial enrollment period or the annual open enrollment period. For medical (PPO plan/HMO) coverage (but not dental, vision care or health care flexible spending accounts), you also may have a special enrollment period based on rules enacted by the Health Insurance Portability and Accountability Act (HIPAA). These rules are summarized on the following page. (The term “dependent” includes a spouse or domestic partner.)

## IF YOU LOSE OTHER MEDICAL COVERAGE

---

You may enroll yourself and/or an eligible dependent during a special enrollment period if you or the dependent had other medical coverage when you previously declined medical coverage under this plan and any of the following applies:

- The other coverage was COBRA coverage, and that coverage has since been exhausted;
- The other coverage was not COBRA coverage, and either:
  - The other employer’s contributions toward the other coverage have been terminated or
  - The other coverage has been terminated due to loss of eligibility for reasons including legal separation, divorce, death, termination of employment or reduction in hours of employment; or
- The other coverage was a Medicaid plan or a state child health plan (“CHIP”) and the coverage has been terminated as a result of loss of eligibility.

A “loss of eligibility” does not include loss due to nonpayment of premiums on a timely basis or termination of the other coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact). Therefore, these circumstances do not give rise to a special enrollment period.

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

## IF YOU GAIN A DEPENDENT

---

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

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

## QUALIFYING EVENTS

---

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

Qualifying events include:

- Qualification for special enrollment rights provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You, your spouse and your dependents have special enrollment rights if you had other health insurance coverage at the time of the annual enrollment period and you are no longer eligible for that coverage, or if you acquire additional dependents as a result of marriage, birth, adoption or placement for adoption.

- A change in status that affects your, your spouse's or dependents' coverage, including a change in:
  - Legal marital status because of marriage, death of a spouse, divorce, legal separation or annulment;
  - Number of dependents because of birth, adoption, placement for adoption or death;
  - Employment status (termination or commencement of employment) by you, your spouse or dependent;
  - Work schedule (reduction or increase in hours of employment) for you, your spouse or dependent because of a switch between part time and full time, or commencement of or return from an unpaid leave of absence that results in acquiring or losing eligibility for health insurance;
  - Dependents' status (an event that causes your dependent to satisfy or cease to satisfy the requirements for coverage because of attainment of age or any similar circumstances as provided by the plan); or
  - Residence or worksite (for you, your spouse or dependent).
- Receipt by the plan of a court order, such as a qualified medical child support order under Section 609 of ERISA.
- Your, your spouse's or dependents' qualification (or loss of qualification) for State Children's Health Insurance Program (S-CHIP) Medicare, Medicaid or other coverage sponsored by a governmental or educational institution.
- There is a significant cost change or a reduction or curtailment of the coverage available during the year. In such a case, you may elect coverage under another option providing similar coverage, or you may drop coverage if no similar option is available. If a coverage option is added or significantly improved or the cost of a coverage option has significantly decreased during the year, eligible employees (including those who have not previously elected coverage) may change their elections to enroll in the new, improved or decreased cost option.
- A change is made in the health coverage available to you, your spouse or dependents through another employer and either that employer plan has a different period of coverage (a different open enrollment period) or has rules allowing changes in election similar to the rules contained in this section.

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

## When Coverage Begins

There is a 42-day waiting period. Coverage begins on day 43 from date of employment or eligibility unless you have a break in service. See break in service rules beginning on page 2.

### Exceptions to When Coverage Begins

#### HEALTH (PPO PLAN/HMO), DENTAL AND VISION CARE

---

If you are not actively at work on the day you complete the waiting period, your coverage begins on the day you return to work. This exception does not apply if the reason you are not at work is due to a medical condition. Also, your dependent's coverage cannot begin before your coverage begins.

# Your Health Care Plan Options

## PPO Plan

The PPO plan provides benefits for you and your covered dependents through Empire Blue Cross using a network of participating providers. It offers the following features:

- Care from in-network providers or out-of-network providers (for some services),
- National and international coverage, and
- Patient responsibility for some pre-certification requirements.

### HOW TO OBTAIN BENEFITS

---

#### **Identification Card**

Once you have enrolled in the PPO plan, you will receive a PPO membership identification card (ID card). It enables you to receive benefits nationally and internationally. From time to time a replacement card may be issued by Empire Blue Cross.

Show your membership card to any Empire Blue Cross participating physician or hospital. The PPO physician or hospital can verify your membership eligibility and coverage. When you visit a PPO doctor or hospital, you will have no claim forms to file.

#### **In-Network Providers**

Obtaining care from a provider in the plan's network requires a fixed copayment for most office visits and there are no claim forms to file.

PPO directories are available by using the following telephone numbers or websites:

- For Central and Western New York and outside New York State, call 800-810-BLUE (800-810-2583) or refer to the Empire Blue Cross website at [www.empireblue.com](http://www.empireblue.com). Click on "Find a Doctor," and then click on "Across the Country."
- For Eastern New York, call 800-377-5156 or refer to the Empire Blue Cross website at [www.empireblue.com](http://www.empireblue.com). Click on "Find a Doctor," and then click on "In Empire's Local Area Medical Network."

You also can obtain information at your campus Benefits Office.

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

#### **Out-of-Network Providers**

Obtaining care from a provider outside the plan's network requires an annual deductible and 20 percent coinsurance for most services. You complete a claim form for reimbursement of allowable charges.

Refer to Prescription Drug Coverage on page 24 for information on prescription drug benefits for PPO participants.

### PPO BENEFITS GUIDE

---

If you enroll in the PPO plan, you will receive a Benefits Guide from your campus Benefits Office. The PPO Benefits Guide will contain:

- Your Benefits at a Glance that outlines for you in chart format an overview of your coverage, including in-network and out-of-network benefit levels;
- General information about the provider network; and
- Benefits sections that describe in detail the health care services covered under the PPO plan.

## PRESCRIPTION DRUG COVERAGE

---

Those enrolled in the RF PPO receive prescription drug benefits through Medco. This plan is designed to cover most medications that require a physician's written prescription. Prescription drugs may be obtained either through mail order or at a retail pharmacy. All prescriptions, whether purchased through mail order or at a retail pharmacy, are subject to a copayment. You can get up to a 90-day supply through mail order but only up to a 30-day supply at a retail pharmacy. If your physician prescribes a brand-name drug when a generic equivalent is available, you are responsible for paying the difference between the two prices in addition to the copayment.

Refer to Where to Get Help on page 6 to locate a participating pharmacy near you, to get a list of preferred drugs, to request claim forms or to obtain assistance in determining medication payment amounts in advance when using the mail order service. For additional information about your prescription drug coverage, refer to the welcome kit you will receive from Medco. The kit, along with this *Research Foundation Benefits Handbook* is your plan and summary plan description.

### **Mail Order**

Use Medco By Mail to fill prescriptions through the mail. This program is particularly convenient for long-term prescriptions and offers the advantage of free home delivery. Up to a 90-day supply of medication can be obtained at one time for only a 60-day copayment (30-day copayment for generic drugs). Refer to Your Prescription Drug Copayments at a Glance on page 26.

### **Retail Pharmacy**

Use a Medco participating retail pharmacy when you need short-term or immediate prescriptions. If you need a prescription immediately but will be taking the medication on an ongoing basis, you may ask your physician for two prescriptions: one for a 14-day or 30-day supply that can be filled at a local pharmacy, and one for up to a 90-day supply that can be ordered through the mail. Refer to Your Prescription Drug Copayments at a Glance on page 26.

### IDENTIFICATION CARD

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

### PARTICIPATING PHARMACY

Filling your prescriptions at a participating pharmacy offers the advantage of discounted prescription drug prices. Your Medco ID card can be used at a network of thousands of participating pharmacies that will provide you with prescription drugs at a discounted price. At a participating pharmacy, you present your ID card, pay the copayment and brand-name differential, if applicable, and receive your prescription. You can find a local pharmacy online at [www.medco.com](http://www.medco.com).

### NONPARTICIPATING PHARMACY

If you have prescriptions filled at a nonparticipating pharmacy (not part of the network of pharmacies participating in the plan), the plan will pay only the discounted cost of the drug that a participating pharmacy would charge. You will be responsible for paying the difference between the discounted price and the actual retail price. At a nonparticipating pharmacy, you pay for prescriptions when you receive them and obtain reimbursement from Medco for allowable expenses.

You and your pharmacist must complete a Medco Prescription Drug Reimbursement Form and submit it to Medco Prescriptions to be reimbursed for prescriptions purchased at a nonparticipating retail pharmacy. A separate Medco reimbursement form is required for each employee or dependent and for each pharmacy used. Instructions for completing and mailing the form are provided on the form. When your claim is processed, Medco will provide you with a new Medco reimbursement form. You may also obtain forms from either your campus Benefits Office or directly from Medco. Refer to *Where to Get Help* on page 6 for more information.

The following table outlines the procedure for filling a prescription, filing a claim and receiving reimbursement when using a nonparticipating pharmacy:

Step	Action
1	Obtain a Medco Prescription Drug Reimbursement Form.
2	Complete and sign Member/Subscriber/Patient Information on the front side of the form.
3	Have prescription filled and pay the full retail price of the generic or brand-name drug; you will receive the prescription and a receipt.
4	Have the pharmacist complete and sign the Pharmacy Information, then tape the original receipt to the claim form. Do not use staples or paper clips.
5	Mail the reimbursement form and receipt to the following address: Medco Health Solutions, P.O. Box 14711, Lexington, KY 40512 Note: Keep a copy for your records.
6	After deducting a copayment (and the brand-name difference, if any), Medco will reimburse you for up to a 30-day supply at the discounted price that a participating pharmacy would charge.

### ***Generic and Brand-Name 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, followed by preferred brand-name drugs. Nonpreferred brand-name drugs have the highest copayment. There is a special coinsurance amount of 50 percent for fertility medications.

Generic and brand-name drugs (unless they fall under *Drugs and Supplies Not Covered* on page 26) are covered under both the mail order and retail pharmacy programs, although your out-of-pocket expenses will usually be higher when you use a nonparticipating pharmacy. If a physician prescribes a brand-name drug when a generic equivalent is available, you must pay the difference in cost. Insulin and insulin needles and syringes are covered under prescription drug benefits. Medications used for treating infertility are subject to a 50 percent coinsurance for both mail order and retail prescriptions.

#### **PREFERRED AND NONPREFERRED DRUGS**

Preferred drugs are brand-name drugs that have been in the market for a time and are widely accepted. Medco has arranged a significant discount on these preferred drugs; therefore, the copayment for these drugs is lower. Nonpreferred drugs are typically higher-cost and/or newer brand-name drugs 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. Because of the high cost of these drugs, the copayment is also higher than for preferred drugs.

## Prescription Drug Copayments at a Glance

	At Retail Pharmacy (30-day supply)	Through Medco By Mail (up to 90-day supply)
<b>Generic Drugs</b>	\$10	\$10
<b>Preferred Brand-Name Drugs</b>	\$20	\$40
<b>Nonpreferred Brand-Name Drugs</b>	\$35	\$70

### ***Specialty Medication***

Specialty medication prescriptions must be filled through Medco's mail order specialty pharmacy. This type of medication usually requires injection or infusion and special handling including temperature control. Patients needing specialty medication require continued treatment for long-term and often complicated diseases and associated conditions. The specialty pharmacy can support these needs with a specially trained team of pharmacists and registered nurses. Call 800-803-2523 to find out more about this program. If you submit a prescription for a specialty medication to a retail pharmacy, the pharmacy will instruct you to instead submit the prescription to the Medco mail order specialty pharmacy.

### ***Drugs and Supplies Not Covered***

The following drugs and supplies are not covered under either the mail order or retail pharmacy programs:

- Nonfederal Legend drugs
- Contraceptive jellies, creams, foams or devices
- Vitamins (except Legend prenatal vitamins)
- Retin-A/Avita/Differin/Epiduo/Tazorac from age 36
- Food supplements
- Over-the-counter smoking deterrents (except transdermal nicotine patches)
- Therapeutic devices or appliances
- Glucowatch
- Mifeprex
- 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
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental Agency, or medication furnished by any other drug or medical service for which no charge is made to the member
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician or any refill dispensed after one year from the physician's original order
- Expenses due to injury or sickness that arise out of or in the course of employment
- Charges for the administration of any drug

### **Quantity/Duration Limits**

Some prescription medicines can be dangerous if not taken properly. Others may be subject to inappropriate use. Medco has numerous features to prevent situations like these. One of them is called “quantity/duration limits.” These apply to drugs in the following categories:

- Anti-influenza agents
- Drugs to treat nausea and vomiting
- Erectile dysfunction therapy
- Hypnotic agents (treatments for insomnia)
- Migraine agents
- Narcolepsy agents
- Pain management (narcotic and non-narcotic analgesics)

### **Determination of Claims and Appeal**

Your prescription drug claim will be treated as a “post-service claim.” Refer to Your Rights Under Federal Laws on page 9 for details.

## **HMOs**

You may enroll in a Health Maintenance Organization (HMO) if this type of coverage is offered by the RF in your geographic area. The HMO will provide you with an HMO handbook and certificate of coverage. These documents, in conjunction with your *Research Foundation Benefits Handbook*, constitute the ERISA plan and summary plan description (SPD). Before enrolling in an HMO, thoroughly review the coverage provisions of the plan. Although HMOs provide hospitalization coverage and a comprehensive plan of medical and surgical care, some provisions differ from those established for the RF PPO. If you are interested in HMO coverage, your campus Benefits Office can give you information about HMOs in your area.

## **HOW TO OBTAIN BENEFITS**

---

In an HMO, you receive health care from physicians or other providers who are part of the HMO, unless you are referred by the HMO to a physician or provider who is not part of the HMO.

HMOs provide identification cards that you present whenever you receive health care. Only emergency and limited care is available to enrollees who require medical services outside the area served by the HMO, although some HMOs have reciprocal agreements with HMOs outside their service area. HMOs provide prescription drug coverage, but may require that prescriptions be filled at a specific pharmacy. HMOs charge a copayment for office visits and prescription drugs.

### **Claims Procedure**

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

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

### **Urgent Care**

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

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

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

### ***Concurrent Care***

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

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

### ***Pre-service Claims***

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

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

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

### ***Post-service Claims***

A “post-service claim” is any claim that is not a “pre-service claim” (in other words, you do not need approval before obtaining medical care).

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

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

### ***Requirements for Notification of an Adverse Benefit Determination***

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

- The specific reason(s) for the adverse determination,
- Reference to the specific plan provisions on which the determination is based,

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

### **Appeal of an Adverse Determination**

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

## **PRESCRIPTION DRUG COVERAGE**

---

For information about prescription drug coverage, refer to your HMO certificate.

## **Dental Care**

Under the plan, administered by Delta Dental, you may choose a dentist who participates in the network or a nonparticipating dentist who is not part of the Delta Dental network.

The Delta Dental network of participating dentists offers the following features and advantages:

- Dentist files claims for you,
- Insurance payment made directly to the dentist,
- Lower dental fees,
- Lower out-of-pocket costs and
- Large network of dentists.

Refer to Where to Get Help on page 6 for Dental Care plan phone numbers.

## **Delta Dental Employee Information Sheet**

You should receive a Delta Dental Employee Information Sheet from your campus Benefits Office. The Employee Information Sheet, in conjunction with your *Research Foundation Benefits Handbook*, constitutes the ERISA plan and summary plan description (SPD). The Employee Information Sheet describes:

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

Your dental claim will be treated as a “post-service claim” under the procedures described on page 28. See also Your Rights Under Federal Laws on page 9 for additional information.

### **TRAVELING OVERSEAS ON RF BUSINESS?**

To support our research, education and training activities around the globe, the RF provides blanket international travel assistance coverage, as well as some health insurance benefits, for all persons (other than independent contractors) traveling overseas on official RF business. Refer to International Travel Assistance on page 89 for information.

If you use a participating dentist, you will not have to complete a claim form. All you need to provide is the ID card you received from Delta. If you do not have the ID card with you, the claim can still be processed automatically if you provide the dentist's office with the Social Security number of the covered employee. Reimbursement is made directly to your dentist by Delta Dental for covered fees or services according to the terms of the plan. You also may print an ID card by registering on Delta's website at [www.deltadentalins.com](http://www.deltadentalins.com).

## Choosing a Dentist

### PARTICIPATING DENTISTS

Names of Delta PPO or Delta Premier participating dentists can be obtained upon request by calling Delta at 800-932-0783 or accessing its website at [www.deltadentalins.com](http://www.deltadentalins.com). You can use either network, but you will have a higher annual maximum benefit and enjoy greater discounts if you use the Delta PPO network. Refer to the Maximum Reimbursements chart below.

If you do not have Internet access, you can obtain a list of dentists in your area from your campus Benefits Office or from Delta Dental.

### NONPARTICIPATING DENTISTS

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

## Benefits

Dental benefits cover preventive care, treatment of teeth affected by injury or decay, and replacement of missing teeth. Payment is provided according to the usual, customary and reasonable fees for a particular area and according to the plan's percentage of reimbursement for each type of dental service and calendar year maximum.

### Maximum Reimbursements

Type of Service	Coverage Level*	Maximum Benefit	
		Delta Premier Network or Nonparticipating	PPO Network
Preventive and Diagnostic Basic Major and Prosthodontic	100% 75% 50%	Combined maximum of \$1,500 per calendar year	Combined maximum of \$2,000 per calendar year
Orthodontic (for dependent children up to and including age 19)	50%	\$2,000 lifetime limit per dependent child	\$2,000 lifetime limit per dependent child

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

## Waiting Periods

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

## Annual Deductibles

This is the amount you pay for services before payment is made by Delta Dental.

### INDIVIDUAL

---

There is no deductible for preventive and diagnostic services or for orthodontics. There is a \$50 deductible for all other services.

### FAMILY

---

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

## How to File a Claim

Please refer to Post-service Claims on page 28.

## 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).

*Note: Orthodontic payments do not fall within the 90-day extended dental insurance provision. However, you may continue dental coverage by paying for an extension of benefits under COBRA. Refer to Continuing Benefits on page 69.*

## Vision Care

The RF Vision Care plan provides coverage for you and your covered dependents. An examination, corrective lenses and frames, or contact lenses are available once every 24 months through participating or nonparticipating providers. If you use a participating provider, you receive maximum plan benefits. The RF pays the full cost of coverage for this plan.

An occupational vision benefit is also available through Davis Vision providers for employees only. This will cover an additional pair of single vision eyeglasses when a different prescription is needed by an employee for job purposes. The employee must obtain the occupational eyeglasses at the same time as the regular eyeglasses. This is not a benefit for dependents. There are optional frame and lens features available subject to additional fees.

Employees and eligible dependents also will have access to laser vision correction services at discounted rates through a network of participating surgeons.

## ENROLLMENT PACKET AND PROVIDER DIRECTORY

After you have completed a six-month waiting period, Davis Vision will send you an enrollment packet, which includes an ID card and a Directory of Vision Care Plan Doctors, which provides a list of participating providers in your area. You can obtain this directory at any time by calling Davis Vision or you can refer to their website for a provider in other areas. When using the Vision Care plan, you can select either:

- A participating provider from the directory or
- A nonparticipating provider.

## Vision Care Plan Benefit Description

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

- How you receive services from a provider in the network,
- How to find network providers,
- What the plan benefits, frequencies and costs are,
- Out-of-network provider benefits,
- Information about laser vision correction services,
- Exclusions,
- Information about the Davis Vision website, and
- Your rights as a patient.

## Benefits

### PARTICIPATING PROVIDERS

---

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) at no cost. This covers plastic and glass lenses, single vision, bifocal or trifocal lenses, postcataract lenses, lens tinting and prescription sunglasses. OR
2. One eye examination and an initial supply of contact lenses from the plan selection with an employee co-payment of \$25. If contact lenses are chosen that are not in the plan selection, there will be a \$45 allowance toward the cost.

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

### 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.

### BENEFIT RESTRICTIONS

---

The following restrictions apply:

- Coverage is only for routine eye examinations, corrective lenses and frames. Benefits for medical treatment of eye disease or injury are provided under the RF Health Care plans.
- All three portions of the benefit (exam, lenses and frames) must be billed at the same time and by the same provider to obtain reimbursement for all portions of the benefit.

- Nonprescription lenses are not covered.
- If you want special designer frames or lenses or no-line bifocals from participating providers, you are responsible for all costs that exceed the plan allowance.
- Specialty lenses (progressive, photosensitive) and lens coatings (antireflective, scratch resistant) are available at a discounted rate.

## How to File a Claim

### PARTICIPATING PROVIDERS

---

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

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 24 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.

### CHECKING CLAIM STATUS

---

You may check the status of your claim payment at any time by contacting Davis Vision.

### CLAIMS APPEAL PROCESS

---

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" under the claims procedures described on page 28.

First, compare the payment against allowable Vision Care expenses as outlined in this handbook. If the reimbursement you received is unclear, call Davis Vision for an explanation.

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

# Coordinating Your Benefits

The RF Health Care and Dental Care plans have rules for coordinating benefit payments when you or your covered dependents are entitled to benefits under more than one plan. These rules determine the order and amount of payment and are designed so that the combined payment by all plans does not exceed the actual cost of the services.

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

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

## Dental Care

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

- A. The plan covering the person as an employee is primary and determines benefits before the plan covering the person as a dependent.
- B. If the person is a dependent child covered by both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year is primary. (If the parents are separated or divorced, see C below.) If both parents have the same birthday, the plan covering the parent for the longest period is primary. If the other plan does not have this rule but instead has a rule based on gender of the employee, the rule of the other plan will determine the order of benefits.
- C. When the person is a covered dependent child of divorced or separated parents, benefits are determined in the following order:
  - 1. By the plan covering the parent with custody of the child
  - 2. By the plan of the spouse of the custodial parent
  - 3. By the plan of the noncustodial parentHowever, if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child, that plan will be primary and will determine its benefits first.
- D. The plan covering the person as an employee or as a dependent of an employee determines its benefits before the plan covering the person as a laid-off or retired employee or as a dependent of a laid-off or retired employee. If the other plan does not have a rule concerning laid-off or retired employees, the rules of this paragraph will not apply.
- E. If the other plan does not have rules establishing the same order as described above, or is a plan which is "excess" or always "secondary," the RF's plan will determine and pay its benefits in the following way:
  - 1. If this plan is the first to determine its benefits, it will pay without regard to coverage under the other plan.
  - 2. If the other plan determines its benefits first, this plan will pay any difference between what the other plan pays and the dentist's charge for the service but no more than this plan would otherwise pay according to its covered benefits.

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

## Important Information About Your Rights Under the Plan

### Pre-existing Conditions and Creditable Coverage

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) expands your health insurance rights. If your RF health coverage ends, your health insurance company will provide you and your dependents with written certification of prior coverage. This can be given to a future employer and used to reduce waiting periods that may apply to pre-existing conditions. To avoid a gap in coverage upon termination of your RF Health Care coverage, consider continuing your coverage under COBRA. Refer to Continuing Benefits on page 69.

None of the Health Care plans offered by the RF exclude pre-existing medical conditions.

### Women's Health and Cancer Rights Act

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

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

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

The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similar benefits. If you have any questions about this coverage, please contact the applicable benefits/claims administrator identified on page 6.

## 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 and HMOs) may not restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a caesarean section.

However, 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 Administration and Human Resources.



SECTION 3

# DISABILITY/ INCOME PROTECTION



DISABILITY / INCOME  
PROTECTION

**in-come pro-tec-tion • noun**

partial income replacement if you become unable to work due to illness or injury

## DISABILITY/INCOME PROTECTION

---

### Benefits at a Glance

The RF provides the following programs that replace a portion of your income when you are disabled and unable to work. A more complete description of these plans can be found in the certificates of insurance on the RF Benefits Website, or by asking your campus Benefits Office. For insurance company contact information, refer to Where to Get Help on page 6.

- Workers' Compensation through Chubb Insurance Company provides partial income replacement as well as payments for medical expenses, for an on-the-job injury or illness. It also provides death benefits for your surviving spouse and eligible dependents.
- New York State Short-Term Disability insurance through First Reliance Standard Life Insurance Company provides partial income replacement for up to 26 weeks for an off-the-job illness or injury.
- Voluntary Short-Term Disability insurance through First Reliance Standard Life Insurance Company supplements New York State Short-Term Disability insurance if you choose to pay for this coverage.
- Long-Term Disability insurance through the First Reliance Standard Life Insurance Company provides partial income replacement for a certified total disability that prevents you from working for more than six months.
- Voluntary Long-Term Care Insurance covers a variety of services to individuals who are unable to care for themselves due to an illness, accident or disability.

Since disability plans (other than Workers' Compensation) do not provide payment for medical expenses, you should submit medical claims to your health insurance carrier.

Plan	When Benefits Begin	When Benefits End
<b>Workers' Compensation</b>	If your work-related injury or illness results in an absence from work of longer than seven consecutive days, you are eligible for income benefits on day eight. However, if the disability exceeds 14 consecutive days, the seven-day waiting period will be waived and income benefits will be paid retroactive to the first day you were unable to work.	When you are no longer disabled.
<b>New York State Short-Term Disability</b>	There is a seven-day waiting period before these benefits begin from the first day you are unable to work because of your disability.	When you are no longer disabled, or a maximum of 26 weeks.
<b>Voluntary Short-Term Disability</b>	There is a seven-day waiting period before these benefits begin from the first day you are unable to work because of your disability.	When you are no longer disabled, or a maximum of 26 weeks.
<b>Long-Term Disability</b>	Benefits begin 180 days after your disability begins.	The length of time benefits are paid while you are disabled depends on your age when the disability began. (Refer to the chart on page 41.
<b>Voluntary Long-Term Care Insurance</b>	For more information about Voluntary Long-Term Care Insurance, refer to page 43.	

## Workers' Compensation

### Benefits

If you are unable to work because of an injury or illness directly caused by your job, you have the following options regarding the use of leave accruals and Workers' Compensation benefits:

- You may use sick leave accruals and remain on the RF payroll from the first day of disability through your current appointment period, or until your sick leave accruals are exhausted, whichever comes first. Refer to Sick Leave Credit on page 83.
- You may elect to receive Workers' Compensation payments from the first day they are due.
- You may receive Workers' Compensation payments and charge partial leave accruals through your current appointment period in order to maintain your income level prior to disability.

Chubb Insurance Company will make Workers' Compensation payments for medical treatment expenses for an injury or illness directly caused by your job.

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

## Coverage Continuation

Your Health, Dental and Vision Care benefits and life insurance coverage will continue in effect when you become disabled while you are receiving income replacement benefits for a total disability, subject to the terms of those plans. Refer to Continuing Benefits on page 69 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 of your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact your campus location.

### SICK LEAVE CREDIT

---

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

## New York State Short-Term Disability

### Benefits

Benefits are available to you if you are totally disabled within the meaning of the NYS Disability Benefits Law and unable to work because of an off-the-job illness or injury, and you have exhausted either your sick leave or a seven-day waiting period, whichever is later. Benefits will be paid for up to 26 weeks, including the period you receive sick leave benefits, 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.

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.

Benefits are 50 percent of your average weekly salary, up to the maximum benefit allowance established under the New York State Disability Benefits Law (as of January 2011, \$170 per week). These benefits will continue until your physician approves your return to work, up to a maximum of 26 weeks. Medical care claims should be submitted to your health insurance carrier.

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

The Health, Dental and Vision Care benefits and 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. Refer to Continuing Benefits on page 69 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

### Benefits

The RF offers eligible employees the option to purchase additional Voluntary Short-Term Disability coverage beyond those benefits provided under the New York State Disability Benefits Law (see page 39). First Reliance Standard Life Insurance Company insures the benefits.

If you are eligible for this plan, you may purchase a weekly benefit in \$100 increments not to exceed the lesser of \$1,250 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 may also 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. However, New York State Short-Term Disability premiums are paid by the RF; therefore, those benefits are taxable.

### 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 when you are first eligible to do so, 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.

## How to Enroll

Contact your campus Benefits Office for an enrollment kit, or log on the RF website and select Your RF Employment, Benefits, then Disability Insurance.

# Long-Term Disability

## Benefits

Long-Term Disability (LTD) insurance through First Reliance Standard Life Insurance Company (First Reliance Standard) is designed to replace a substantial part of a totally disabled eligible employee's income. The benefit is 60 percent of your regular monthly salary, up to a maximum of \$7,500 per month. 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.

You must be continuously disabled for 180 days before benefits start.

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. Benefits for alcoholism or drug addiction require that you participate in rehabilitation. Benefits will be limited to 24 months (unless hospital confined) if disability is due to alcoholism and/or drug addiction.

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 should apply for Social Security disability benefits and file all available appeals. First Reliance Standard can provide you with assistance. First Reliance Standard will estimate Social Security benefits and reduce your LTD benefits by this amount until it receives a final written decision from the Social Security Administration. First Reliance Standard will make adjustments, if needed, when it receives the final written decision.

The length of time benefits are paid while you are totally disabled depends on your age when the disability began. Refer to Long-Term Disability on page 73 in the Continuing Benefits section of this handbook for more information.

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.*

First Reliance 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.

The LTD plan is subject to ERISA. Contact your campus Benefits Office to request a copy of the First Reliance Standard Life Insurance Company Certificate of Insurance or download one from the RF Benefits Website. The certificate provides details about the RF's LTD plan. The certificate, together with this *Benefits Handbook*, constitutes the plan and summary plan description.

## Work Incentive Benefit

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

## Coverage Continuation

The Health, Dental and Vision Care benefits and life insurance coverage in effect at the time you became disabled will be continued based on your date of employment. Refer to Continuing Benefits on page 69 for more information.

## How to File a Claim

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

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

## CLAIMS APPEAL

---

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

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

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

## Retirement Contributions

If you are vested in the Basic Retirement plan at the time you become disabled, First Reliance Standard will make contributions to your annuity contract and/or mutual funds while you are receiving LTD payments. The contribution will be allocated to TIAA-CREF in the same proportion as when your disability began. You may change your allocation at any time by calling TIAA-CREF or using their website ([www.tiaa-cref.org/rfsuny](http://www.tiaa-cref.org/rfsuny)).

For more information, refer to Continuing Benefits on page 69.

## Voluntary Long-Term Care Insurance

### Benefits

Voluntary Long-Term Care Insurance from CNA offers comprehensive, flexible benefits at an affordable price. This insurance protection comprises a variety of services available to individuals who are unable to care for themselves due to an illness, accident or disability. The services are provided in a setting other than the acute care portion of a hospital. Services can be provided on a temporary or permanent basis in a nursing home, assisted living facility or in a person's home. Long-term care services can range from simple help with meal preparation to assistance with bathing and dressing or to complete 24-hour monitored care.

With Voluntary Long-Term Care Insurance from CNA, you choose a plan that's right for your needs. Because not everyone needs the same amount of coverage, you determine the amount of daily benefit and the lifetime maximum.

#### FOR MORE INFORMATION

For more information about the plan, you can obtain a CNA Long-Term Care Insurance brochure from your campus Benefits Office or download it from the RF Benefits Website. You may also visit the CNA website at [www.ltcbenefits.com](http://www.ltcbenefits.com) (password `trfsunyltc`), or call CNA Group Long-Term Care Customer Service toll-free at 877-777-9072.

### Eligibility

Salaried employees working at least 50 percent of full time are eligible to purchase Voluntary Long-Term Care Insurance through CNA. You may participate after six months of employment, and pay the full cost of the insurance through payroll deduction on an after-tax basis. Also eligible are your spouse or domestic partner, parents, parents-in-law, grandparents and grandparents-in-law. Relatives other than your spouse or domestic partner will be billed directly by CNA. Premiums are per person and based on the individual's age on the effective date of coverage.

If you are an eligible employee and enroll during your initial eligibility period, you are guaranteed acceptance. Spouses, domestic partners and other eligible family members may enroll at this time but their coverage is subject to CNA medical underwriting approval and is not guaranteed.

New York state offers a tax break to residents who purchase long-term care insurance policies. Consult with your tax advisor to claim this credit, which is 20 percent of your paid premium.

## How to Enroll

To enroll:

- Visit the CNA website at [www.ltcbenefits.com](http://www.ltcbenefits.com) (password trfsunyltc) or
- Call CNA Group Long-Term Care Customer Service toll-free at 877-777-9072.

The Voluntary Long-Term Care Insurance enrollment kit contains the various applications and brochures that outline the plan design, rates, exclusions and limitations. The completed application should be mailed to: CNA Insurance, P.O. Box 946760, Maitland, FL 32794-9776.



SECTION 4

# LIFE INSURANCE

---

## life in-sur-ance • *noun*

a protection against the loss of income that would result from the death of the insured

# LIFE INSURANCE

---

## Benefits at a Glance

The RF provides life insurance benefits for active employees through The Prudential Insurance Company of America. Refer to Where to Get Help on page 6 for life insurance plan phone numbers. The Basic Life and Accidental Death and Dismemberment insurance plan is subject to ERISA. The certificate of coverage, together with this *Benefits Handbook*, constitutes the plan and the summary plan description for these benefits.

- Basic Life insurance pays a benefit to your beneficiary upon your death. Your enrollment in this plan is automatic upon reaching eligibility. The RF pays the entire cost of this coverage.
- Optional Life insurance allows eligible employees to purchase additional life insurance coverage. You pay the entire cost of this coverage via payroll deduction on an after-tax basis. There is no cash value resulting from premiums paid for Optional Life insurance.
- Accidental Death and Dismemberment (AD&D) benefits are provided under both Basic Life and Optional Life insurance plans. The benefits apply only if dismemberment or death results from an accident occurring while you are insured under this coverage.

## Basic Life and Accidental Death and Dismemberment Insurance

Basic Life and Accidental Death and Dismemberment (Basic Life) insurance is paid to your beneficiary upon your death from any cause. If you became eligible before July 1, 1992, and have not had a break in service, you are insured for an amount equal to three times your basic annual salary, rounded to the next higher \$1,000, up to a maximum of \$50,000. If you became eligible on or after July 1, 1992, you are insured for \$10,000, regardless of salary.

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

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

## How to Enroll

Enrollment in Basic Life is automatic after six months of eligible service.

## Optional Life and Accidental Death and Dismemberment Insurance

You can obtain additional coverage through the Optional Life and Accidental Death and Dismemberment (Optional Life) insurance plan. The combined maximum coverage limit for both Basic and Optional Life insurance is \$300,000 per employee. Premiums are paid on an after-tax basis through payroll deduction.

Optional Life insurance is paid to your beneficiary upon your death. You indicate the amount of optional coverage you wish to purchase when you complete the RF Benefits Enrollment Form.

Your Optional Life insurance coverage can equal one, two, three, four, five, six or seven times your annual salary, rounded to the next higher \$1,000, minus the amount of Basic Life insurance coverage.

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

### Dependent Life Insurance

You also may purchase Optional Life insurance coverage for your spouse/domestic partner and/or your dependent children. Premiums are paid on an after-tax basis through payroll deduction.

Coverage amounts available for spouse/partner coverage are as follows: \$10,000, \$20,000, \$40,000, \$60,000, \$80,000 or \$100,000. Amounts of \$10,000 and \$20,000 are available on a guaranteed basis as long as your spouse/partner is not confined for medical care or treatment at home or elsewhere when the coverage goes into effect. Domestic partners must meet the eligibility requirements listed in the Health Care section of this handbook. Coverage purchased for a spouse or domestic partner cannot exceed the amount of your employee coverage.

Coverage amounts for eligible dependent children are as follows: \$2,000, \$4,000, \$6,000, \$8,000 or \$10,000. One premium provides coverage for any number of dependent children. All coverage amounts are offered on a guaranteed basis as long as your dependent child is not confined for medical care or treatment at home or elsewhere when the coverage goes into effect.

### How to Enroll

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

## About AD&D

Accidental Death and Dismemberment (AD&D) benefits are provided under both the Basic Life and Optional Life plans. Benefits apply only if dismemberment or death results from an accident occurring while you are insured under this coverage. The dismemberment or death must occur within 365 days of the accident.

This benefit is provided in addition to your Basic Life and Optional Life insurance coverage. In the event of accidental death, you are insured for the same dollar amount as your Basic Life and Optional Life insurance coverage. For example, if you have \$200,000 in Basic Life and Optional Life insurance coverage, that amount (the "principal amount") is also paid for AD&D benefits. Payment will be made to your beneficiary.

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

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

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

AD&D benefits will not be paid for any loss caused by:

- A disease or illness of any kind, physical or mental infirmity, or medical or surgical treatment of these;
- Ptomaine or bacterial infection, except infection as a result of an accidental cut or wound;
- Suicide or attempted suicide;
- An injury or a sickness that is intentionally self-inflicted, or any attempt to inflict such injuries;
- Declared or undeclared war, any act incident to war, service in any military of any country while the country is engaged in war, or police duty as a member of any military organization;
- Taking part in, attempting to take part in, or as a result of taking part in, the commission of a felony;
- Participation in hazardous sports, such as but not limited to, hang-gliding, skydiving and bungee jumping; or
- Drugs or alcohol.

## Accelerated Death Benefit

Benefits also may be paid to you prior to your death, if you are terminally ill. If you have a terminal illness in which life expectancy is less than six months, you may receive a one-time, lump-sum payment of up to 75 percent of your combined Basic Life and Optional Life insurance (if applicable) benefit, not to exceed \$50,000.

The minimum amount of your accelerated death benefit is the lesser of:

- 25 percent of your amount of life insurance or
- \$50,000.

The amount of life insurance coverage that remains in effect will be reduced by the amount paid out under the accelerated death benefit.

## Designating Your Beneficiaries

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

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

If you name more than one beneficiary, you must specify in fractions or percentages (rather than dollar amounts) the portion payable to each beneficiary. If you do not specify portions, each beneficiary will share equally in the benefit. Refer to How Benefits Are Paid below for information and a schedule of payments to your designated beneficiary(ies).

## Changing Your Beneficiaries

You may change your beneficiary designation at any time by completing a new RF Benefits Enrollment Form and submitting it to your campus Benefits Office.

The effective date of the change will be the day you signed the form, but the form must be received before Prudential pays any benefits.

## How Benefits Are Paid

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

- Payment will be made to the primary beneficiary(ies) in the manner indicated on the enrollment form.
- If no primary beneficiary is living, benefits are paid to the contingent beneficiaries.
- If the beneficiary is a minor, application for benefits must be made by the court-appointed guardian of the minor's property. Prudential will require a notarized copy of the guardianship appointment prior to payment of the benefit.
- If no beneficiary designation was made, the indemnity for loss of life will be payable in equal shares to the surviving relatives of the highest rank as listed below:
  - Spouse of the employee (legally married)
  - Lawful living children of the employee
  - Father and mother of the employee
  - Brothers and sisters of the employee
  - Estate

## Filing a Claim

### Basic Life and Optional Life

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

### AD&D

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

### Accelerated Death Benefit

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

## Claims Appeal

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

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

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

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

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

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

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

## Policy Conversion

### UPON EMPLOYMENT TERMINATION

---

You may convert your Basic Life and Optional Life insurance coverage to an individual policy when your employment terminates or you are no longer eligible. You may not exceed the amount for which you were insured under the RF's group policy. In addition, the amount you may convert is reduced by any other group life insurance for which you are eligible or for which you become eligible within 31 days after your RF insurance ends. This individual policy will be issued at the insurance company's regular rates and will not require proof of good health. You must submit an application and pay the first premium within 31 days after your coverage ends. Call Prudential to request an application.

## PORTABILITY OF OPTIONAL LIFE COVERAGE AT EMPLOYMENT TERMINATION

---

Instead of converting your Optional Life insurance coverage to a whole life policy, you may instead select a lower-cost term life policy. Premiums, however, will increase as you age and coverage will end at age 70. Portability is not offered when employment termination is due to retirement.

## UPON REDUCTION DUE TO AGE

---

If you are still employed at or after age 70, when your life insurance amount reduces, you may purchase an individual policy equal to the amount by which your RF coverage was reduced. This individual policy will be issued at the insurance company's regular rates and will not require proof of good health. You must submit an application and pay the first premium within 31 days after your birthday, which coincides with the reduction in coverage.

## Certificate of Insurance

Contact your campus Benefits Office to request a copy of Prudential's Certificate of Insurance, which provides details about the RF's Group Life and AD&D Insurance Plan.



# RETIREMENT

---

## re-tire-ment in-come • *noun*

the money one receives after leaving work based on personal savings and investments, retirement benefit assets, Social Security and other forms of income

# RETIREMENT

---

## Benefits at a Glance

The RF retirement plans are designed to provide you with income during your retirement.

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

For information about continuing Health Care benefits when you retire, refer to Continuing Benefits on page 69. Refer to Where to Get Help on page 6 for TIAA-CREF phone numbers.

## Basic Retirement Plan

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

### Eligibility

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

- Full-time SUNY students employed in a specific RF student title; however, student service as an RF employee will be considered toward the waiting and vesting periods if the student is subsequently appointed as a regular RF employee;
- Members of a collective bargaining unit unless participation is agreed to pursuant to good faith bargaining;
- Leased employees; and
- Persons engaged as independent contractors.

## RF Contributions

After you complete the one-year waiting period, the RF will make contributions to your Basic Retirement plan account. These contribution amounts will be equal to a percentage of your annual earnings (as described under Contribution Rate below). According to IRS rules, the RF may make contributions on up to only \$245,000 of annual earnings.

In addition, Section 415 of the Internal Revenue Code limits the total annual contribution that can be made to a retirement plan to the lesser of \$49,000 or 100 percent of your compensation.

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

### CONTRIBUTION RATE

---

Contributions will be made according to the criteria below:

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

You will receive notification after you complete the one-year waiting period. This notification will also inform you of the default investment funds. TIAA-CREF will send your contract information directly to you. Once you receive this information, you can redistribute your balance and direct future contributions to any fund offered by the plan.

### CONTRIBUTION ON UNUSED SICK LEAVE AT RETIREMENT

---

If you terminate employment on or after age 55 and are eligible for retiree health insurance, you will be provided with an additional retirement plan contribution on your unused sick leave accrual. This contribution is calculated by multiplying the value of your accrued sick leave, up to a maximum of 200 days, by your contribution rate at the time you retire. This benefit is subject to the contribution limits described above. Refer to Continuing Benefits on page 69 for age and service requirements, which are the same as for retiree health insurance.

## YOUR W-2 TAX STATEMENT

---

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

## Vesting

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

## Employment Service Credit

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

- An accredited college or university in the United States, including State University of New York or
- A private, nonprofit research organization incorporated in the United States under section 501(c)(3) of the Internal Revenue Code. The primary function of this organization must be research.

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

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

## REQUEST FOR RETIREMENT CREDIT BASED ON OTHER EMPLOYMENT SERVICE

---

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

## IF YOU LEAVE RF

---

### ***Before You Satisfy the Waiting Period***

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

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

### ***After You Are Vested***

Once you are vested, your benefits cannot be taken away. The funds in your contracts continue to share TIAA-CREF earnings/losses, even if no further contributions are made. If you return to eligible RF employment at some future date, you will immediately return to plan participation without a waiting period. Contributions will be invested according to your most recent fund allocation. If your contracts were settled (cashed out or annuitized), the default investment will be a target retirement date fund appropriate for your age, but you can change the investment at any time.

### **CERTIFIED DISABILITY**

---

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

### **MILITARY LEAVE**

---

Retirement contributions cease when you go off the payroll while on military leave. If you return to active employment following military leave, military service qualifying under the Uniformed Services Employment and Re-employment Rights Act (USERRA) will be credited toward eligibility and vesting service. Retroactive contributions will be made to the Basic Retirement plan for the period of military service, based on your salary in effect at the start of the military leave.

### **FAMILY AND MEDICAL LEAVE (FMLA)**

---

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

## **Directing Your Investment**

Once you have begun your participation in the plan, contributions will be invested in an appropriate target-age retirement fund via a group retirement annuity (GRA) contract. You can redirect the investment of contributions at any time and may divide your contributions among the funds offered in any whole percentage. Go to [www.tiaa-cref.org/rfsuny](http://www.tiaa-cref.org/rfsuny) and click on "Access My Account" or call a TIAA-CREF customer service representative toll free at 800-842-2776.

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

*Note: If you received your contract prior to January 1, 2007, then your contract is not a GRA contract. It is an individual retirement annuity (RA) contract. This impacts your options at termination. Refer to Other Payment Options from Annuity Contracts on page 56 for more information.*

### **INVESTMENT FUND OPTIONS**

---

A listing of funds available for investment can be obtained from TIAA-CREF (see Where to Get Help on page 6), or go online to [www.tiaa-cref.org/rfsuny](http://www.tiaa-cref.org/rfsuny) and select "Investment Choices."

## TRANSFERRING FUNDS

---

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

## Changing Your Name, Address or Beneficiary

You may change your name, address or beneficiary on your contracts by contacting TIAA-CREF. All personal information except name changes can be made online. Refer to Selecting your Beneficiary on page 60 for restrictions on naming a beneficiary if you are married. See Where to Get Help on page 6 for contact information.

## Quarterly Accumulation Statements and Annual Illustration

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

## How Benefits Are Paid

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

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

## BENEFIT PAYMENTS FROM MUTUAL FUNDS

---

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

## NORMAL FORM OF PAYMENT FROM ANNUITY CONTRACTS

---

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

## ANNUITY PAYMENT OPTIONS

---

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

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

- A single-life annuity pays you an income for as long as you live. All payments stop at your death. Payments will not be made to a beneficiary unless you select a guaranteed period. With a guaranteed period feature, if you die before the end of the guaranteed period you selected (10, 15 or 20 years), payments will continue to your beneficiary for the remainder of the guaranteed period. The guaranteed period may not exceed your life expectancy.
- A two-life annuity pays you and your annuity partner income for as long as either of you live. Payments may be continued to a different beneficiary by electing a guaranteed period feature. With a guaranteed period feature, if you and/or your annuity partner die before the end of the guaranteed period you selected (10, 15 or 20 years), payments will continue to your beneficiary for the remainder of the guaranteed period. The guaranteed period may not exceed your joint life expectancy. The payment amount continuing after your death or the death of your annuity partner depends on which of the following benefit payment options is chosen:
  - Full benefit to survivor. The benefit payment does not change at the death of the first person.
  - Two-thirds benefit to survivor. The benefit payment is reduced to two-thirds of the original amount at either your death or the death of your annuity partner.
  - Half-benefit to second annuitant. The benefit payment to you (the former employee) is never reduced. The benefit payment to your annuity partner is reduced to one-half the original amount at your death.

## OTHER PAYMENT OPTIONS FROM ANNUITY CONTRACTS

---

Refer to Making a Cash Withdrawal and Tax Implications on page 58 for more information.

- A Cash Option allows you to receive your TIAA Real Estate, TIAA-CREF mutual funds and CREF accumulations in one or more lump sum payments, if you are terminated from RF employment. This may include systematic withdrawals where you design your own periodic payment plan. If your contributions are being made to a GRA contract, then you also have the option to cash out your TIAA Traditional Annuity within 120 days of your termination of employment (a surrender charge of 2.5 percent applies). After 120 days have elapsed since your termination of employment, this payment option under a GRA contract is no longer available. This option pertaining to the TIAA Traditional Annuity is not available under individual retirement annuity (RA) contracts.
- The TIAA Transfer Payout Annuity (TPA) Option allows you to receive your TIAA Traditional Annuity accumulation in 10 annual installments over a nine-year period, if you are terminated from RF employment. After your death, any remaining balance will be paid to your beneficiary.

- The Installment Refund Option is available to you if your TIAA Traditional Annuity contract was issued before January 1, 1985, and pays you an income for life. If you die before receiving total contractual payments equal to the full TIAA Traditional Annuity accumulation in your account when annuity payments began, the income will be continued to your beneficiary until the sum of all contractual payments equals that accumulation amount. If you live longer than it takes to pay the original accumulation, payments still continue for the rest of your life, but there are no payments to your beneficiary when you die.
- The Retirement Transition Benefit allows you to receive a cash payment of up to 10 percent of your TIAA or CREF accumulations at the time you start annuity income.
- The TIAA Interest Only Option allows you to receive interest income payments from your TIAA Traditional Annuity, while leaving the principal amount intact, if you are terminated from RF employment. This option may be discontinued only by converting to another annuity option or to the Minimum Distribution Option (MDO). Refer to When Distribution Must Begin below.
- The Minimum Distribution Option (MDO) is available to participants who are at least age 70½. It allows them to collect the minimum amount required under IRS regulations, while delaying selection of a lifetime annuity income. They must begin receiving income by April 1 following the calendar year in which they turn age 70½. Refer to When Distribution Must Begin below.

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

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

## WHEN DISTRIBUTION MUST BEGIN

---

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

- The calendar year in which you reach age 70½ or
- The calendar year in which you terminate RF employment.

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

If you are planning to receive periodic distributions to satisfy the minimum distribution requirement, you may wish to consider beginning required distributions by December 31 of the year you attain age 70½ to avoid receiving two taxable distributions in the calendar year following attainment of age 70½.

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

## BENEFITS IF YOU DIE BEFORE TAKING AN ANNUITY

---

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

Normally, your entire balance must be distributed to your beneficiary by December 31 of the fifth calendar year after your death. If elected, death benefits may be payable over the life expectancy of the beneficiary, if the distribution of benefits begins no later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your opposite-sex spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 70½ had you lived.

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

If you die after all funds have been annuitized, any additional payments will be determined by the annuity option you selected at retirement.

There is no death benefit if you are not vested.

## MAKING A CASH WITHDRAWAL AND TAX IMPLICATIONS

---

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

Cash distributions are subject to ordinary income taxes and may be subject to an additional early withdrawal tax penalty. TIAA-CREF must withhold 20 percent from any single sum benefit paid to you and send it to the IRS, unless you instruct TIAA-CREF to make a direct rollover to another qualified plan or an individual retirement annuity/account. The IRS will apply the amount toward income taxes due.

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

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

If you are married to a person of the opposite sex, your spouse must consent in writing to the cash withdrawal. For more information, refer to Selecting Your Beneficiary on page 60. TIAA-CREF will provide additional tax reporting information when a distribution is made. Neither this handbook nor the information provided by TIAA-CREF is intended to be relied upon solely for tax advice. You are encouraged to consult a tax advisor.

## ROLLOVER TO ANOTHER QUALIFIED RETIREMENT PLAN OR TRADITIONAL IRA

---

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

- Certain payments spread over a period of at least 10 years or over your life or life expectancy (or the lives or joint life expectancy of you and your beneficiary),
- Required minimum distributions after age 70½ (or after death),
- Hardship distributions,
- Corrective distributions of contributions that exceed tax law limitations, and
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends).

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

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

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

## PHASED RETIREMENT PROGRAM

---

The RF offers a Phased Retirement Program that permits eligible RF employees to maintain their employee benefits (including Long-Term Disability) and begin withdrawing funds from their retirement accounts when changing from full-time to part-time employment prior to full retirement. Employees must be at least age 55 with at least 10 years of full-time RF service (or the equivalent in part-time service) to be eligible for the program. In addition, your manager and department head or principal investigator must approve the reduction in work hours and the period of phased retirement. The phased retirement period lasts for a maximum of three years.

For more information, refer to the Phased Retirement Program Disclosure on the RF Benefits Website at [www.rfsuny.org/benefits](http://www.rfsuny.org/benefits). Click Regular Employees, Retirement, then Phased Retirement.

## Selecting Your Beneficiary

### SPOUSAL RIGHTS

---

You may not choose the single life annuity option or designate an annuity partner who is not your opposite-sex spouse unless your spouse consents in writing during the 180 days preceding the date benefits begin. If you are married to a person of the opposite sex and die before annuity benefit payments begin or before your mutual fund balances are distributed, your spouse is automatically designated as your beneficiary and must receive a benefit that is at least 50 percent of your retirement plan accumulations. No other beneficiary may receive more than 50 percent of your accumulations unless your spouse waives this benefit in writing.

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

### BENEFITS IF YOU BECOME DIVORCED OR SEPARATED

---

In the event that a judgment, decree or court order establishes the rights of your former opposite-sex spouse to your benefits under the plan, and where there is a qualified domestic relations order, payments will be made by TIAA-CREF in accordance with that order. A court order may preempt the usual requirement that your spouse be considered your primary beneficiary for a portion of the accumulation. A copy of the plan's procedures for determining whether a judgment, decree or order is a "qualified domestic relations order" (QDRO) can be obtained from TIAA-CREF. Under the Federal Defense of Marriage Act, a QDRO can not be used to assign a part of your retirement benefit to a same-sex spouse.

## Federal Insurance

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

## How to File a Claim

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

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

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

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

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

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

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

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

## Optional Retirement Plan

The Optional Retirement plan is a defined contribution plan operating under section 403(b) of the IRC, under which employees of tax-exempt organizations can enter into salary reduction agreements with their employers. Under the agreement, a portion of your compensation is deducted from your pay on a before-tax basis and contributed to an annuity contract or mutual fund custodial account administered by TIAA-CREF rather than being paid directly to you. The money you tax-defer is invested in the way you designate. These amounts, together with any earnings, are not subject to state or federal income tax until you or your beneficiary start receiving benefits.

### Eligibility

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

### How to Enroll

To participate in the Optional Retirement plan, complete the Salary Reduction Agreement. This form indicates the percentage or dollar amount of salary you would like to contribute and lets you stipulate when the contributions should begin.

**Unless you direct otherwise, your contributions will be invested in a target retirement date fund that is designed for your age and estimated retirement date.** If you would like to invest in a different fund, you must complete a TIAA-CREF enrollment form or change your investment online. If your contribution reaches TIAA-CREF before your enrollment form, your contribution will be invested in the target retirement date fund; however, you can transfer this balance to another investment option.

Contact your campus Benefits Office to request a Salary Reduction Agreement or download one from the RF Benefits Website.

## Your Contributions

### IRS MAXIMUM SALARY REDUCTION ALLOWANCE

---

The IRS places limitations on the amount of your salary that may be placed in a tax-deferred annuity or mutual fund custodial account. The first limitation, under section 402(g) of the IRC, is a dollar limit. This limit is \$17,000 for 2012. After 2012, the 402(g) limit will be adjusted by the IRS for changes in the cost of living. The second limitation, under IRC 415, is 100 percent of compensation.

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

#### ***If You Have an Outside Business***

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

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

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

### CHANGING YOUR SALARY REDUCTION AGREEMENT

---

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

- On the payroll at the end of the calendar year, the agreement will remain in effect through each calendar year.
- Not on the payroll at the end of the calendar year, the agreement will end.

A new Salary Reduction Agreement is required if you return to employment in a subsequent calendar year.

### CONTRIBUTIONS DURING LEAVE OF ABSENCE

---

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

### STOPPING YOUR CONTRIBUTIONS

---

You may stop your contributions at any time by providing your campus Benefits Office a written request to cancel your Salary Reduction Agreement. To start contributions again, a new Salary Reduction Agreement is necessary.

### CHANGING YOUR FUTURE CONTRIBUTIONS

---

You may change the value of your future contributions at any time, and as frequently as you choose, by completing a new Salary Reduction Agreement, which is available from your campus Benefits Office.

## ACCEPTANCE OF ELIGIBLE ROLLOVER DISTRIBUTIONS

---

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

## CATCH-UP CONTRIBUTIONS

---

If you are at least age 50 by the end of the plan year (December 31) and otherwise make the full salary reduction contribution available to you under the Optional Retirement plan, you may make an additional salary reduction contribution to the plan of up to \$5,500 in 2012. After 2012, the catch-up limit will be adjusted by the IRS for changes in the cost of living.

## Vesting

All contributions to the Optional Retirement plan are immediately vested; however, funds can be withdrawn only under limited circumstances. Refer to Making Cash Withdrawals and Tax Implications on page 58.

## Retirement Savings Credit ("Saver's Credit")

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

- \$55,000 for Married Filing Jointly,
- \$41,625 for Head of Household or
- \$27,750 for Single, Married Filing Separately, qualifying widow(er) with dependent child or taxpayers who are age 18 or over before the end of their taxable year, other than full-time students or persons claimed as dependents on another taxpayer's return.

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

## Investment Funds

For information on investment funds, refer to Where to Get Help on page 6 or go online to [www.tiaa-cref.org/rfsuny](http://www.tiaa-cref.org/rfsuny) and select "Investment Choices."

## CHANGING YOUR DISTRIBUTION OF FUNDS

---

For information on changing your distribution of funds for your TDA contracts, contact TIAA-CREF. You may transfer accumulations among any TIAA or CREF accounts or mutual funds at any time in amounts of at least \$1,000.

Certain investment options, including the TIAA Traditional Annuity, may have restrictions on transfers.

## Changing Your Name, Address or Beneficiary

You may change your name, address or beneficiary on your accounts by contacting TIAA-CREF. If you are married, see Selecting Your Beneficiary on page 60.

## Quarterly Accumulation Statements

TIAA-CREF sends you quarterly statements indicating premiums remitted during the previous quarter and the total accumulation of your contract(s). You also can use several retirement planning tools by contacting TIAA-CREF or by visiting their website at [www.tiaa-cref.org/rfsuny](http://www.tiaa-cref.org/rfsuny).

## Group Supplemental Retirement Annuity (GSRA) Loan Option

If you own a GSRA contract, TIAA-CREF offers a loan provision that allows you to use your accumulations as collateral for a loan without making a withdrawal from your contract. If you are married, your spouse must consent to the loan.

You may borrow up to 45 percent of the funds remitted through the RF to your TIAA-CREF GSRA contract. The minimum loan is \$1,000; the maximum is \$50,000. The loan amount you request may be reduced by any outstanding loans under this option. Repayments are made quarterly over a five-year period except when the loan is used to purchase a principal residence. In that case, the repayment period may be up to 10 years. The term of the loan cannot extend past April 1 of the year in which you attain age 70½. Your TIAA Traditional Annuity accumulation is used as collateral to secure the loan and must be at least 110 percent of the loan amount. You may transfer TIAA Real Estate and CREF funds to a TIAA Traditional Annuity to increase the collateral. Since the TIAA Traditional Annuity accumulation securing the loan remains in your account, it continues to earn interest and dividends. After the loan is paid, you can transfer the TIAA Traditional Annuity accumulation back to TIAA Real Estate and CREF accounts.

The interest rate on the loan is a variable rate based on Moody's corporate bond yield average. The rate is determined quarterly and will not change unless the new rate differs from the current rate by at least 0.5 percent. Other than interest on the loan, there are no fees for using this service and no credit review will be done. If you fail to make a loan payment, the outstanding loan balance, plus the interest on that payment, will be subject to ordinary income taxes and may be subject to the tax penalties applied to early withdrawals.

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

## Hardship Withdrawals

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

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

- Unreimbursed medical expenses incurred by you, your spouse or dependents;
- Purchase (excluding mortgage payments) of your principal residence;
- Payment of tuition and related fees and room and board expenses for the next 12 months of postsecondary education for yourself, your spouse or dependents;
- Payment of amounts necessary to prevent eviction from your principal residence, or foreclosure of your principal residence;
- Funeral expenses; or
- Repairs to your principal residence.

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

- The distribution does not exceed the financial need plus anticipated taxes and penalties,
- You have obtained all distributions and nontaxable loans available from the Optional Retirement plan and
- Your salary reduction contributions are immediately suspended for six months.

Specific documentation requirements are necessary to complete the hardship withdrawal. Refer to the RF Benefits Website or your campus Benefits Office for applicable forms.

## Taxes

Retirement distributions from TIAA-CREF contracts are normally subject to ordinary income taxes. Refer to Making a Cash Withdrawal and Tax Implications on page 58. A 10 percent tax penalty will generally apply to cash withdrawals made before age 59½ unless you have medical expenses exceeding the tax-deductible limit, become disabled, die or end employment at age 55 or older.

## Spousal Rights

Refer to Spousal Rights on page 60. In addition, your opposite-sex spouse must consent in writing to any TIAA-CREF GSRA loan, as described on page 64.

### YOUR RETIREMENT BENEFITS IF YOU BECOME DIVORCED OR SEPARATED

Refer to Your Retirement Benefits if You Become Divorced or Separated on page 60.

## If You Leave the Research Foundation

The funds in your TIAA-CREF accounts and mutual funds continue to share in earnings/losses if you leave the RF even if no additional contributions are made. The same options you have available to you for changing your distribution of funds as an active employee remain unchanged.

### GSRA

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

### TDA

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

## How Benefits Are Paid

### BENEFIT PAYMENTS FROM TIAA-CREF CONTRACTS AND ACCOUNTS

---

Payment options for accounts at TIAA-CREF are explained under How Benefits Are Paid for the Basic Retirement Plan on page 55, but please note the following differences:

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

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

### MINIMUM DISTRIBUTION REQUIREMENTS

---

The minimum distribution requirements for retirement funds from TIAA-CREF are the same for the Basic and Optional Retirement plans. Refer to When Distributions Must Begin on page 57.

### BENEFITS IF YOU DIE

---

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

Your entire balance must normally be distributed to your beneficiary by December 31 of the fifth calendar year after your death. If elected, death benefits may be payable over the life expectancy of a designated beneficiary if the distribution of benefits begins no later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your opposite-sex spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 70½, had you lived.

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

If you die after all funds have been annuitized, any additional payments will be determined by the annuity option you selected at retirement.

## MAKING CASH WITHDRAWALS

---

### **GSRA Contracts**

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

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

## Deferred Compensation Plan

The RF's Deferred Compensation plan allows eligible employees to supplement their retirement savings with pretax, biweekly contributions as defined under section 457(b) of the Internal Revenue Code. This is an "unfunded" plan, meaning that although plan participants reduce their salary and put that money aside in accounts with their names, these funds are part of the RF's general assets and, as such, are subject to the claims of RF's creditors. The RF has no obligation to set aside any funds for the purpose of making any benefit payments under this plan, and plan participants do not have any rights to any unpaid amounts that are greater than those of an unsecured creditor.

### Eligibility

Participation in the plan is limited to active employees who:

- Are "highly compensated employees" as defined by the IRS (annual salary of at least \$115,000 in 2012) and
- Perform services in one of the following job categories established by the RF:
  - Project Employees in one of the following titles: Clinical Investigator, Co-Principal Investigator, Principal Investigator, Principal Medical Practice Plan Administrator, Principal Nursing Administrator, Project Administrative Officer, Agency Administrative Officer, Senior Clinical Investigator, OR
  - Administrative Employees in titles assigned to one of the following grades: E.7, (e.g., Director, Assistant Vice President), E.8 (e.g., Vice President), E.9 (e.g., Senior Vice President) or E.0 (Officers of the Employer).

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





SECTION 6

# CONTINUING BENEFITS

---

**con·tin·u·ing ben·e·fits** • *verb*

extending employment benefits coverage during certain periods when the individual is not actively working

## CONTINUING BENEFITS

---

### Continuing Benefits at a Glance

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 or during one of these events:

- 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.

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 77); 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 in the Health Care section beginning on page 15).

Health insurance also can be continued on a direct-payment basis with the carrier. If you are interested, contact Empire Blue Cross or your HMO.

## Certification of Prior Group Health Plan Coverage

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health insurance carrier will provide you and your dependents with certification of prior health insurance coverage. The certificate can be given to a future employer and be used to reduce waiting periods that may apply to pre-existing conditions. If your health plan does not provide you with a certification of prior health insurance coverage, contact your campus Benefits Office and request a certification.

## Basic and Optional Life

You may convert your Basic Life and Optional Life coverage to an individual whole-life policy by contacting Prudential 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 Life Insurance on page 45.

## New York State Unemployment Insurance

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

### ELIGIBILITY

---

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

### WHEN BENEFITS BEGIN AND END

---

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

### COMPENSATION

---

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

### HOW TO FILE A CLAIM

---

When you terminate employment, you will receive a DOL Record of Employment form that includes your exact date of termination. You can file your claim for unemployment insurance benefits online using the DOL website ([www.labor.state.ny.us/ui/ui\\_index.shtm](http://www.labor.state.ny.us/ui/ui_index.shtm)) or by calling the telephone claims center at 888-209-8124 for New York State residents (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. You will be notified by the DOL if you are not eligible for benefits. You have the right to appeal a claim in accordance with DOL guidelines. Refer to Where to Get Help on page 6 for phone number and website.

# If You Retire from the RF

## Retiree Health Care Coverage

This section describes Retiree Health Care rules now in effect. The RF reserves the right to change these rules in the future.

The RF will continue your Health Care coverage after you retire, if you meet the following eligibility requirements and pay the required premium. You must:

- Be enrolled in the RF Health Care plan when you retire;
- Have completed a minimum of 10 years of continuous, full-time service or the equivalent in part-time service at 50 percent or more of full-time effort (e.g., a person working 50 percent of full time for 20 years would qualify) with the RF immediately before you retire;

*Note: A break in service of one year or more will disqualify your previous service toward Retiree Health Care. Time spent working as a SUNY employee will not count as a break in service, nor will it count as eligible service. This break-in-service rule does not apply to retirements on or after January 1, 2012.*

- Be at least age 55;
- Be continuously employed by the RF during the one-year period immediately prior to retirement; and
- Enroll in Original Medicare Parts A and B when you reach age 65, but not part D.

If you do not meet these eligibility requirements, you may still continue coverage under the RF Health Care plan under COBRA.

The RF will continue Health Care coverage for your eligible dependents if they have been covered under your plan for at least one year before you retire. No new dependents can be added to your coverage after you retire. If you die, health insurance for your covered dependents will continue for the remainder of their lifetime, while your dependents remain in an eligible status and pay the required premium.

### IF YOU CHOOSE NOT TO CONTINUE HEALTH INSURANCE

If you do not choose to continue your health insurance with the RF at the time you retire, there is no option for enrolling in the Retiree Health Care plan at a later date.

## PAYMENT OF HEALTH INSURANCE PREMIUMS

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

<b>If you were hired</b>	<b>then</b>
<b>before January 1, 1986</b>	The RF will pay the full premium for your coverage. You must enroll in Original Medicare Parts A and B when you reach age 65 and pay the Part B premium.
<b>on or after January 1, 1986, and are eligible to retire on or before December 31, 2011</b>	Until you become covered by Medicare, you are responsible for the same share of the premium as an active employee. Payment details will be provided at the time of retirement. The RF will pay the full premium for your coverage once you become covered by Original Medicare Parts A and B, which occurs at age 65. You must pay the Part B premium.
<b>on or after January 1, 1986, and are not eligible to retire on or before December 31, 2011</b>	The amount you pay will vary with the number of full-time equivalent years of service you have at retirement. For those age 65 or over, premiums will be offset in part by the standard cost of Medicare Part B. See the health coverage in retirement rate tables below for more information.

### Retiree Health Care Rate Tables

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

If the full number of years of service at retirement is ...	And the covered person is ...	Your contribution rate is ...	Spouse contribution rate is ...
<b>10 to 14 years</b>	Between 55 and 64 years old	40% of premium	85% of premium
<b>10 to 14 years</b>	Age 65 and over	40% of premium minus 25% of standard Part B cost	85% of premium minus 25% of standard Part B cost
<b>15 to 19 years</b>	Between 55 and 64 years old	20% of premium	50% of premium
<b>15 to 19 years</b>	Age 65 and over	20% of premium minus 75% of standard Part B cost	50% of premium minus 75% of standard Part B cost
<b>20 or more years</b>	Between 55 and 64 years old	10% of premium	25% of premium
<b>20 or more years</b>	Age 65 and over	10% of premium minus standard Part B cost	25% of premium minus standard Part B cost

For those hired on or after January 1, 2012

If the full number of years of service at retirement is ...	And the covered person is ...	Your contribution rate is ...	Spouse contribution rate is ...
<b>10 to 14 years</b>	Between 55 and 64 years old	80% of premium	85% of premium
<b>10 to 14 years</b>	Age 65 and over	80% of premium minus 25% of standard Part B cost	85% of premium minus 25% of standard Part B cost
<b>15 to 19 years</b>	Between 55 and 64 years old	35% of premium	50% of premium
<b>15 to 19 years</b>	Age 65 and over	35% of premium minus 75% of standard Part B cost	50% of premium minus 75% of standard Part B cost
<b>20 or more years</b>	Between 55 and 64 years old	10% of premium	25% of premium
<b>20 or more years</b>	Age 65 and over	10% of premium minus standard Part B cost	25% of premium minus standard Part B cost

### HOW MEDICARE AFFECTS YOUR HEALTH INSURANCE BENEFITS

You must enroll in Medicare Part A (hospital) and Part B (medical/surgical) if:

- You are age 65 or older and are retired from RF active employment or
- You have received Social Security disability benefits for two years or longer.

If you delay enrollment in Original Medicare Parts A and B, benefits that would otherwise be paid under the RF plan will be reduced by the amount that would have been paid by Medicare. If you enroll in a Medicare plan other than Original Medicare, your secondary benefits through the RF may be reduced or eliminated. Please contact your campus Benefits Office before enrolling in a Medicare Plan that is not Original Medicare.

If you qualify for RF Retiree Health Care, you should not enroll in Medicare Part D (prescription drug coverage) because the RF receives a subsidy from the federal government for providing your prescription drug benefits and because the RF benefits provide better coverage.

## DENTAL COVERAGE CONTINUATION

---

If you qualify for RF Retiree Health Care, you and your covered dependents may continue your dental coverage throughout your retirement if you pay the full premium. You must have been enrolled in Dental Care coverage for at least one year prior to your retirement to continue coverage.

## VISION CARE, BASIC LIFE AND OPTIONAL LIFE COVERAGE CONTINUATION

---

Refer to Termination beginning on page 69.

# 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 nonwork-related illness or injury, the RF will continue the benefits in effect at the time of your disability.

If you currently 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 71.

### 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 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 following table. (For more information about LTD benefits, refer to page 41.)

## Benefits Continuation After One Year on Long-Term Disability<sup>1</sup>

(For Long-Term Disabilities Beginning After January 1, 2012)

Your Hire Date	Full-Time Equivalent Service at the Time Disability Begins	
	At Least 10 Years	Less than 10 Years
<b>On or after January 1, 1986<sup>2</sup></b>	<p>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.</p> <p><b>If your LTD payments end after you reach age 55,</b> your Health Care coverage will continue under the Retiree Health Care plan as long as you pay the premium.</p> <p><b>If your LTD payments end before you reach age 55,</b> you may continue your coverage in accordance with COBRA benefits continuation rules.</p>	<p>You may continue your Health, Dental and Vision Care coverage in accordance with COBRA benefits continuation rules.</p>
<b>Before January 1, 1986</b>	<p>The Health, Dental and Vision Care coverage (and coverage level) you have in effect at the time your disability begins will continue at no cost until your LTD payments are exhausted or you reach age 65, whichever comes first.</p> <ul style="list-style-type: none"> <li>• If you reach age 65 first, your Health Care coverage will continue under the Retiree Health Care plan; your Dental and Vision Care coverage will end, but may be continued under COBRA.</li> <li>• If your LTD payments are exhausted first and             <ul style="list-style-type: none"> <li>– You are at least age 55, your Health Care coverage will continue under the Retiree Health Care plan.</li> <li>– You have not reached age 55, you may continue coverage in accordance with COBRA benefits continuation rules.</li> </ul> </li> </ul>	<p>You may continue your Health, Dental and Vision Care coverage in accordance with COBRA benefits continuation rules.</p>

<sup>1</sup> If you are under age 65 when you become totally disabled, the Health, Dental and Vision Care coverage (and coverage level) you had in effect at the time your disability began will continue at no cost while you are receiving LTD payments for up to one year. If you are age 65 when you become totally disabled, the Health, Dental and Vision Care coverage you had in effect at the time your disability began will continue under the Retiree Health Care plan if eligible.

<sup>2</sup> Applies to disabilities beginning on or after January 1, 2012.

## If You Become Totally Disabled Prior to January 1, 2012

When you become totally disabled, the Health, Dental and Vision Care coverage (and coverage level) 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 on the following page.

## Benefits Continuation After One Year on Long-Term Disability

(For Long-Term Disabilities that Begin Before January 1, 2012)

Your Hire Date	Full-Time Equivalent Service at the Time Disability Begins	
	At Least 10 Years	Less than 10 Years
<b>On or after January 1, 1986</b>	<p>Your Health Care coverage will continue at no cost until your LTD payments are exhausted or you reach age 65, whichever comes first. Your Dental and Vision Care coverage will end, but may be continued under COBRA.</p> <ul style="list-style-type: none"> <li>• If you reach age 65 first, your Health Care coverage will be continued under the Retiree Health Care plan.</li> <li>• If your LTD payments are exhausted first and                             <ul style="list-style-type: none"> <li>– You have met age and service requirements, your Health Care coverage will be continued under the Retiree Health Care plan.</li> <li>– You have not met the age and service requirements, you may continue coverage in accordance with COBRA continuation rules.</li> </ul> </li> </ul>	<p>You may continue Health, Dental and Vision Care coverage for the remainder of the COBRA period by paying the required premium. If you had at least five years of full-time equivalent service at the time your disability began, you will be credited with service toward eligibility for retiree Health Care while you are receiving LTD payments, provided you continue Health Care coverage during your disability by paying the total premium (employer and employee share). If you are still totally disabled upon reaching age and service requirements, your Health Care coverage will continue under the Retiree Health Care plan.</p>
<b>Before January 1, 1986</b>	Refer to the table Benefits Continuation After One Year on Long-Term Disability (For Long-Term Disabilities Beginning After January 1, 2012) on page 74.	

## RETIREMENT CONTRIBUTIONS CONTINUATION

If you participate in the RF Basic Retirement plan when you become totally disabled, First Reliance Standard Life 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-CREF directly.

## 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
<b>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,</b>	Benefits will continue for one year beyond the time New York State Short-Term Disability benefits cease. <i>Note: After one year, benefits may be continued for a limited period under COBRA, if you pay the full premium.</i>
<b>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,</b>	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 if you pay the required premium.
<b>Are no longer receiving a Social Security disability benefit,</b>	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 insurance 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.
- 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 insurance 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 insurance coverage continuation above also apply to Optional Life insurance.

# 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 FMLA 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 page 77 for additional information on continuing your benefits.

## Military Leave

### HEALTH, DENTAL AND VISION CARE COVERAGE CONTINUATION

---

During periods of approved military leave under the Uniformed Services Employment and Reemployment 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 below 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 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 RF health plans may elect to continue existing coverage for a period of time. If you had employee and spouse/domestic partner or employee and child(ren) coverage at the time of the qualifying event, you may change to employee only coverage when you elect COBRA.

### DEATH, DIVORCE, MEDICARE ENTITLEMENT

---

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

### LOSS OF DEPENDENT STATUS

---

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

## Duration of Continuation Coverage

### FEDERAL LAW

---

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

### NEW YORK STATE LAW

---

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

### DISABILITY EXTENSION

---

If an individual is entitled to COBRA continuation coverage because of a termination of employment or reduction in hours of employment, the plan is generally required to make COBRA continuation coverage available to that individual for 18 months. However, if the individual entitled to COBRA continuation coverage in the covered employee's family is disabled (as determined under the Social Security Act) and satisfies the applicable notice requirements, the plan must provide COBRA continuation coverage for up to 29 months, rather than 18 months, to any qualified beneficiary in the family that elects this extended coverage. The COBRA premium will increase to 150 percent of the full premium after the initial 18 months of continuation coverage. To qualify for the extension, the individual must be disabled at the time of termination of employment or reduction in hours of employment or become disabled during the first 60 days of COBRA continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. If the Social Security disability determination was received prior to the date of the qualifying event, you must provide the notice to the Plan Administrator not later than the last day of your COBRA election period. The affected individual must notify the RF Office of Administration and Human Resources within 60 days of any final determination that the individual is no longer disabled.

## Second Qualifying Event Extension

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

Except in the case of a bankruptcy (see page 80), continuation coverage will not last beyond 36 months from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

## Bankruptcy

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

## Your Responsibilities

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

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

## Paying for 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 RF health plan, the qualified beneficiary becomes covered by another group plan, unless that plan contains any pre-existing condition exclusions or limitations that apply to the qualified beneficiary;
- You become entitled to Medicare; or
- Dental or vision coverage was extended for up to 29 months for a person disabled under Social Security rules, and there has been a final determination that the qualified beneficiary is no longer disabled.

## Health Care Flexible Spending Account

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

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

## Effect of Not Electing COBRA

If you do not choose continuation coverage, your Health, Dental and Vision Care coverage and your participation in the Health Care FSA will end on the date specified by the plan. If you have at least a 63-day break in health benefit coverage, you could lose the ability to join another health plan without the imposition of an exclusion or waiting period with respect to any pre-existing condition you or your spouse or dependents may have.

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

Under New York state law, your adult children may be able to continue or elect RF coverage until their 30th birthday if you or they pay the full premium, provided they are:

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

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





SECTION 7

# WORK/LIFE BENEFITS



WORK / LIFE BENEFITS

**work/life balance** • *noun*

proper prioritization between one's professional and personal responsibilities, goals and aspirations

## WORK/LIFE BENEFITS

---

### Benefits at a Glance

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 Leave

Salaried employees appointed to at least 50 percent of full time are eligible to accrue leave. Unless there are special circumstances, an employee cannot take leave 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 leave.

This section describes various types of paid leave. For additional information on eligibility for leave and how it is administered, refer to the Employee Handbook, which is available online at [www.rfsuny.org](http://www.rfsuny.org). Log in with your username and password, and select "Your RF Employment" from the menu at the left of the screen. 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 Leave

The primary purpose of sick leave is to provide a reasonable measure of protection against loss of income due to illness or disability. The amount of sick leave 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 Leave

Subject to managerial approval, vacation leave may be taken at your request. Personal leave may be used for absences due to pressing personal business and other similar circumstances, e.g., medical 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 leave 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.

## 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 leave before their employment terminates, the holiday leave 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 Reemployment 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. Effective August 16, 2006, spouses of members of the armed forces who have been deployed during a period of military conflict are allowed to take 10 days unpaid leave when that employee's spouse is on leave from the armed forces.

## Jury Duty

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

## Other Types of Leave

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

## Family and Medical Leave

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

## Flexible Benefits Program (Pretax Health Contributions)

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

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

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

Because of tax advantages under the Flexible Benefits Program, a few special rules apply. Under IRS regulations, once your pretax deduction becomes effective for a calendar year, you may not change your coverage election until the next open enrollment period unless you qualify for a special enrollment period or another exception. Refer to Open Enrollment in the Health Care section on page 19.

The only exception is if you meet one of the qualifying events described in the Flexible Benefits Plan booklet. To change your election, complete a new RF Benefits Enrollment Form and submit this within 60 days of the qualifying event.

## Health Care and Dependent Care Flexible Spending Accounts

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

The Health Care FSA maximum deposit is \$4,000 annually. This amount reduces to \$2,500 in 2013 under federal law.

The Dependent Care FSA maximum annual deposit is based on your tax filing status and ranges from \$2,500 to \$5,000. In addition, the RF will provide an annual lump-sum subsidy to your Dependent Care FSA, ranging from \$300 to \$800 based on your full-time equivalent income. There is a six-month waiting period to participate in these accounts.

## Flexible Benefits Plan Booklet

You should receive The Research Foundation of State University of New York and FBMC Flexible Benefits Plan booklet from your campus Benefits Office. You also can obtain a copy from the RF Benefits Website ([www.rfsuny.org/benefits](http://www.rfsuny.org/benefits)) by selecting Regular Employee and then Flexible Spending Accounts. The Flexible Benefits Plan booklet, in conjunction with your *Research Foundation Benefits Handbook*, constitutes the ERISA summary plan description (SPD). The Flexible Benefits Plan booklet describes in detail:

- Important information about eligibility and enrollment,
- How to get more information,
- Eligible expenses,
- Ineligible expenses,
- How to request reimbursement,
- Permitted election changes during a plan year,
- Appeal process and
- FBMC Privacy Notice.

In order to enroll, you must complete a Flexible Spending Account Enrollment Form and return it to your campus Benefits Office. To stay in the plan you must complete a new enrollment form each calendar year.

## College Savings Program

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

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

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

## Program Overview

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

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

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

## Upromise Rewards

Upromise offers a unique opportunity to add additional credits to your account simply by registering for the rewards program and by making qualifying purchases from any of the plan's numerous nationwide partners. Refer to Program Information on page 87 to learn how to get additional details.

## New York's College Savings Program Brochure

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

In order to enroll you must:

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

## Payroll Deductions

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

## Overpayments

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

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

## Program Information

Program information can be obtained by calling 877-NYSAVES (877-697-2837) or by visiting [www.nysaves.org](http://www.nysaves.org).

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

RF employees enjoy a discount of up to 10 percent over standard rates for personal auto and homeowner's insurance (including renter's insurance) with Liberty Mutual's Groups 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, call Liberty Mutual directly at 800-524-9400 and identify yourself as an RF employee (or provide them with the RF client number 111756). You also can enroll online at [www.libertymutual.com/rfsuny](http://www.libertymutual.com/rfsuny) or in person at your local Liberty Mutual office. There are no payroll forms to complete.

## RF Ride Commuter Transit and Parking Benefit

The RF contracts with WageWorks to offer RF Ride. This plan can help you save money by letting you pay for eligible 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) and fees for parking at station lots. No income tax, Social Security or Medicare tax will be withheld from the amount of your eligible expenses. You can enroll in RF Ride even if your campus does not already offer a pretax parking benefit. Enroll online at [www.getwageworks.com/rfsuny/commuter](http://www.getwageworks.com/rfsuny/commuter) or by calling WageWorks at 877-924-3967.



SECTION 8

INTERNATIONAL  
TRAVEL  
ASSISTANCE

---

**in-ter-na-tion-al tra-vel • noun**

journeying to various countries in support of the RF's research, education and training activities

**ass-is-tance • noun**

providing resources or information to help someone with a task

## INTERNATIONAL TRAVEL ASSISTANCE

---

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 blanket international travel assistance coverage, as well as emergency health insurance benefits, for all persons (other than independent contractors) 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 after a \$25 annual deductible. 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 (GBT)

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

### GeoBlue Expatriate (GBE)

RF employees on an international assignment for longer than 180 consecutive days can use the HTH Worldwide GBE program 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).

### Frontier Medex

The RF contracts with Frontier Medex 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 day a year.





## SECTION 9

# 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.

## KEY TERMS

---

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

**Annuitant** – A person receiving retirement annuity payments.

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

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

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

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

**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 (\$250,000 in 2012) 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 (ERISA) entitling employees to benefits rights and protections.

**GSRA** – A TIAA-CREF Group Supplemental Retirement Annuity contract for employee tax-deferred funds.

**HIPAA** – Health Insurance Portability and Accountability Act of 1996.

**HMOs** – Health Maintenance Organizations. Certified health care organizations that provide hospitalization coverage, a comprehensive plan of medical and surgical care, and prescription drugs. HMOs operate within designated regions.

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

**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.

**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).

**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."

**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.

**Qualified domestic relations order** – 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.

**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.

**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-CREF Tax-Deferred Annuity contract for employee tax-deferred funds.

**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.

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



## SECTION 10

# INDEX

---

# INDEX

## A

Accidental Death and Dismemberment (AD&D).....	3, 8, 45
Auto, Homeowner's and Renter's Insurance	
Discount Program.....	6, 87

## B

Basic Life insurance.....	3, 6, 8, 45
Basic Retirement.....	4, 6, 9, 51
benefits continuation .....	69
COBRA.....	77
if you become disabled.....	73
if you retire.....	71
if you take a leave of absence.....	76
if your employment ends .....	69
break in service .....	2-5, 45, 53, 54, 71

## C

changing coverage.....	19
claims, filing and appealing	
Dental Care.....	29
Disability: Long-Term.....	42
Disability: New York State .....	40
Health Care.....	10
HMOs.....	27-29
life insurance .....	48
prescription drug coverage (PPO) .....	27
unemployment insurance .....	70
Vision Care.....	33
Workers' Compensation.....	39
COBRA – <i>see benefits continuation</i>	
College Savings Program.....	86
continuing benefits – <i>see benefits continuation</i>	
coordination of benefits, rules for .....	34
costs, benefits .....	2-5
coverage	
benefit plan guidelines.....	2-5
changing.....	19
waiting periods.....	2-5
waiving, when newly eligible.....	18
when it begins, exceptions.....	2-5, 22
when it ends .....	2-5

## D

Davis Vision – <i>see Vision Care</i>	
Deferred Compensation Plan.....	67
Delta Dental – <i>see Dental Care</i>	
Dental Care .....	29
benefits .....	30
claims, filing and appealing.....	31
contact information .....	6
deductibles, annual .....	31
family.....	31
individual .....	31
dentists	
participating.....	30
nonparticipating.....	30
maximum reimbursements .....	30
waiting periods .....	30
dependents	
adding coverage .....	16, 21
coordinating your benefits.....	34
eligibility .....	16
disability	
benefits	
begin, end.....	38
Long-Term Disability.....	41
New York State Short-Term Disability .....	39
Voluntary Short-Term Disability .....	40
Workers' Compensation.....	38
claims	
Long-Term Disability.....	42
New York State Short-Term Disability .....	40
Workers' Compensation.....	39
continuing other benefits while disabled	
Long-Term Disability.....	42
New York State Short-Term Disability .....	40
Workers' Compensation.....	39
retirement contributions while on long-term disability .....	43
domestic partners .....	16
drugs – <i>see prescription drugs</i>	

<b>E</b>		<b>I - K</b>	
eligibility		identification card	
benefits .....	2-5	Dental Care.....	30
dependents .....	16	Health Care (HMO) .....	27
Health Care .....	15	Health Care (PPO) .....	23
Retirement plan, Basic .....	51	International Travel Assistance .....	89
Retirement plan, Optional .....	61	prescription drug coverage (PPO) .....	24
Voluntary Long-Term Care Insurance.....	43	Vision Care.....	32
Voluntary Short-Term Disability.....	40	International Travel Assistance .....	89
Empire Blue Cross, contact information .....	6		
enrollment		<b>L</b>	
College Savings Plan .....	87	late enrollment.....	19
Flexible Benefits Program.....	85	leave of absence	
Health Care .....	18	Family and Medical Leave (FMLA) .....	54, 76, 77
late .....	19	continuing benefits during.....	73 - 80
Life Insurance, Basic.....	45	holidays.....	84
Life Insurance, Optional.....	46	jury duty .....	84
open .....	19	military .....	54, 77, 84
Retirement plan, Optional .....	61	retirement plan contributions during.....	62
special enrollment rights.....	20	sick leave .....	83
Voluntary Long-Term Care Insurance.....	44	vacation and personal leave.....	83
Voluntary Short-Term Disability.....	41	Liberty Mutual, contact information .....	6
ERISA, your rights under .....	9	life insurance	
		accelerated death benefit.....	47
<b>F</b>		Basic Life and Accidental Death and Dismemberment .....	45
Family and Medical Leave (FMLA).....	54, 76, 77	beneficiaries	
Flexible Benefits Program, pretax health contributions .....	85	changing .....	48
Flexible Spending Accounts (FSAs).....	85	designating.....	47
Health Care FSA continuation under COBRA.....	81	certificate of insurance .....	50
		claims, filing and appealing.....	48-49
<b>G</b>		Dependent Life insurance.....	46
Group Supplemental Retirement Annuity (GSRA).....	64	Optional Life and Accidental Death and Dismemberment .....	46
		payment of benefits.....	48
<b>H</b>		policy conversion .....	49
Health Care .....	15		
changing coverage.....	19	<b>M</b>	
claims, filing and appealing.....	10	Medicare	
contact information .....	6	domestic partner or same-sex spouse .....	17
coordination of benefits, rules for .....	34	effect on your health care benefits .....	72
coverage options .....	18	eligibility as an active employee.....	18
eligibility .....	15	if you retire from the RF.....	71
enrollment.....	18	Medco, contact information .....	6
Flexible Benefits Program, pretax health contributions .....	85	military leave .....	54, 77, 84
Health Maintenance Organization (HMO).....	27		
HIPAA.....	11	<b>N</b>	
Preferred Provider Organization (PPO).....	23	Newborns and Mothers Health Protection Act.....	36
prescription drug coverage (PPO) .....	24	New York State Short-Term Disability.....	4, 6, 8, 39
Health Insurance Portability and Accountability		New York State Unemployment Insurance .....	5, 6, 9, 70
Act of 1996 (HIPAA) .....	11		
		<b>O</b>	
		open enrollment.....	19
		Optional Life Insurance – <i>see also life insurance</i> .....	46
		Optional Retirement – <i>see also retirement plans</i> .....	61

<b>P</b>			
pharmacies.....	24	making cash withdrawals .....	67
phased retirement.....	59	minimum distributions requirements .....	66
prescription drug		payment of benefits.....	66
coverage (PPO).....	24	saver's credit.....	63
brand name drugs.....	25	spousal rights .....	65
claims, filing and appealing .....	27	taxes .....	65
drugs and supplies not covered .....	26	vesting .....	63
generic drugs .....	25	your contributions.....	62
identification card.....	24		
mail order.....	24	<b>S</b>	
pharmacies .....	24	same-sex spouse .....	16 – 17, 20
preferred and nonpreferred drugs.....	25	special enrollment rights .....	20
quantity/duration limits.....	27	spousal rights (retirement plans).....	65
retail.....	24	survivor benefits	
specialty medication .....	26	life insurance .....	48
coverage (HMO).....	29	retirement plans .....	57
privacy – <i>see Health Insurance Portability and Accountability Act of 1996 (HIPAA)</i>			
		<b>T</b>	
<b>Q</b>		tax-deferred annuity (TDA) – <i>see retirement plans</i> .....	63, 65
qualifying events.....	21	TIAA–CREF, contact information.....	6
<b>R</b>		<b>U</b>	
RF Ride Commuter Transit and Parking Benefit.....	88	Unemployment Insurance, State of New York .....	5, 6, 9, 70
retirement plans			
Basic Retirement plan .....	51	<b>V</b>	
benefits if you die.....	57	Vision Care .....	3, 6, 8, 31
changing name, address or beneficiary .....	55	claims, filing and appealing.....	33
claims, filing and appealing .....	60	changing coverage.....	20
directing your investment.....	54	late enrollment .....	19
eligibility .....	51	providers .....	32
employment service credit .....	53	restrictions .....	32
if you leave the RF .....	53	Voluntary Long-Term Care Insurance.....	43
investment fund options.....	54	Voluntary Short-Term Disability.....	40
payment of benefits.....	55		
phased retirement .....	59	<b>W</b>	
RF contributions.....	52	waiting periods .....	2-5
rollovers .....	59	waiving coverage, when newly eligible .....	18
selecting your beneficiary .....	60	Workers' Compensation – <i>see disability</i>	
tax implications of cash withdrawal.....	58	Women's Health and Cancer Rights Act .....	35
transferring funds.....	55		
vesting .....	53		
when distributions must begin.....	57		
Optional Retirement plan .....	61		
benefits if you die.....	66		
changing distribution of funds .....	63		
changing name, address or beneficiary .....	63		
eligibility .....	61		
hardship withdrawals.....	64		
how to enroll.....	61		
if you have an outside business.....	62		
if you leave the RF .....	65		
investment funds .....	63		
loan option.....	64		





*The Research Foundation of 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 the June 2010 Benefits Handbook as well as all previous Research Foundation Benefits Handbooks and addenda.*



.....