

2022 Benefits Handbook

RETIREES



The Research
Foundation for

The State University of New York

About the Research Foundation for SUNY

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

About the Benefits Handbook

With respect to the welfare benefits that are subject to the Employee Retirement Income Security Act of 1974 (ERISA), this handbook, in combination with handbooks and certificates from the insurance companies, constitutes the ERISA plan and summary plan description.

The Research Foundation for the State University of New York Retirement Plan and The Research Foundation for the State University of New York Optional Retirement Plan have separate plan documents, which shall govern in the event of a discrepancy between this handbook and those plan documents.

This handbook is intended to:

- Provide a summary outline about RF benefits plans and programs for retirees,
- 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.

For additional information, or if you have questions about your benefits coverage, contact RF Benefit Services at 518-434-7101.

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Contact the following companies for questions regarding service providers, claim reimbursement or pension benefits. For additional information, questions about your benefits coverage or enrollment forms, contact RF Benefits Services.

BENEFIT	BENEFITS / CLAIM ADMINISTRATOR	PHONE	WEBSITE
HEALTH CARE			
Health Plan Payments	PayFlex	844-729-3539	www.payflex.com
Preferred Provider Organizations (PPOs)	Empire Blue Cross: <ul style="list-style-type: none"> • Member Services • Locate providers in Eastern New York State, including downstate • Locate providers in Central and Western New York State or outside New York State • Mental Health or Substance Abuse • Pre-certification • Personal Health Advisor 	800-342-9816 800-342-9816 800-810-BLUE (800-810-2583) 800-626-3643 800-982-8089 877-TALK2RN or 877-825-5276	www.empireblue.com
Prescription Drugs (PPO Plan)	Express Scripts: <ul style="list-style-type: none"> • Find participating retail pharmacies • Obtain order forms, claim forms and envelopes • Get information about your prescriptions and coverage • Order mail-order prescription labels printed in Braille • Speak with a representative in Spanish • Fax prescriptions (ask your doctor to call for participating locations) • Reach Member Services for hearing-impaired members (TTY) 	800-251-7690* 800-251-7690* 800-251-7690* 800-251-7690* 800-711-0917* 888-327-9791 800-759-1089	www.express-scripts.com
Health Maintenance Organizations (HMOs)	Blue Choice (Rochester/Excellus) Capital District Physician's Health Plan (CDPHP) Independent Health Association (IHA) MVP Health Plan (All Areas)	800-462-0108 800-777-2273 800-501-3439 888-687-6277	www.excellusbcbs.com www.cdphp.com www.independenthealth.com www.mvphealthcare.com

*24 hours a day/7 days a week

BENEFIT	BENEFITS / CLAIM ADMINISTRATOR	PHONE	WEBSITE
Aon Retiree Health Exchange™	Aon	844-689-7837	myhealthexchange4retirees.com/rfsuny
Medical Decision Support	Consumer Medical	888-361-3944	www.myconsumermedical.com
Medicare		800-633-4227	www.medicare.gov
Dental Care	Delta Dental of New York, Inc.	800-932-0783	www.deltadentalins.com
RETIREMENT			
Retirement Plans	TIAA	800-842-2252	www.tiaa.org/public/tcm/rfsuny
Social Security		800-772-1213	www.ssa.gov

Health

The RF Health Care benefits available to you and your eligible dependents as a retiree depend on your eligibility for Medicare. Those who are not yet eligible for Medicare may remain enrolled in the RF's group Health Care insurance plan. Medicare-eligible retirees and/or their Medicare-eligible dependents age 65 and older will be able to choose a health plan through a private health exchange and use an RF-funded Health Reimbursement Account (HRA) to help pay for that coverage.

Health Care Coverage for Retirees and Dependents Who Are Not Eligible for Medicare

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 group Health Care coverage after you retire until you reach age 65 and become eligible for Medicare if you pay the required premium and meet the following eligibility requirements.

You must:

- Be enrolled in the RF Health Care plan when you retire;
- Have completed a minimum of 10 years of full-time service or the equivalent in part-time service at 50 percent or more of full-time effort with the RF (e.g., a person working 50 percent of full time for 20 years would qualify);
- Be at least age 55; and
- Be continuously employed by the RF during the one-year period immediately prior to retirement.

If you do not meet these eligibility requirements, you may still continue coverage under the RF Health Care plan under COBRA, or select coverage through the health insurance marketplace (see page 23).

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. When 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.

Break in Service

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

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

Health Care Plan Handbook

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

Your Medicare Eligibility Matters

If you or your eligible dependent(s) are age 65 or older and eligible for Medicare, turn to page 11.

Enrolling in Retiree Health Care

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 (for Retirees and Dependents Who Are Not Eligible for Medicare)

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

IF YOU WERE HIRED	THEN
Before January 1, 1986	The RF will pay the full premium for your coverage until you reach age 65. See page 11 for health care coverage at age 65 or older.
On or after January 1, 1986, and were eligible to retire on or before December 31, 2011	Until you reach age 65, you are responsible for the same share of the premium as an active employee. Payment details will be provided at the time of retirement. See page 11 for health care coverage at age 65 or older.
On or after January 1, 1986, and were not eligible to retire on or before December 31, 2011	The amount you pay will vary with the number of full-time equivalent years of service you have at retirement. See the Retire Health Care Rate Tables below for more information. See page 11 for health care coverage at age 65 or older.

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

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

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

For those hired on or after January 1, 2012.

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

Changing Your Coverage

Each year the RF schedules an Open Enrollment period to allow you to make changes to your Health Care coverage that are not usually permitted during the calendar year. During Open Enrollment, you may change to or from any Health Care plan currently offered by the RF in the area where you live. You may drop dependent and/or individual coverage at any time; however, you cannot add dependents. If you drop your coverage, you will not be able to re-enroll at a later date.

You will receive a *Benefits Bulletin* announcing plan changes that will take effect on January 1 of the new year. Name, address, phone number and service area information on all Health Care plans will be provided.

A summary of benefit changes will be provided; however, detailed benefit information will be provided directly by the Health Care plans. We suggest that you keep the *Benefits Bulletin* in a place where you can find it so you will have the health provider contact information.

RF retirees (employees hired January 1, 1986, or after) who pay for their Health Care coverage will be notified of any change in the required payment for the new year.

If you wish to make a change during Open Enrollment, you must complete a new benefits enrollment form, which can be obtained by contacting RF Benefits Services at 518-434-7101 or by visiting the RF website at www.rfsuny.org/retirees.

If you do not make any changes during Open Enrollment, your existing coverage will remain in effect for the next plan year.

Coordinating Your Benefits

The RF Health 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.

How to Update Your Personal Information

If your address or phone number changes, you can update your information by calling the RF at 518-434-7101 or by sending an email to benefits@rfsuny.org. If you like, you can mail your new information to the Research Foundation for SUNY, Attn: RF Benefits Services, 35 State Street, Albany, NY 12207-2826.

An Information Update form is available online at www.rfsuny.org/retirees.

Your Health Care Plan Options

PPO Plans

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

Identification Card

Once you have enrolled in either PPO plan, you will receive a PPO membership identification card (ID card). It enables you to receive benefits nationally and internationally. Show your membership card to any 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.

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

Choosing a Provider

In-Network Providers

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

Contact Empire Blue Cross

800-342-9816

www.empireblue.com

PPO Benefits Guide

If you enroll in a PPO plan, you will receive a Benefits Guide. 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.

In Case of Emergency

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

You can find in-network providers 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 visit www.empireblue.com and click on "Menu," then "Find a Doctor."
- For Eastern New York, call 800-377-5156 or visit www.empireblue.com and click on "Menu," then "Find a Doctor."

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

Out-of-Network Providers

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

Physician Office Visits

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

Preventive Care

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

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

Approved Clinical Trials

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

Prescription Drug Coverage

Prescription drug benefits are provided by Express Scripts and are the same under both PPO options. This plan is designed to cover most medications that require a physician's written prescription. Prescription drugs may be obtained either through mail order or at a retail pharmacy. When you fill a prescription, whether through mail order or at a retail pharmacy, you will pay a copayment.

Contact Express Scripts

800-251-7690

www.express-scripts.com

Express Scripts Welcome Kit

For additional information about your prescription drug coverage, refer to the welcome kit you will receive from Express Scripts. The kit, along with this Research Foundation Benefits Handbook is your plan and summary plan description (SPD).

Identification Card

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

Cross PPO card at the pharmacy. Empire Blue Cross does not cover prescription drugs for members of the PPO plan.

Choosing a Pharmacy

Participating Retail Pharmacy. Your Express Scripts ID card can be used at a network of thousands of participating pharmacies that will provide you with prescription drugs at a discounted price. At a participating pharmacy, you present your ID card, pay the copayment (see page 9) and brand-name differential, if applicable, and receive your prescription. You can find a local pharmacy online at www.express-scripts.com.

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

Nonparticipating Retail Pharmacy. If you fill a prescription at a pharmacy that does not participate in the plan's network, the plan will pay only the discounted cost of the drug that a participating pharmacy would have charged. You will be responsible for paying the difference between the discounted price and the actual retail price. At a nonparticipating pharmacy, you pay for prescriptions when you receive them and obtain reimbursement from Express Scripts for allowable expenses. To be reimbursed, you and your pharmacist must complete a reimbursement form and submit it to Express Scripts.

How to Request Reimbursement When Using a Nonparticipating Pharmacy

1. Obtain an Express Scripts reimbursement form from either your campus Benefits Office or directly from Express Scripts.
2. Complete and sign the Member/Subscriber/Patient Information on the front side of the form.
3. Have the prescription filled, pay the full retail price and request a receipt.
4. Have the pharmacist complete and sign the Pharmacy Information section of the form.
5. Tape the original receipt to the claim form. Do not use staples or paper clips.
6. Make copies for your records and mail the reimbursement form and original receipt to: Express Scripts, ATTN: Commercial Claims, P.O. Box 2872, Clinton, IA 52733-2872.

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

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

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

Categories of Prescription Drugs

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

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

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

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

Nonpreferred Brand-Name Drugs. These drugs have the highest copayment, and there is a special coinsurance amount of 50 percent for fertility medications. Generally, these are high-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available. If a physician prescribes a brand-name drug when a generic equivalent is available, you must pay the difference in cost in addition to a copayment.

Annual Out-of-Pocket Maximum

There is an annual out-of-pocket maximum of \$1,320 for individuals and \$2,640 per family on a calendar-year basis for covered drugs.

Specialty Medication

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

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

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

Medically Necessary Self-Injectables

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

If You Are Diagnosed With End Stage Renal Disease

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

Prescription Drug Copayments

	AT RETAIL PHARMACY(30-DAY SUPPLY)	MAIL ORDER (UP TO 90-DAY SUPPLY)
Generic Drugs	\$10	\$10
Preferred Brand-Name Drugs	\$25	\$50
Nonpreferred Brand-Name Drugs	\$45	\$90

Drugs and Supplies Not Covered

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

Quantity/Duration Limits

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

How to File a Claim

If you pay in full at the pharmacy and wish to file a claim for reimbursement, your prescription drug claim will be treated as a *post-service claim*, as described on page 10. Refer to *Your Rights Under State and Federal Laws* on page 25 for details.

HMOs

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

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

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

Identification Card

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

Preventive Care

The HMOs fully cover preventive care services when received from an in-network provider. For a partial list, see *Preventive Care* on page 7.

Prescription Drug Coverage

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

Claims Procedure

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

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

Urgent Care Claims

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

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

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

Contact your HMO

Refer to *Contacts* on page 2.

HMO Handbook

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

Concurrent Care Claims

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

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

Pre-Service Claims

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

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

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

Post-Service Claims

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

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

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

Requirements for Notification of an Adverse Benefit Determination

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

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

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.

Specialty Pharmacy Copay Assistance Program

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

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

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

Health Care Coverage for Retirees and Dependents Who Are Age 65 or Older and Eligible for Medicare

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

Medicare-eligible retirees and/or their Medicare-eligible dependents age 65 and older will be able to choose from a wide variety of Medicare supplemental medical and prescription drug plans available through the Aon Retiree Health Exchange™, a well-established private health exchange. Retirees also may select Medicare supplemental medical and prescription drug plans not offered by the Aon Retiree Health Exchange; however, they will not be eligible to receive the Aon Retiree Health Exchange's enrollment support services.

Retirees or eligible dependents who are not yet age 65 or Medicare-eligible will continue to be enrolled in the current RF group Health Care plan until they reach age 65 and become Medicare-eligible. (See page 4.) Any covered dependent children will continue to be enrolled in the RF group Health Care plan until they reach the age limitation of the plan.

If you do not meet the eligibility requirements, you may still continue coverage under the RF Health Care plan under COBRA, or select coverage through the health insurance marketplace (see page 23).

The Health Reimbursement Account (HRA)

The RF will make an annual contribution to an HRA for most retirees to help pay for health and prescription drug insurance premiums and other eligible health care expenses, including deductibles, copays, and coinsurance. The HRA is administered by the Aon Retiree Health Exchange. You will receive informational materials when you become eligible for the HRA.

The RF will provide HRA contributions after you retire, if you meet the following eligibility requirements. The amount contributed to the HRA is determined annually by the RF; however, these contributions are not guaranteed. The RF reserves the right to modify or discontinue the HRA.

You must:

- Be eligible for Medicare;
- Be at least age 65;
- Be enrolled in the RF Health Care plan when you retire and are age 65 or older;
- Have completed a minimum of 10 years of full-time service or the equivalent in part-time service at 50 percent or more of full-time effort with the RF (e.g., a person working 50 percent of full time for 20 years would qualify);
- Be continuously employed by the RF during the one-year period immediately prior to retirement; and
- Enroll in Original Medicare Parts A and B.

The RF will provide an HRA contribution for your Medicare-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. When you die, the HRA contribution will continue for your dependents' lifetime as long as they remain in an eligible status.

How to Enroll

The Aon Retiree Health Exchange will send you an informational package to your home address. Your informational package will include a specific telephone appointment date and time, scheduled just for you, to speak with your personal Benefits Advisor. Benefits Advisors are certified, licensed insurance agents. If you elect to enroll in Medicare supplemental medical and prescription drug plans not offered by the Aon Retiree Health Exchange, please contact the insurance company directly to enroll.

Prescription Drug Reimbursements

The RF will provide you with a layer of protection for Medicare Part D (prescription drug coverage) catastrophic claims.

To request reimbursement of out-of-pocket prescription costs, you'll need to submit a claim form, along with an Explanation of Benefits (EOB) from your prescription carrier, indicating that you have entered the prescription catastrophic coverage level.

Medical Decision Support by ConsumerMedical

The RF provides a valuable free service to RF retirees enrolled in an RF Health Care plan and their covered dependents. ConsumerMedical helps RF retirees by providing the most recent research and information on any medical condition.

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

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

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

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

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

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

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

By Phone

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

ConsumerMedical Website

RF retirees enrolled in an RF Health Care plan and their covered dependents can access ConsumerMedical services online at www.myconsumermedical.com.

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

Contact ConsumerMedical

888-361-3944

www.myconsumermedical.com

Dental Care

Continuation of dental coverage as a retiree is available for individuals who retired on or after January 1, 2002, and who elected to continue dental coverage within 60 days after retirement. There is no option to elect dental coverage after an individual has retired. You can continue coverage into retirement if you pay the full premium.

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

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

Benefits Summary

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

Maximum Reimbursements

TYPE OF SERVICE	COVERAGE LEVEL ¹	MAXIMUM BENEFIT	
		Delta Premier Network or Nonparticipating Provider	PPO Network Provider
Preventive and Diagnostic ²	100%	Combined maximum of \$1,500 per calendar year	Combined maximum of \$2,000 per calendar year
Basic	75%		
Major and Prosthodontic	50%		
Orthodontic (for dependent children up to and including age 19)	50%	\$2,000 lifetime limit per dependent child	\$2,000 lifetime limit per dependent child

¹Percentage 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.

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

Annual Deductibles

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

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

Choosing a Dentist

Participating Dentists

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

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

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

Nonparticipating Dentists

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

Delta Dental Website

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

Extended Dental Benefits After Termination of Coverage

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

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

Orthodontic payments do not fall within the 90-day extended dental insurance provision.

How to File a Claim

Your dental claim will be treated as a *post-service claim* as described on page 10. See also *Your Rights Under State and Federal Laws* on page 25 for additional information.

Contact Delta Dental

800-932-0783

www.deltadentalins.com

Dental Care Information Sheet

You should have received a Delta Dental Booklet or Employee Information Sheet while you were employed. If you need a replacement copy, you may request one from RF Benefit Services by calling 518-434-7101. The Delta Dental booklet or information sheet, in conjunction with this Research Foundation Benefits Handbook, constitutes the ERISA plan and summary plan description (SPD) for the Dental Care plan.

Retirement

The RF retirement plans are designed to provide you with income during your retirement. In the Basic Retirement plan, the RF contributed an amount equal to a percentage of your annual earnings while you were employed. You did not contribute to this plan. The Optional Retirement plan offered you a way to increase your retirement savings 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.

Online Account Management

You can make changes to your Basic and Optional Retirement plans online at www.tiaa.org/public/tcm/rfsuny. First-time users will need to set up an online account by clicking “Log in,” then “Register for Access.”

On the website, you can change your default investment in the Basic or Optional Retirement plan at any time without having to complete a form.

Basic Retirement Plan

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

While you are retired, the value of your contracts will continue to fluctuate based upon the performance of the various funds in which you are invested, even if no further contributions to your plan contracts are made. If you return to eligible RF employment at some future date, retirement contributions will be made for you immediately. You will not have to satisfy a new waiting period, although a new retirement account may be required.

Directing Your Investment

You can redirect the investment of contributions at any time and may divide your contributions among the funds offered in any whole percentage. Go to www.tiaa.org/public/tcm/rfsuny and click on “Log in” or call a TIAA customer service representative toll-free at 800-842-2252.

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

Investment Options

A listing of funds available for investment can be obtained from TIAA, or go to www.tiaa.org/public/tcm/rfsuny and select “Investment Options.”

Transferring Funds

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

Changing Your Name, Address or Beneficiary

You may change your name, address or beneficiary on your contracts by contacting TIAA. All personal information except name changes can be made online. Refer to *Selecting Your Beneficiary* on page 19 for restrictions on naming a beneficiary if you are married. Also see *Contacts* on page 2.

Contact TIAA

800-842-2252

www.tiaa.org/public/tcm/rfsuny

Quarterly Accumulation Statements and Annual Illustration

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

How Benefits Are Paid

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

Benefits Payments From Mutual Funds

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

Normal Form of Payment From Annuity Contracts

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

Annuity Payment Options

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

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

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

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

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

Other Payment Options From Annuity Contracts

Refer to *Making a Cash Withdrawal and Tax Implications* on page 18 for more information.

A Cash Option allows you to receive your accumulations from your TIAA Real Estate Account, any mutual funds and any CREF accounts in one or more lump-sum payments. This may include systematic withdrawals where you design your own periodic payment plan. If your contributions are being made to a GRA contract, then you also have the option to cash out your TIAA Traditional Annuity within 120 days of your termination of employment (a surrender charge of 2.5 percent applies). After 120 days have elapsed since your termination of employment, this payment option under a GRA contract is no longer available. This option pertaining to the TIAA Traditional Annuity is not available under the Retirement Annuity (RA) contract.

The TIAA Transfer Payout Annuity (TPA) Option allows you to receive your TIAA Traditional Annuity accumulation in 10 annual installments over a nine-year period. After your death, any remaining balance will be paid to your beneficiary. You also can reinvest your TPA in other funds offered in the RF plans, even as a terminated employee.

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 72. It allows you to collect the minimum amount required under IRS regulations, while delaying selection of a lifetime annuity income. You must begin receiving income by April 1 following the calendar year in which you turn age 72. Refer to *When Distribution Must Begin* below.

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

When Distribution Must Begin

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

- The calendar year in which you reach age 72 or
- The calendar year in which you terminate RF employment.

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

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

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 72 to avoid receiving two taxable distributions in the calendar year following attainment of age 72.

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

Benefits If You Die Before Taking an Annuity

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

Normally, your entire balance must be distributed to your beneficiary by December 31 of the fifth calendar year after your death. If elected, death benefits may be payable over the life expectancy of the beneficiary, if the distribution of benefits begins no later than December 31 of the calendar year immediately following the calendar year of your death. If the designated beneficiary is your spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 72 had you lived.

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

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

If you die after all funds have been annuitized, any additional payments will be determined by the annuity option you selected at retirement. There is no death benefit if you are not vested.

Making a Cash Withdrawal and Tax Implications

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

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

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

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

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

have to wait until age 59½ to take a cash distribution of the account balance.

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

Rollover to Another Qualified Retirement Plan or Traditional IRA

As a terminated employee, a rollover into the RF Basic Retirement Plan from another plan is not allowed. However, the RF's plans do permit rollovers out to other plans 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 72 (or after death),
- Hardship distributions,
- Corrective distributions of contributions that exceed tax law limitations, and
- Loans treated as deemed distributions (for example, loans in default due to missed payments before your employment ends).

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

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

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

Selecting Your Beneficiary

Spousal Rights

You may not choose the single life annuity option or designate an annuity partner unless your spouse consents in writing during the 180 days preceding the date benefits begin. If you are married and die before annuity benefit payments begin or before your mutual fund balances are distributed, your spouse is automatically designated as your beneficiary 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 spouse to your benefits under the plan, and where there is a qualified domestic relations order, payments will be made by TIAA in accordance with that order. A court order may preempt the usual requirement that your spouse be considered your primary beneficiary for a portion of the accumulation. A copy of the plan's procedures for determining whether a judgment, decree or order is a "qualified domestic relations order" (QDRO) can be obtained from TIAA.

Federal Insurance

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

How to File a Claim

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

furnished before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring the extension and the date by which the Plan Administrator expects to make its decision.

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

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

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

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

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

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

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

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 compensation is deducted from the employee's pay on a before-tax basis and contributed to an annuity contract or mutual fund custodial account administered by TIAA. These pretax contributions may be invested in the way the employee instructs or they will be invested in the plan's default option. These amounts, together with any earnings, are not subject to state or federal income tax until you or your beneficiary starts receiving benefits.

The value of your contracts will continue to fluctuate based upon the performance of the various funds in which you are invested, even if no further contributions to your RF Optional Retirement plan contracts are made. You have the same options available to you for changing your allocation of funds as you did during employment.

Directing Your Investment

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

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

Investment Funds

A listing of funds available for investment can be obtained from TIAA, or go to www.tiaa.org/public/tcm/rfsuny and select "Investment Options."

Transferring Funds

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

Changing Your Name, Address or Beneficiary

You may change your address or beneficiary on your accounts online at www.tiaa.org/public/tcm/rfsuny or by contacting TIAA. Name changes require you to complete a form and return it to TIAA. If you are married, see *Selecting Your Beneficiary* on page 19.

Quarterly Accumulation Statements

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

Group Supplemental Retirement Annuity (GSRA) Loan Option

If you own a GSRA contract, TIAA offers a loan provision. If you are married, your spouse must consent to the loan. You may have no more than three outstanding loans at a time.

You may borrow up to 45 percent of the funds remitted through the RF to your TIAA GSRA contract. The minimum loan is \$1,000; the maximum is \$50,000. The loan amount you request may be reduced by any outstanding loans under this option. Repayments are made quarterly over a five-year period except when the loan is used to purchase a principal residence. In that case, the repayment period may be up to 10 years. The term of the loan cannot extend beyond April 1 of the year in which you attain age 72.

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 Account 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 the TIAA Real Estate Account and CREF accounts.

There is a \$25 annual maintenance fee. The fee covers the cost to initiate the loan and maintain the loan on the your behalf.

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.

Taxes

Retirement distributions from TIAA contracts are normally subject to ordinary income taxes. Refer to *Making a Cash Withdrawal and Tax Implications* on page 18. A 10 percent tax penalty will generally apply to cash withdrawals made before age 59½ unless you have medical expenses exceeding the tax-deductible limit, become disabled, die or end employment at age 55 or older.

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

Spousal Rights

Refer to *Spousal Rights* on page 19. In addition, your spouse must consent in writing to any TIAA GSRA loan.

Your Retirement Benefits If You Become Divorced or Separated

Refer to *Benefits If You Become Divorced or Separated* on page 19.

How Benefits Are Paid

Payment options from TIAA contracts and mutual funds are explained under *How Benefits Are Paid* for the Basic Retirement plan on page 16 but please note the following differences:

- If you have contributed under a TDA deduction, then the payment options are the same as the options of an individual retirement annuity. Therefore, in this case, you cannot withdraw funds from a TIAA Traditional Annuity in a lump sum.

- If you have contributed under a Supplemental Retirement Annuity (SRA) deduction, you do not have any restrictions when withdrawing from the TIAA Traditional Annuity. Also, the fixed-period option allows you to receive income from your GSRA contract over a fixed number of years — from 5 to 30, not to exceed your life expectancy — from all annuity accounts. If you die during that period, payments will continue to your beneficiary.

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

Minimum Distribution Requirements

The minimum distribution requirements for retirement funds from TIAA are the same for the Basic and Optional Retirement plans. Refer to *When Distribution Must Begin* on page 17.

Benefits If You Die

If you die before you have annuitized all funds in your TIAA contracts, any unannuitized balance is available to your beneficiary in a lump sum, unless you have chosen another payment option for your beneficiary, as described in your annuity contract. Your beneficiary may also contact TIAA 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 spouse, the commencement of benefits may be deferred until December 31 of the calendar year when you would have attained age 72, had you lived.

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

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

Continuing Benefits

This handbook is intended for retirees who qualify for Health Care coverage as described in the *Health* section beginning on page 4.

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

COBRA

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

Qualified Beneficiary

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

To be a qualified beneficiary, an individual must generally be covered under the group health plan on the day before the qualifying event that causes a loss of coverage (such as termination of employment, or a divorce from or death of the covered employee). However, a dependent child born to you or placed for adoption with you while you have COBRA continuation coverage has the same right to elect COBRA continuation coverage as the dependents who were covered by the plan on the day before the event that created your COBRA rights. Electing COBRA continuation coverage for newborn or adopted children is important if, during the first 18 months of COBRA

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

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

Qualifying Events

Death, Divorce, Medicare Entitlement

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

Loss of Dependent Status

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

Duration of COBRA Continuation Coverage

Federal Law

The law requires that your dependent be afforded the opportunity to maintain continuation coverage for 36 months.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualifying beneficiary eligible to elect coverage, except for bankruptcy.

Bankruptcy

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

Your Responsibilities

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

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

Paying for COBRA Continuation Coverage

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

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

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

Termination of COBRA Continuation Coverage

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

- The RF no longer provides group health coverage to any of its employees;
- The premium for your continuation coverage is not paid on time;
- After electing continuation coverage under the RF health plan, the qualified beneficiary becomes covered by another group plan, unless that plan contains any pre-existing condition exclusions or limitations that apply to the qualified beneficiary; or
- After electing continuation coverage under the RF Health Care plan, your dependent becomes entitled to (enrolled in) Medicare.

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.

The Health Insurance Marketplace: An Alternative to COBRA

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

General Information

Summary of Plans

Plan Administrator

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

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

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

Agent for Service of Legal Process

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

Employer Identification Number

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

Plan Information

PLAN NAME	ERISA PLAN NUMBER	PLAN TYPE	TYPE OF ADMINISTRATION	FUNDING	END OF PLAN YEAR
HEALTH CARE					
Post-retirement Benefits Plan	515	Health and dental	Group health insurance contracts and dental administrative services agreement	Group health insured, dental self-insured*	December 31
Post-65 Retiree Health Reimbursement Account	N/A	Health Reimbursement Account	Administrative services agreement with Aon	Self-insured*	December 31
RETIREMENT PLAN					
Basic Retirement Plan	001	Defined contribution	Retirement annuity contracts and mutual fund accounts	Insured and variable accounts	December 31
Optional Retirement Plan	003	Tax-deferred annuity (TDA)	Retirement annuity contracts	Insured and variable accounts	December 31
		Group supplemental retirement annuity (GSRA)	Retirement annuity contracts	Custodial accounts	December 31
		Tax-deferred mutual funds	Mutual fund accounts	Insured and custodial accounts	December 31

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

Your Rights Under State and Federal Laws

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

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

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

Right to Receive Information About Your Plan and Benefits

You are entitled to:

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

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.

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

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

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

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

- To determine if an individual is participating in the plan;
- To modify, amend or terminate the plan;
- To obtain premium bids to provide insurance coverage for the plan, including reinsurance;
- To carry out other administrative functions of the plan such as:
 - Claims Assistance: Designated personnel may assist "covered persons" (i.e., employees of the RF who are plan participants and their covered dependents) in attaining a resolution of any issues related to obtaining payment for claims, including coverage and eligibility issues.
 - Appeal of Benefit Denials: Designated personnel may assist covered persons in appealing benefit denials of the insurer or third-party claims administrator.
 - Individual Rights Requests: Refer to *Your Rights Regarding Your PHI* on page 27 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 page 24, the RF may receive PHI in connection with its role as the final arbiter of claims that have been appealed as provided under the administrative services agreements.

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

- Not further use or disclose the PHI other than as permitted or required by the plan documents or as required by law;
- Ensure that any agents, including an insurance broker or a subcontractor, to whom it provides PHI received from the plan, agree to the same restrictions and conditions that apply to the RF with respect to such information;
- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the RF;
- Report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for herein, of which it becomes aware;
- Make available PHI as required by 45 CFR §164.524;
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;
- Make available the PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the plan available to the Secretary for purposes of determining compliance by the plan;

- If feasible, return or destroy all PHI received from the plan that the RF still maintains in any form, and not retain copies when the PHI is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the plan and the RF is established.

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

The plan will disclose, as permitted or required by the plan, PHI to only the following class of employees or other persons under the control of the RF: employees who administer the group health plans. These employees and the designated personnel shall use and disclose only the minimum amount of PHI necessary to perform the administrative functions identified in this section.

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

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

Your Rights Regarding Your PHI

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

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

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

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

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

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

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

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

Right to receive a Notice of Privacy Practices. You have the right to receive a Notice of Privacy Practices from the plan. To obtain a copy of this notice, please contact the Privacy Official at the Benefits/Claims Administrator listed on page 2. For self-insured plans, the RF provides the *Notice of Privacy Practices*, which is on the RF website.

Discrimination Is Against the Law

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

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

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

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019, 800-537-7697 (TDD).

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

Spanish

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

Chinese

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

Russian

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

French Creole

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

Korean

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

Italian

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

Yiddish

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

Bengali

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

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-518-434-7101.

Arabic

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

French

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

Urdu

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

Tagalog

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

Greek

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

Albanian

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

Key Terms

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

Affordable Care Act – see PPACA.

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.

Aon – a global provider of risk management, insurance and reinsurance brokerage, and human resources solutions and outsourcing services. Aon is the administrator of the Aon Retiree Health Exchange.

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

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

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

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

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

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

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

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

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

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

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

HIPAA – Health Insurance Portability and Accountability Act of 1996.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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The Research Foundation for SUNY may terminate, suspend, withdraw, amend or modify the plans described in this handbook, in whole or in part, at any time. As the plan administrator, it has the discretionary authority necessary to administer these plans in accordance with their terms. This includes the power to interpret the plans, to construe any missing or disputed terms, to make determinations of fact, to answer all questions that arise under the plans, to determine the eligibility of any person to participate in and/or to receive benefits under the plans, and to determine the amount of benefits due for self-insured plans.

These decisions shall be final, conclusive and binding; shall be given deference in a court of law; and shall not be overturned unless found to be arbitrary and capricious.

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

12/2021



**The Research
Foundation for**

The State University of New York