Health Insurance Summary Plan
Description

Health Insurance benefits are provided by BluePreferred PPO and MVP Health Plan.

Colgate University reserves the right to amend, otherwise modify or terminate any of the benefit programs at any time.
SUMMARY PLAN DESCRIPTION

for all eligible employees of

COLGATE UNIVERSITY

Participating with Blue Preferred PPO and MVP Health Plan

January 1, 2003

This booklet is your Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). It describes the highlights of your rights and obligations under the Plan Sponsor, provided that you are a participant of the Plan. All of the details of the Plan are not provided. The operation of the Plan is governed by the Plan Documents. A copy of the Plan Document can be obtained from the Human Resources Department during normal business hours.

To the extent there are any inconsistencies between the Plan Document and this Summary Plan Description, the Plan Document will govern.

The Plan Sponsor reserves the right to change or discontinue the Plan at any time. This Summary Plan Description does not create a contract of employment.
**Name of Plan:**
The name of the Plan is the Colgate University Health Insurance Plan

**Plan Number:**
The Plan Number assigned to the Plan is 502

**Employer Information:**
Colgate University  
13 Oak Drive  
Hamilton, New York 13346-1398  
(315) 228-7411

The Employer’s federal identification number is: 15-0532078

**Plan Administrator:**
The Plan Administrator is the Employer. The Employer can be reached at the address and telephone number set forth above.

**Agent of Legal Process:**
The Plan Administrator is the designated agent for service of process.

**Plan Type:**
The Plan described in this Summary Plan Description is a "Welfare Benefit Plan" for purposes of ERISA, to provide health benefits to participants and beneficiaries.

**Plan Year:**
The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends on each December 31.

**Type of Administration:**
The Plan is administered on behalf of the Plan Administrator by Blue Cross Blue Shield of Utica-Watertown, Inc. and MVP Health Plan pursuant to the terms of the following: The Health benefits are paid from funds provided by the Employer on behalf of the Plan in accordance with contracts between Blue Cross Blue Shield of Utica-Watertown, Inc. and MVP Health Plan.

**Eligibility:**
All regular full-time and regular part-time employees working at least 1040 hours per year.

**Source of Contributions and Funding:**
The Plan is funded by the payment of premium required by the insurance policy.

The employee’s contribution toward the cost of the plan is at a rate determined by the Employer. The amount of employee contribution is communicated to employees prior to the start of each Plan Year.
**Discretion of Plan Administrator:**

Notwithstanding any other provision in the Plan and this Summary Plan Description to the contrary, and to the full extent permitted by ERISA and the Internal Revenue Code, the Plan Administrator shall have the authority to construe any uncertain or disputed term or provision in the Plan and this Summary Plan Description, and the exercise of this discretionary authority shall be binding upon all interested parties, including, but not limited to, the participant, the participant’s estate, any beneficiary of the participant and the Employer.

**Amendment or Termination of Plan:**

The Plan is not a contract. The Employer makes no promise to continue Plan benefits in the future, and rights to future benefits will never vest. The Employer has the right to amend or terminate the Plan at any time and from time to time. Retirement or other termination of employment does not give any former employee any vested right to continue Plan benefits. Any benefits, rights or obligations of participants and beneficiaries under the Plan following termination are described in detail in your insurance certificate in which this ERISA information has been inserted.

**Plan Benefits:**

Currently, eligible employees may choose between the following health benefit options -

- BluePreferred PPO
- MVP Health Plan

The Plan's provisions relating to eligibility of participants and termination of eligibility, as well as a description of the benefits provided by the Plan are described in detail in the applicable insurance certificate(s), booklet(s) and/or subscriber contract(s). These descriptions are hereby incorporated by reference and made a part of this Summary Plan Description.

**How to Appeal A Claim:**

Please refer to the applicable insurance certificate, booklet and/or subscriber contract for more details. However, if the benefit information provided by the insurer does not provide a claims procedure that satisfies the requirements of ERISA, the following benefit claims procedures will apply:

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

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

An appeal of an adverse decision (denial) regarding an urgent care claim will be decided within 72 hours after the appeal request is filed.
Concurrent Care: A “concurrent care claim” involves a decision by the Plan or an issuer to reduce or stop a course of treatment that has already begun.

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

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

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

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

Post-Service Claims: A “post-service claim” is any claim that is not a “pre-service claim” (in other words, no prior approval is 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 or information 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: A claimant may request a review of an adverse benefit determination within 180 days following receipt of the adverse benefit 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.

Your Rights Under ERISA:

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- 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, 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 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.

Continue Group Health Plan Coverage: Continue health care coverage for yourself, spouse or dependent 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 such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting 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 continuation coverage, when your COBRA continuation 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 preexisting condition exclusion for 12 months (18 months for late enrollees).

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 employee benefit 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 welfare benefit or exercising your rights under ERISA.
Enforce Your Rights: If your claim for a welfare 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 this 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 materials 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 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 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Health Insurance Portability and Accountability (HIPAA):

Non-Discrimination Rules: This Plan will not deny group health benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or medical condition (including both physical and mental health conditions). For example, the group health benefits will not exclude coverage for self-inflicted injuries due to a suicide attempt by a person who suffers from depression.

Privacy Rules: This Plan will protect individually identifiable health information as required by the “Administrative Simplification” provisions of the HIPAA regulations.

Qualified Medical Child Support Orders (QMCSOs):

A Qualified Medical Child Support Order (QMCSO) is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer’s plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents get divorced. When the Employer, as Plan sponsor, receives a QMCSO, we must promptly notify the employee and the child that the order has been received and what procedures we will use to determine if the order is "qualified." If we determine the order is qualified and the employee must provide coverage for his/her child pursuant to the QMCSO, we will deduct from the employee's paycheck the amount necessary to pay for such coverage. We will notify the affected employee once we determine whether or not the order is qualified. Participants and beneficiaries can obtain a copy of the procedures governing QMCSO determinations from the Plan Administrator without charge.
Maternity Minimum Stay Provisions:

The Newborns' and Mothers' Health Protection Act generally prohibits group health plans and health insurance issuers offering group insurance coverage from:

- restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or
- requiring that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

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

Effect of the FMLA and the USERRA:

Any benefits required to be provided by the Family and Medical Leave Act of 1993, as amended from time to time (FMLA) and/or the Uniformed Employment and Reemployment Rights Act of 1994, as amended from time to time (USERRA), shall be provided to the extent required by the FMLA and USERRA.

COBRA Continuation Coverage:

COBRA: The term "COBRA" refers to the Consolidated Omnibus Budget Reconciliation Act of 1985, which, as amended, provides you with the rights to health continuation coverage described in this Summary Plan Description. A “Qualified Beneficiary” may elect “COBRA coverage for either or both types of coverage upon the occurrence of a “Qualifying Event” as explained below.

Qualified Beneficiary: A "Qualified Beneficiary" may be you or your spouse or child (individually, "spouse" or "dependent child"; collectively "family members"); who has health continuation rights with respect to an event that is a Qualifying Event.

- An individual normally must have coverage on the day before a Qualifying Event in order to be a Qualified Beneficiary.
- However, a child who is born to or placed for adoption with you during a period that you have COBRA coverage also is considered a Qualified Beneficiary. The COBRA period is measured from the same date as for other Qualified Beneficiaries with respect to the same Qualifying Event.

Qualifying Events for a Participant To Elect COBRA Coverage: You may elect health continuation coverage for yourself and covered family members, if coverage is lost because of a reduction in hours of employment or termination of employment, for reasons other than gross misconduct on your part. This is referred to as a "Termination-of-Employment Qualifying Event."

Qualifying Events for a Spouse To Elect COBRA Coverage: Your spouse may elect health continuation coverage for himself or herself (and affected family members) if coverage would end due to one of the following Qualifying Events:

(a) a Termination-of-Employment Qualifying Event;
(b) your death;
Qualifying Events for a Dependent Child To Elect COBRA Coverage: A dependent child may elect health continuation coverage if coverage otherwise would end due to any of the following five Qualifying Events:

(i) a Termination-of Employment Qualifying Event;
(ii) your death;
(iii) divorce or legal separation of you and your spouse;
(iv) your becoming entitled to Medicare; or
(v) loss of dependent child status under the terms of the Plan.

Notice Provisions; Election of Coverage:

(A) You (or a family member or a legal representative) must inform your Employer within 60 days of the date that there is a divorce, a legal separation, or a loss of dependent child status. If timely notice is not given, the right to COBRA health continuation coverage will be lost.

(B) Subject to the requirement in (A), when applicable, the affected Qualified Beneficiary or Beneficiaries will be notified of the right to choose COBRA health continuation coverage if a Qualifying Event occurs. The election for COBRA coverage must be made within 60 days from the later of the date of notification about COBRA or the date of loss of coverage. If an election is not made timely, coverage under the Plan will end and there will be no further COBRA rights.

Cost of Continuation Coverage: A Qualified Beneficiary who chooses to continue health coverage may be required to pay up to, but not more than, 102 percent of the full cost to the Plan for the health coverage, except as provided for costs during a "disability extension period" as explained below. The first premium payment must be made, with any payments owed from the date health coverage ended, within 45 days from the date the Qualified Beneficiary chooses to continue health coverage.

Length of Continuation Coverage:

- A Qualified Beneficiary may continue health coverage for up to 36 months in the event of death, divorce or legal separation, entitlement to Medicare, or ineligibility for dependent coverage.
- A Qualified Beneficiary may continue health coverage for 18 months in the event of a Termination-of-Employment Qualifying Event. However, the 18-month coverage period for that event may be extended to 36 months, for covered spouses and dependent children, if another Qualifying Event occurs during the initial 18-month period (or during the disability extension period explained below, if applicable).

Note: Your entitlement to Medicare will not be a Qualifying Event for family members if they still have health coverage because you are still actively employed. However, if family members later lose Plan coverage due to a Termination-of-Employment Qualifying Event, their COBRA coverage period will be the 36-month period measured from the date you became entitled to Medicare, if that is longer than the 18-month period measured from the Termination-of-Employment Qualifying Event.
Extension For Disabled Individuals and Increased Premium:

- The 18-month period for a Termination-of-Employment Qualifying Event may be extended from 18 to 29 months for all Qualified Beneficiaries entitled to COBRA coverage on the basis of that event, if any of them receives a determination of disability under the Social Security Act, finding that he or she became disabled within 60 days of the Qualifying Event. The Employer must be notified of the determination of disability within 60 days after the determination date and before the first 18 months of COBRA coverage ends.

- During a disability extension period, the Plan may charge up to 150% of the premium as long as the disabled Qualified Beneficiary is part of the covered group. This higher limit applies if the 29-month period is extended to 36 months on the basis of another Qualifying Event that occurs during the disability extension period.

Termination of COBRA Continuation Coverage: The COBRA coverage will end before the end of the applicable maximum time period in case of any of the following:

1. the Employers cease to provide health coverage to any employees;

2. the premium is not paid on a timely basis under the COBRA rules;

3. the Qualified Beneficiary becomes covered under another group health plan (not merely eligible) after the date on which COBRA coverage is elected for the Qualified Beneficiary and either: (i) the other plan does not contain any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary; or (ii) the exclusion or limitation in the other plan either doesn’t apply to the Qualified Beneficiary or has been satisfied, based on applicable law;

4. the Qualified Beneficiary becomes entitled to Medicare (not merely eligible) after the date on which the COBRA coverage under this Plan is elected; or

5. if the disability extension applies, there is a final determination that the Qualified Beneficiary is no longer disabled under the Social Security Act. The Employer must be notified within 30 days of the date of any final determination that the disability has ended. The extended health coverage will be terminated in the month that begins more than 30 days after the date of the final determination that the Qualified Beneficiary is no longer disabled.