Plan Document and Summary Plan Description for the Canisius College Health and Welfare Benefit Plan

- Flexible Spending Accounts

Effective Date: 07/01/2016
Introduction

Canisius College (the “Employer” or “Company”) is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your flexible spending accounts and serves as the Summary Plan Description (SPD) and Plan document for the Canisius College Health and Welfare Benefit Plan (“the Plan”).

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with disclosure requirements under the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended.

The Plan is intended to meet the requirements of Code Section 125 and the Treasury Regulations thereunder. The Health Care Flexible Spending Account is intended to qualify as a self-insured medical reimbursement plan under Code Section 105. The Dependent Care Flexible Spending Account is intended to qualify as a “dependent care assistance plan” under Code Section 129. Eligible expenses reimbursed are excluded from income in accordance with the applicable Code section above.

We encourage you to read this booklet and become familiar with your benefits.

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.
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Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency or leasing organization, persons hired on a seasonal or temporary basis, independent contractors and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

For purposes of the Health Care Flexible Spending Account, your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status; or
- an individual you claim as a dependent on your Federal income tax return and who is not a dependent of any other taxpayer.

See IRS Publication 969 – Health Savings Accounts and Other Tax-Favored Health Plans for additional information.

For purposes of the Dependent Care Flexible Spending Account, your qualifying dependents are defined by Code Section 21(b)(1) of the Code and include:

- a child under age 13 in your custody whom you claim as a dependent on your Federal tax return;
- a spouse who is incapable of self-care; and
- a dependent, that is not your child, who lives with you – such as a child over age 13, a parent, a sibling, or an in-law who is incapable of self-care, and whom you claim as a dependent on your Federal tax return.

Generally, to be claimed as a dependent on your Federal tax return, an individual must be dependent on you for more than one-half of his or her support (principally supported), as defined by Code Section 152 of the Internal Revenue Code.

Special rules apply for children of divorced/separated parents. The IRS has issued guidance for divorced/separated parents, or parents who live apart, to determine which parent may claim a Federal income tax exemption for a dependent child. You should consult your tax advisor if you have any questions concerning a dependent’s status.
When Coverage Begins

You are eligible for coverage on the first day of your employment and after you meet all eligibility requirements.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any salary reduction contributions from your pay.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will have no coverage for the remainder of the plan year.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. You must make a new election each year to participate in the Flexible Spending Accounts. Current year elections will not automatically continue in the new Plan year. The elections you make will take effect on the following July 1 and stay in effect through June 30, unless you have a qualifying change in status.

Effect of Tax Regulations on this Plan

This Plan is designed and administered in accordance with Sections 125 and 129 of the Internal Revenue Code. These code sections enable you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the date you have a qualifying change in status as described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child’s eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Company work location or home address that changes your overall benefit options and/or prices;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent’s coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

Additionally, your election(s) may be modified downward during the plan year if you are a Key Employee or Highly Compensated Individual (as defined by the Internal Revenue Code) if necessary to prevent the Plan from becoming discriminatory.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. You should report a status change as soon as possible, but no later than 31 days after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

**When Coverage Ends**

Your coverage under this Plan ends on your last day of employment (or the date you otherwise cease to be eligible for coverage under the Plan).

If your coverage under the Health Care Flexible Spending Account ends due to a COBRA qualifying event, you will be given the opportunity to continue your coverage the same coverage you had in effect the day before the qualifying event on a self-pay basis. However, you will be eligible for COBRA Continuation Coverage only if you have a positive Health Care Expense Account balance at the time of the COBRA qualifying event (taking into account all claims submitted by you before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the Plan Year (and any extended period) in which the qualifying event occurs and coverage will cease at the end of the Plan Year. Coverage will not be continued for the next Plan Year.

**Cancellation of Coverage**

If you fail to pay any required premium for coverage under the Plan, your coverage will be canceled and no claims incurred after the effective date of cancellation will be paid.

**Rescission of Coverage**

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the
Plan’s claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days’ advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as “excepted benefits” under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you.

**Coverage While Not at Work**

In certain situations, coverage may continue when you are not at work, so long as you continue to pay your required contributions to the Plan. You should discuss with your supervisor what options are available for remitting your Flexible Spending Account contributions while you are absent from work.
Your Flexible Spending Account Benefits

Your Health Care Flexible Spending Account

The Health Care Flexible Spending Account offers you a convenient way to pay for eligible, unreimbursed health care expenses using pre-tax dollars. You “fund” your account by directing a portion of your pay to your Flexible Spending Account.

Health Care Expense Account

If you elect to participate in the Health Care Flexible Spending Account, a Health Care Expense Account will be established for you. This account will be maintained for bookkeeping purposes only to keep track of contributions and reimbursements, and to determine forfeitures. It will not be funded.

Your Health Care Expense Account will be credited with the amount you authorize to be deducted from your pay and debited with any amount reimbursed to you for allowable medical care expenses.

Maximum Annual Amount

The maximum annual benefit amount that you may elect under the Health Care Flexible Spending Account for a Plan Year is determined by the IRS each year. Please contact Human Resources to verify the maximum election amount. The minimum amount is $100.

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

Eligible Medical Expenses

The Health Care Flexible Spending Account will pay only claims incurred during the year that are for eligible “Medical Expenses”, as that term is defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise.

Expenses may be submitted for you, your spouse, and your “qualified dependents”, as such term is defined in Internal Revenue Code Section 152.

The following expenses do not qualify for reimbursement:

- any expense you claim as an itemized deduction on your Federal income tax return;
- premium payments for other health care coverage, including COBRA premiums;
- weight loss programs or dietary supplements;
- hair replacement treatments;
- over-the-counter drugs or medicines unless the purchase was obtained by prescription;
- cosmetic surgery or dentistry procedures, unless related to a congenital abnormality, a personal injury resulting from accident or trauma, or a disfiguring disease; or
- any expense determined to be ineligible as determined by the Plan Administrator.

For a list of eligible expenses, contact the Claims Administrator. Allowable Medical Expenses may also be found in IRS Publication 502 Medical and Dental Expenses or on the IRS Website at www.irs.gov.
Payment of Health Care Expense Account Claims

The maximum amount available to you for reimbursement will be the lesser of:

- The amount of allowable medical expenses submitted for reimbursement; or
- The total annual Salary Reduction Contribution you elected for the year, less any prior reimbursements.

The Plan will reimburse only those allowable medical expenses which have been incurred by you and/or your dependents that are in excess of any payments or other reimbursements made under any other health care plan. Advance reimbursement will not be made for projected or future expenses.

If you are participating in the Health Care Flexible Spending Account on the last day of the Plan Year and you have an unused amount remaining in your FSA, up to $500 may be carried forward to be used in the following Plan Year. Carry forward amounts from the previous plan year may:

- reduce your amount available to pay previous plan year expenses during the run-out period,
- will be counted against the permitted carryover amount, and
- cannot exceed the carryover amount.

Continuation Coverage Upon Termination

If your Employer is covered by COBRA and your coverage in the Health Care Flexible Spending Account terminates due to a COBRA qualifying event, you will be given the opportunity to continue (on a self-pay basis) the same coverage you had in effect on the day before the qualifying event, as prescribed by COBRA. However, you may not be eligible for COBRA if you “overspent” your Health Care Flexible Spending Account at the time of the COBRA qualifying event. Your account is overspent if your remaining annual benefit (maximum annual benefit minus the total amount of reimbursable claims submitted before the date of the qualifying event) is less than the maximum COBRA premium that can be charged for the rest of the year. If COBRA is elected, it will be available only for the remainder of the year in which the qualifying event occurs and will cease at the end of that year. Your Health Care Flexible Spending Account coverage cannot be continued for the next year.

Qualified Reservist Distribution

In accordance with the “Heroes Earning Assistance and Relief Tax Act of 2008” (“HEART Act”), a qualified reservist distribution (QRD) is permitted for all or part of any unused Health Care FSA amounts if you are a reservist called to active duty provided that:

- You are called up for a period of 180 days or more or for an indefinite period of time; and
- The request for a distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the Health Care FSA for that plan year.

To receive a QRD of all or part of any unused Health Care FSA amounts, you must give notice by contacting the Plan Administrator as soon as you receive your orders or are called
Your Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account offers you a convenient way to pay for eligible, unreimbursed day care expenses for your eligible dependents using pre-tax dollars. You “fund” your account by directing a portion of your pay to your Flexible Spending Account.

Dependent Care Expense Account

If you elect to participate in the Dependent Care Flexible Spending Account, a Dependent Care Expense Account will be established for you. This account will be maintained for bookkeeping purposes only to keep track of contributions and reimbursements, and to determine forfeitures. It will not be funded. The Dependent Care Expense Account will be credited with the amount you authorize to be deducted from your pay each pay period and debited with amounts reimbursed to you for eligible dependent care expenses.

Maximum Annual Amount

The maximum annual benefit amount that you may elect under the Dependent Care Flexible Spending Account for a Plan Year is the smallest of the following amounts: 1) $5,000 ($2,500 if you are married and filed your Federal tax return as Married – Filing Separately); or 2) the lesser of the calendar year earned income limitation for you or your spouse described in Section 129(b) of the Code. If your spouse is not employed and is either 1) physically or mentally incapable of self-care; or 2) a student during a month in which you incur a dependent care expense, Earned Income shall be the amount specified in Code Section 21(d)(2). The minimum amount you may contribute is $100.

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

Eligible Dependent Care Expenses

You may use the Dependent Care FSA to pay certain dependent care expenses that are necessary to allow you – and your spouse, if you are married – to work or attend school full-time. The Plan will reimburse all employment-related expenses defined by Section 21(b)(2) of the Code, incurred by you on behalf of a qualifying dependent. These include payments to babysitters or companions inside or outside the home, licensed day care centers, as well as Federal and state taxes which you pay for providers of dependent care. For purposes of this Section, a qualifying dependent will be defined by Section 21(b)(1) of the Internal Revenue Code.

Reimbursement will be made upon your submission of documentation that such expenses were incurred to enable you to be gainfully employed for any period during which there was one or more qualifying dependents, provided however that:

- If such amounts are paid for expenses incurred outside your household, they shall constitute employment-related expenses only if incurred for a qualifying dependent under Section 21(b) of the code, who regularly spends at least 8 hours per day in your household;
• If the expense is incurred outside your home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all state and local laws and regulations, including licensing requirements, if any; and

• Employment-related expenses for you do not include amounts paid or incurred to your child over the age of 19 or to an individual who is a dependent of you or your spouse.

NOTE: The Family Support Act of 1988 requires that you provide the name, address, and taxpayer identification number (or Social Security number) of your provider. You must include this information when you submit a claim for reimbursement.

The following expenses do not qualify for reimbursement:

• Transportation expenses to or from the day care center;
• Care provided by an individual who could be claimed as a dependent on your or your spouse’s Federal tax return;
• Services which are eligible for reimbursement under any other plan or program;
• Clothing, education, or food, unless food and education are provided by the day care center or nursery school as part of its prescribed care services. Food and education expenses are not covered for kindergarten or higher;
• Tuition;
• Overnight camp expenses;
• Expenses for days when you are not working (such as sick or vacation days) or any other day when you do not meet the eligibility requirements.

A complete list of allowable dependent care expenses can be found in IRS Publication 503 Child and Dependent Care Expenses or on the IRS Web site at www.irs.gov.

If you have questions about what is considered an eligible expense under the Dependent Care Flexible Spending Account, contact the Claims Administrator.

Payment of Dependent Care Expense Account Claims

The maximum amount available for reimbursement at any time from a Dependent Care Expense Account shall be the lesser of:

• The amount of allowable dependent care expenses submitted for reimbursement; or
• The amount credited to the Participant’s Dependent Care Expense Account at that time, reduced by previous reimbursements during the year.

Your Dependent Care Expense Account will be reduced by the amount of the reimbursement paid. Advance reimbursement shall not be made for projected or future expenses.

If you are participating in the Dependent Care Flexible Spending Account on June 30 of any calendar year and you incur an allowable expense between July 1 and September 15 of the following calendar year, such expense may be treated as being incurred either during the year preceding the date on which the expense was incurred or during the year in which the allowable dependent care expense was incurred (provided you elected to participate in the Dependent Care Flexible Spending Account for such year).
Dependent Care Expense Account Annual Statement of Benefits

On or before January 31 of each calendar year, as required by applicable law and regulations, the Plan Administrator will provide you with a summary of all Dependent Care Expense Account benefits paid to you during the previous calendar year. This amount is typically shown on your Form W-2.

Child Care Tax Credit

The IRS allows you to claim work-related dependent care expenses for credit on your Federal income tax return. The tax credit is determined by applying a percentage to your total work-related dependent care expenses. You may use both a dependent care flexible spending account and the tax credit, provided you do not claim the same expenses for both. You must also adjust your tax credit by the amount you contribute to the Dependent Care Flexible Spending Account. For more information about the child care tax credit, see IRS Publication 503 or IRS Form 2441 and the accompanying instructions. You may also wish to consult with your tax advisor to determine which option is best for your particular tax situation.

Submitting a Claim for Reimbursement

There are a few possible reimbursement methods for FSAs. The methods that are available to you depend on how your FSA is administered. These methods may include, for example, submitting manual or electronic claim forms or allowing you to use an FSA debit card. When you are enrolled in the FSA, your Employer will provide you with more specific information on how your FSA reimburses eligible expenses. Keep in mind that an expense can be reimbursed only after it is incurred. Expenses are incurred at the time the service is received, not when the care or service is billed, charged or paid. In general, prepayment is not permitted. Your FSA can only be used to reimburse eligible expenses. In some circumstances, the Claims Administrator may ask you to provide additional documentation to show that an expense is eligible for reimbursement from your FSA. If you do not provide this information, your claim for reimbursement may be denied.

Claims Submission and Cut-Off

The Plan Administrator will establish and communicate to all participants the cut-off date by which all claims for the year must be submitted. You must submit claims no later than 90 days after the end of the Plan Year. Claims submitted after that date will not be eligible for reimbursement and will be forfeited.

Forfeitures

After processing all claims for a Plan Year, any amount credited to your Expense Account as of the end of that Plan Year will no longer be available for further claims and will be forfeited.
Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

Plan Sponsor and Administrator

Canisius College is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Canisius College  
2001 Main Street  
Buffalo, NY 14208  
716-888-2240

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.
Plan Year
The Plan Year is July 1 through June 30.

Type of Plan
This Plan is called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers
The Employer Identification Number (EIN) and Plan number for the Plan is:
EIN: 16-0743942       PLAN NUMBER: 508

Plan Funding and Type of Administration
Funding and administration of the Plan is as follows.

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<th>Benefits are self-funded and are administered through contracts with third-party administrators.</th>
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<td>Funding</td>
<td>The Company fully funds the cost of the Plan. Benefits will be paid solely from the general assets of the Company.</td>
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Claims Administrators
The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below.

Nova Healthcare Administrators, Inc.
FSA Claims Administrator
6400 Main Street
Suite 210
Buffalo, NY 14221
716-932-5000
www.novahealthcare.com

Agent for Service of Legal Process
If any disputes arise under the Plan, papers may be served upon:
Canisius College
2001 Main Street
Buffalo, NY 14208
716-888-2240
Service of legal process also can be made upon the Plan Administrator.
No Obligation to Continue Employment
The Plan does not create an obligation for the Company to continue your employment or interfere with the Company’s right to terminate your employment, with or without cause.

Non-Alienation of Benefits
With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Severability
If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits
All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned. If you receive care from a non-network provider, it is your responsibility to pay the non-network provider for the charges you incurred, including any difference between what you were billed and what the Plan paid. You may not assign your benefits under the Plan to a non-network provider without the Company's consent. The Company (or a Claims Administrator) reserves the right, in its discretion, to pay a non-network provider directly for services rendered to you. Direct payment to a non-network provider shall not be deemed to constitute consent by the Company or waive the consent requirement for assigning benefits.

Payment of Benefits to Others
The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses
All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the Company.

Fraud
No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.
Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative (“Plan Administration Employee”) of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Non-discrimination

The Health Care Flexible Spending Account shall not discriminate in favor of “highly compensated individuals” as to eligibility to participate or benefits available. The Health Care Flexible Spending Account shall be operated consistently with Code Section 105(h), regulations promulgated thereunder, and guidance issued by the Department of Labor or the Internal Revenue Service relating to discrimination testing.

The Dependent Care Flexible Spending Account shall not discriminate in favor of “highly compensated employees” or more than 5 percent owners of a company. The Dependent Care Flexible Spending Account shall be operated consistently with Code Section 129, regulations promulgated thereunder, and guidance issued by the Department of Labor or the Internal Revenue Service relating to discrimination testing.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.
Claims and Appeal Procedure

This section describes what you must do to file or appeal a claim for services.

Time Frames for Processing Health-Related Claims

Health-related claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims with different time frames applicable to each. For purposes of the Health Care FSA, claims are treated as post-service health claims.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Claims Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond their control, the Claims Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Once you have received your notice from the Claims Administrator, review it carefully. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If you disagree with this decision, you or your representative may file a written appeal for review of a denied claim with the Claims Administrator within 180 days after receipt of a notice of denial.

You will have the right to submit for review, written comments, documents, records, and other information related to the claim as well as any additional information you believe would support your claims. You also have the right to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

If after such review the Claims Administrator continues to deny the validity of the claim in full or in part, you may file a 2nd level appeal with the Plan Administrator. This appeal must be filed within 60 days of the first level appeal denial notice from the Claims Administrator. You should include any information necessary to perfect your claim and any other information that you believe supports your claim.

You will be notified of the Plan Administrator’s decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

Each level of appeal will be independent from the previous level (i.e., the same persons involved in a prior level of appeal would not be involved in the next level). On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information.
The final decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

**Time Frames for Processing All Other Claims**

For all non health-related claims, you may file a claim with the Claims Administrator. The Claims Administrator will notify you of its decision in writing within 90 days after the claim is received.

Special circumstances may require an extension of this period up to 180 days for non-disability claims, but if an extension is required, you will be notified of any extension within the initial 90-day period. If an extension is necessary because you failed to submit necessary information, the days from the date the Claims Administrator sends you the extension notice until you respond to the request for additional information are not counted as part of the claim determination period.

If your claim is denied, you will receive in writing the specific reasons that your claim was denied, the specific reference to the Plan provision(s) on which the denial was based, a description of any additional material or information necessary for you to perfect the claim and why such material or information is necessary, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, internal rules, guidelines, protocol, records and information relevant to your claim, and information regarding the Plan’s appeal procedures and time frames, including what steps you need to take to appeal your claim.

To appeal a denied claim, you or your representative must send a written request for review to the Plan Administrator within 60 days after the denial is received. You should state the reason why you believe your claim should be reviewed and submit for review any written comments, documents, records, or other information that is relevant to your claim.

The Plan Administrator will conduct a review and make a final decision within 60 days after receipt of your request for review (or within 120 days if special circumstances warrant an extension, provided you are notified of the extension within the initial 60-day period).

You will be notified of the Plan Administrator’s decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

The final decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

**Exhaustion Required**

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. You cannot take any other steps or file any other claims or suits for benefits unless and until you have exhausted all administrative appeals.
Your Rights under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, 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 copies of the latest annual report (Form 5500 Series), if applicable, 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 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 such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 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 previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it 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, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.
Such suit must be filed within 180 days from the date of an adverse appeal determination notice. 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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

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 Employee Benefits Security Administration at 1-866-444-3272.
Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules. You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:
• Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
• Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
• Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
• Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
• Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
• Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
• Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
• Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
• If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
• Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

• Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
• Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
• Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
• Report to the HIPAA Plans any security incident of which it becomes aware.
Continuing Your Health Care FSA through COBRA

This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

If your coverage under the Health Care Flexible Spending Account ends due to a COBRA qualifying event, you will be given the opportunity to continue the same coverage you had in effect the day before the qualifying event on a self-pay basis.

COBRA Continuation Coverage will be available to you only if you have a positive Health Care Expense Account balance at the time of the COBRA qualifying event (taking into account all claims submitted by you before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the Plan Year (and any extended period) in which the qualifying event occurs and coverage will cease at the end of the Plan Year. Coverage will not be continued for the next Plan Year.

COBRA Notifications

If you lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

Cost of COBRA Coverage

You or your eligible dependent pay the full cost for healthcare coverage under COBRA, plus any required administrative fee up to two percent, or up to 102 percent of the full premium cost, except in the case of an 11-month disability extension where you may be required to pay up to 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full payment is received. Each month’s premium is due prior to the first day of the month of coverage. You are responsible for making timely payments.

If you fail to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier’s check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA
administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.
Definitions

COBRA
The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Employee
A person who works for the Company in an employer-employee relationship.

ERISA
The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Family and Medical Leave Act
The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant’s home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant’s own serious health condition; or
- any qualifying exigency arising from an employee’s spouse, son, daughter, or parent being a member of the military on “covered active duty”. Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

HIPAA

Participant
An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
A Federal law covering the rights of participants who have a qualified uniformed services leave.

WHCRA
The Women’s Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the
other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.
Adoption of the Plan

The Canisius College Health and Welfare Benefit Plan, effective 01/01/2010, as amended and restated herein, is hereby adopted as of 07/01/2016. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this __________ day of _________________________________, 201 .

BY: _______________________________________

TITLE: _______________________________________

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