Employee Welfare Benefit Plan

Revised Apr, 2009

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EMPLOYEE WELFARE BENEFIT PLAN RESOLUTION

I. This Employee Welfare Benefit Plan Resolution and Summary Plan Description set forth the provisions of the Sub-Board I, Inc. Employee Welfare Benefit Plan (herein referred to as *the Plan*) established by the Board of Directors of Sub-Board I, Inc. (herein referred as *the Corporation*).

II. **ELIGIBILITY.** Subject to the conditions stated in Section III, the following classes of employees are eligible to participate in the Plan:

> ***Regular Full-time Employees***
> *A Regular Full-time Employee is an employee hired by the Corporation or by an Affiliated Employer for a duration of not less than six months in a year, and who normally works for the Corporation or for an Affiliated Employer at least twenty-five hours a week.*

The following classes of employees are specifically excluded from eligibility in the Plan:

> ***Part-time Employees*** who normally work for the Corporation or for an Affiliated Employer fewer than twenty-five hours a week.
>
> ***Temporary or Seasonal Employees*** who are hired by the Corporation or by an Affiliated Employer for a duration of less than six months in a year.
>
> ***Full-time Students*** enrolled at the State University of New York at Buffalo for not less than twelve credit hours per semester.

If an employee works concurrently for either the Corporation and an Affiliated Employer, or for more than one Affiliated Employer, hours worked for each employer cannot be combined for purposes of eligibility.

III. **PARTICIPATION.** All eligible employees may begin participation in the Plan upon commencement of, and contingent upon, employment with the Corporation or an affiliated employer, unless otherwise specified in the Summary Plan Description.

IV. **AFFILIATED EMPLOYERS.** Eligible employees of the following affiliates are covered under the Plan:

Undergraduate Student Association
350 Student Union – SUNY at Buffalo
Amherst, NY 14260

Graduate Student Association
310 Student Union – SUNY at Buffalo
Amherst, NY 14260

Medical Student Polity
40 CFS Addition – SUNY at Buffalo
Buffalo, NY 14214

ASDA / Dental Student Association
325 Squire Hall – SUNY at Buffalo
Buffalo, NY 14214

Student Bar Association
101 O'Brian Hall – SUNY at Buffalo
Amherst, NY 14260

Graduate Management Association
206J Jacobs Hall – SUNY at Buffalo
Amherst, NY 14260

The Spectrum Student Periodical, Inc.
132 Student Union – SUNY at Buffalo
Amherst, NY 14260

Schussmeister's Ski Club, Inc.
360 Student Union – SUNY at Buffalo
Amherst, NY 14260

V. **BENEFITS.** All benefits under the Plan are described in the attached Summary Plan Description.

VI. **FUNDING AND CONTRIBUTIONS.** The Corporation and Affiliated Employers fund the entire cost of the Plan through their yearly operating budgets, unless otherwise specified in the attached Summary Plan Description.

VII. **LOSS OR CHANGE OF BENEFITS.** While it is expected that the Plan will continue indefinitely, the Corporation has the right to amend or terminate the Plan at any future time. No consent of any participant or beneficiary or Affiliated Employer is required to terminate, modify, amend or change the Plan. An employee's individual coverage terminates:

1. When the employee is no longer employed.
2. When the employee is no longer eligible.
3. When the Plan terminates.
4. When there is a break in service. A break in service will have been deemed to occur when:
   - ♦ An employee fails to meet the minimum eligibility requirements for a period of at least 30 days.

- An employee takes a leave of absence without pay for a period greater than 30 days.

- Periods of New York State Disability will not constitute a break in service.
- Periods during which an employee charges an absence to accrued leave(s) will not constitute a break in service.
- Academic year appointments will not constitute a break in service.

Note: If an employee ceases active work, the employee should contact the Plan Administrator to determine what arrangements, if any, may be made to continue coverage.

VIII. **EMPLOYER IDENTIFICATION NUMBER.** 16-0981909

IX. **PLAN ADMINISTRATOR.** The Executive Director of the Corporation, located in 341 Student Union, SUNY at Buffalo, is the administrator of the Plan performing those duties required for the operation of the Plan. The administrator may designate, in writing, other persons to carry out duties under the Plan.

X. **PLAN YEAR.** The Plan year is January 1 through December 31 of each year. Records for each participant are maintained on a calendar year basis.

XI. **HOW TO FILE A CLAIM OR APPLY FOR BENEFITS.** Claim forms or applications for benefits may be submitted to the Plan Administrator and/or his/her designee or to the designated insurance agent (if applicable).

XII. **REQUESTS FOR INFORMATION AND OTHER CLAIMS PROCEDURES.** Requests for information and claims of service of legal process concerning eligibility, participation, or other aspects of the operation of the Plan should be submitted in writing to the Plan Administrator. If a written request or claim is denied, the Plan Administrator shall, within a reasonable time, provide in writing to the participant, the basis for such denial. A participant may request in writing a review of a denial of a claim and may review pertinent documents and submit issues and comments in writing to the Plan Administrator. The Plan Administrator shall provide in writing to the participant, a decision upon such request for review of denial of claim within sixty (60) days of receipt of the request.

XIII. **STATEMENT OF ERISA RIGHTS.** Participants in the Corporation's Employee Welfare Benefit Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the US Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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 annual report, if the Plan has more than 100 participants.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate this Plan, called *fiduciaries* of the Plan, have a duty to do so prudently and in the interest of the Plan participants and beneficiaries. No one, including the employer, may discharge or otherwise discriminate against participants in any way to prevent them from obtaining a welfare benefit to which they are entitled under the Plan or exercising their rights under ERISA. If a participant's claim for a welfare benefit is denied in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the Plan review and reconsider the claim. Under ERISA, there are steps participants may take to enforce the above rights. For example, if a participant requests materials from the Plan and does not receive them in 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to $100 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a claim for benefits is denied or ignored, in whole or in part, a participant may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if a participant is discriminated against for asserting his or her rights, he or she may seek assistance from the US Department of Labor, or may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If the participant is successful the court may order the person sued to pay these costs and fees. If the participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim is frivolous. Contact the Plan Administrator if there are any questions about this Plan. If there are any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, US Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, US Department of Labor, 2000 Constitution Avenue, NW, Washington, DC 20210.

SBI
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SUMMARY PLAN DESCRIPTION

INTRODUCTION

The following Summary Plan Description for this Plan is provided to you in accordance with the Employee Retirement Income Security Act of 1974. It is intended to summarize for you, in non-technical terms, the provisions of the Plan. Further provisions for participants' benefits rights and obligations are provided under the terms and conditions of contracts between the employee and the benefit carriers.

This summary is intended only as a summary of the Plan's highlights. In the event of any inconsistencies between this summary and the benefit contracts, the contracts shall govern.

If you have any questions, please contact the Plan Administrator, or you may contact the benefit carriers directly.

DESCRIPTION OF BENEFITS

I. *HEALTH AND MEDICAL BENEFITS*

Eligible Dependents.
If you enroll in the health benefit plan, you may choose among Employee Only coverage, Employee & Spouse coverage, Employee & Child(ren) coverage, or Family coverage.

Eligible dependents are:

- Your spouse (unless you are legally separated).

- Your unmarried dependent children.

Enrollment Restrictions and Limitations.

You must enroll within 31 days of becoming eligible to participate in order to choose the coverage category you want. Otherwise, you will be enrolled for Employee Only coverage, and you will not be able to change your coverage until the next annual open enrollment period, or until you have a life event.

- If you first enroll during an annual open enrollment period, coverage will become effective April 1.
- If you enroll for coverage in the Plan but do not enroll your eligible dependents, those dependents will not be able to join the plan until the next annual open enrollment period or until you have a life event.
- If you enroll your eligible dependents during the annual open enrollment period, coverage will be effective April 1.

Changes in Coverage during the Year.

You can change your coverage category (e.g., Employee Only to Employee & Spouse, or Employee & Spouse to Family, etc.) at any time if you have a life event. A life event includes marriage, birth or adoption of a **first** child, divorce, death of a dependent, employment of spouse, or termination of spouse's employment.

- For example, if you are single and get married, your personal status will change. You can change your coverage category from Employee Only to Employee & Spouse if you wish to cover your spouse under the Plan.
- You will have 31 days from the life event to change your coverage category. If you do not enroll your dependents within 31 days after they first become eligible, you may not enroll them until the next annual open enrollment period.
- If your personal status changes so that you no longer have eligible dependents, you should report this change to the Plan Administrator. The dependent coverage, and your contributions for it, will end.
- You can discontinue coverage for any reason during the year. If you discontinue coverage, you will not be eligible to receive the prorated share of the employer's contribution.
- You cannot enroll in the plan if you have previously refused health coverage, unless you have a life event. You must wait until the next annual open enrollment period to make such changes. Coverage will become effective April 1.

Health Coverage during Leaves of Absence Covered by the Family and Medical Leave Act of 1993.

In 1993 Congress passed the Family and Medical Leave Act. Under the Act, covered employers are required to provide eligible employees leaves of absence, either paid or unpaid, for up to twelve workweeks during a twelve month period, under certain conditions. The conditions under which Family and Medical Leave must be provided include:

- The birth and care of a newborn child of the employee
- Placement of a child with the employee for adoption or foster care.
- Care of a spouse, son, daughter, or parent who has a serious health condition.
- A serious health condition suffered by you, that makes you unable to perform your job.

The Act also requires the employer to ensure that the employee continues to be covered under any "group health plan" at the same level and under the same conditions of coverage as existed before the employee took Family and Medical Leave. The employer may recover its costs for providing health coverage during the employee's leave only if the employee fails to return to work for reasons other than:

- The continuation, recurrence, or onset of a serious health condition that entitles the employee to leave under the Act; ***or***
- Other circumstances beyond the control of the employee.

The Act also states conditions under which the employer is **not** required to provide Family and Medical Leave. The employer is not required to provide Family and Medical Leave to any employee who has worked for the employer fewer than 12 months or fewer than 1,250 hours in a twelve-month period.

During Family and Medical Leave, your health coverage continues as before the leave. If the leave is paid, deductions, where applicable, will continue to be made from your pay. If the leave is unpaid, you must make arrangements with the Plan Administrator to pay the employee portion of the premium(s) that would otherwise be deducted from your pay.

If an additional leave of absence is approved beyond the legal maximum of twelve weeks, and the leave of absence is unpaid, health coverage for you and your eligible dependents will terminate on the last day of the month in which the twelve-week legal maximum expires. You should contact the Plan Administrator's office to arrange for continuance of coverage and payment of

premiums. You will be responsible for the entire cost of coverage if you elect continuance. Premiums must be paid within 30 days of the date they are due or coverage will be terminated.

For a more complete description of your rights and responsibilities, refer to the section ***Notice of Family and Medical Leave Act*** elsewhere in this document.

Health Coverage during Other Leaves of Absence.
During a paid leave, your health coverage continues as before the leave. Deductions, where applicable, will continue to be made from your pay.

During an unpaid leave of absence, health coverage for you and your eligible dependents will terminate on the last day of the month following 30 days after the unpaid leave of absence begins. Prior to your leave, you should contact the Plan Administrator's office to arrange for the continuance of coverage and the payment of premiums. You may continue coverage for up to one year during the leave. You will be responsible for the entire cost of coverage if you elect continuance. Premiums must be paid within 30 days of the date they are due or coverage will be terminated.

If you voluntarily discontinue your coverage during a leave of absence, you cannot re-enroll until the annual open enrollment period following your return to work unless you experience a life event.

If your coverage terminates during the leave due to the expiration of the permitted coverage period, you may re-enroll for coverage provided that reapplication is made within 31 days from the date you return to work.

Termination and Extension of Coverage.
If you terminate your employment for any reason, health coverage for you and your dependents ends on the last day of the month in which your employment ends. In certain situations you may arrange for continuation of coverage at your own expense. For a complete description of your legal rights to continuation of coverage, refer to the ***Notice of Federal Continuation Rights*** elsewhere in this document.

Independent Health *"FlexFit Select"*

You must choose a primary care physician from Independent Health's network of participating doctors. There are three plan options from which you may choose: *"FlexFit Active", "FlexFit Independent" and "FlexFit Family"*.

Please refer to the **Health Benefit Coverage Summaries** for a description of benefits, co-payments, limitations and exclusions.

Coverage begins on the first day of the month following the employee's date of hire or eligible employment.

Plan Highlights.

- Refer to **Health Benefit Coverage Summaries.**

Plan Out-of-pocket Costs and Co-payments.

- Refer to **Health Benefit Coverage Summaries.**

Plan Premiums.

- The premium for **Employee Only coverage** is as follows: the employer pays 90% of the total monthly premium, with the employee paying 10% of the total monthly premium through payroll deduction.
- The premium for **Employee & Spouse coverage** is as follows: the employer pays 82.4% of the total monthly premium, with the employee paying 17.6% of the total monthly premium through payroll deduction.
- The premium for **Employee & Child(ren) coverage** is as follows: the employer pays 86% of the total monthly premium, with the employee paying 14% of the total monthly premium through payroll deduction.
- The premium for **Family coverage** is as follows: the employer pays 80% of the total monthly premium, with the employee paying 20% of the total monthly premium through payroll deduction.

Please note: **Except on the date of employment, the anniversary date for the Health Benefit Plan is *April 1*.**

II. *VALUE-CARE DENTAL PLAN*
GUARDIAN LIFE INSURANCE COMPANY

Eligible Dependents.
You may choose either Individual Coverage or one of the Family Coverage options. Individual Coverage covers only you. Family Coverage options are:

- Employee plus spouse
- Employee plus child or children
- Employee plus spouse and child/children

Enrollment Restrictions and Limitations.
You must enroll within 31 days of becoming eligible to participate in order to choose the coverage category you want. Otherwise, you will be enrolled in Individual Coverage, and you will not be able to change your coverage until the next annual open enrollment period, or until you have a life event.

- If you first enroll during an annual open enrollment period, coverage will become effective April 1.
- If you enroll for coverage in the Plan but do not enroll your spouse or eligible dependents, those dependents will not be able to join the plan until the next annual open enrollment period or until you have a life event.
- If you enroll your spouse or eligible dependents during the annual open enrollment period, coverage will be effective April 1.

Changes in Coverage during the Year.
You can change your coverage category (Individual Coverage to one of the Family Coverage options, or Family Coverage to Individual Coverage, or among Family Coverage Options) at any time if you have a life event. A life event includes marriage, birth or adoption of a child, divorce, death of a dependent or spouse, employment of spouse, or termination of spouse's employment. You will have 31 days from the life event to enroll your spouse or eligible dependents. If you do not enroll your spouse or dependents within 31 days after they first become eligible, you may not enroll them until the next annual open enrollment period.

Termination and Extension of Coverage.
If you terminate your employment for any reason, dental coverage for you and your dependents ends on the last day of the month in which your employment ends. In certain situations you may arrange for continuation of coverage at your own expense. For a complete description of your legal rights to

continuation of coverage, refer to the ***Notice of Federal Continuation Rights*** elsewhere in this document.

Plan Highlights.

- Preventive Services covered at 100%:
  - Routine oral examinations
  - Emergency treatment
  - X-rays
  - Teeth cleanings
  - Fluoride treatment for children under age 14
  - Topical sealants for children under age 16
  - Space maintainers for children under age 16
  - Harmful habit appliances.
- Basic Services covered at 80%:
  - Fillings (amalgam, silicate, and acrylic)
  - Acrylic/plastic crowns.
  - Maintenance of bridgework and dentures.
  - Periodontal services
  - Root canal
  - Oral surgery
- Major Services covered at 50%:
  - Gold and porcelain fillings and crowns
  - Installation of bridgework and crowns
- Orthodontia (children only)

Plan Out-of-pocket Costs and Co-payments.

- Basic Services and Major Services are subject to a $50 calendar year deductible per person. (There is no deductible for Preventive Services.)
- Preventive Services, Basic Services and Major Services are limited to a $1,000 calendar year maximum benefit per person.
- Basic Services are subject to a 20% co-payment.
- Major Services are subject to a 50% co-payment.
- Orthodontia is subject to a 50% co-payment, and limited to a $1,000 lifetime maximum benefit per child.
- Any dentist may be used for base benefits. However, using a Guardian preferred provider guarantees out-of-pocket costs.

A more complete description of benefits, limitations and exclusions can be found in the Guardian brochure in the Plan Administrator's office, and in the contract issued directly to the employee by Guardian.

Coverage begins on the first day of the month following the employee's date of hire or eligible employment.

Plan Premiums.

- The employer pays 100% of the premium for Individual Coverage. There is no employee deduction for Individual Coverage.
- The employer pays 100% of the premium for all Family Coverage options. There is no employee deduction for Family Coverage.

Family Coverage provides coverage for eligible unmarried children until age 20, and until age 26 if a full-time student, at which times coverage will automatically terminate without notice.

III. *LIFE, ACCIDENTAL DEATH, AND DISMEMBERMENT INSURANCE*
STANDARD LIFE INSURANCE COMPANY

Plan Highlights.

- Group life insurance with a death benefit for the principal sum of $20,000 for employees under age 65. (Benefits are reduced to 65% at age 65; 50% at age 70; 35% at age 75.)
- Group accidental death and dismemberment insurance providing benefits for bodily injuries sustained directly from an accident, and specifically resulting in loss of life or loss(es) of hand(s), foot(feet), and/or eye(s).
- Accelerated payment of death benefits in advance of death, in the event of a terminal illness.

A more complete description of benefits, limitations and exclusions can be found in the *Group Life Insurance Certificate* issued directly to the employee by the Standard Life Insurance Company. A copy of the complete Group Insurance Certificate is available for review in the Plan Administrator's office.

Coverage begins on the first day of the month following the employee's date of hire or eligible employment.

Plan Premiums.

The full premium for **Individual Coverage** is paid by the employer. **Family Coverage** is not available.

IV. *GROUP TOTAL DISABILITY INSURANCE*
STANDARD LIFE INSURANCE COMPANY

Plan Highlights.

- Monthly income benefit during periods of total disability equal to 60% of covered monthly salary, not to exceed $4,000 monthly, inclusive of any income benefits payable from Social Security, Worker's Compensation and any benefits payable under an employer-sponsored plan.
- Monthly income benefits will be increased by 3% compounded annually beginning with the first anniversary of benefit payments.
- Monthly annuity premium benefit of 12% contributed to the employee's TIAA-CREF regular retirement contract(s).

A more complete description of benefits, limitations and exclusions can be found in the *Group Life Insurance Certificate* issued directly to the employee by the Standard Life Insurance Company and in the Group Policy available for review in the Plan Administrator's office.

Coverage begins on the first day of the month following one year of eligible employment.

Plan Premiums.

The full premium for **Individual Coverage** is paid by the employer. **Family Coverage** is not available.

V. *TUITION ASSISTANCE PLAN*

Plan Highlights.

- The employer will reimburse the employee for the cost of tuition for academic courses, seminars or workshops that are job-related and that will clearly benefit the employee's performance. Reimbursement will be for a maximum of two courses, seminars or workshops per academic semester, including each summer session, and for a maximum dollar amount of $400 per semester.

- The employee may apply for reimbursement from the employer by submitting a written request no later than 2 weeks after the first day the class, seminar or workshop. Included in the written request must be a complete description of the course(s), seminar(s) or workshop(s), the dates of attendance, the total cost, and a justification of its(their) job-related nature. The employer will notify the employee in writing, either approving or denying the application for reimbursement, and the reasons for such approval or denial. Any approval for reimbursement by the employer will be preliminary, pending the satisfactory completion of study by the employee. The employee must submit proof of satisfactory completion of coursework before being reimbursed. Satisfactory completion means a passing grade of *C* or better, or if letter grades are not applicable, certification from the instructor that the employee has satisfactorily completed the course in all respects. In addition, the employee must be actively employed by the employer at the time study is completed and must also be actively employed by the employer at the time proof of satisfactory completion is submitted by the employee to the employer.
- Specifically excluded from reimbursement are fees and charges other than tuition, such as college fees, student activity fees, room and board charges, charges for books, supplies or equipment, and any other miscellaneous costs that may be assessed.

Revised 4/09

NOTICE OF FAMILY AND MEDICAL LEAVE ACT

******VERY IMPORTANT NOTICE******

Introduction

Effective August 5, 1993, the Family and Medical Leave Act (*FMLA*) requires covered employers to provide up to 12 weeks of unpaid leave to "eligible" employees for certain medical reasons. Leave may be taken in a continuous block of time, intermittently, or on a reduced work schedule depending on medical necessity. However, when leave is needed for planned medical treatment, the employee must try to schedule treatment so as not to unduly disrupt the employer's workplace.

Purpose

FMLA is intended to balance the demands of the workplace with the needs of families. By providing workers faced with family obligations or serious family/personal illnesses with reasonable amounts of leave, FMLA encourages stability in the family and productivity in the workplace.

Who is Eligible?

To be eligible, an employee must have:

- Worked for the covered employer for at least 12 cumulative months, and
- Have worked at least 1,250 hours during the 12 consecutive months preceding the date leave is requested to begin. To calculate this requirement, the employer must include all hours for which the employee was paid.

Employee Entitlement to Leave

Eligible employees are entitled to take up to 12 weeks of unpaid leave per year for the following reasons:

- The birth and care of a newborn child of the employee (*leave must be concluded within one year of birth*), or to care for a son or daughter who is incapable of self-care because of a mental or physical disability. A son or daughter includes a biological, adopted, or foster child, a stepchild, a legal ward, or a child of personal standing *in loco parentis*, who is under 18 years of age.
- Placement of a son or daughter with the employee for adoption or foster care (*leave must be concluded within one year of placement*).
- Care of a spouse, son, daughter, or parent who has a serious health condition. A serious health condition is an illness, injury, impairment, or physical or mental condition that involves: (1) inpatient care in a hospital, hospice, or residential medical care facility; or (2) continuing treatment by a health care provider.
- A serious health condition suffered by you, that makes you unable to perform your job.

  NOTE: Spouses who work for the same employer are entitled only to a combined total of 12 weeks.

Unpaid vs. Paid Leave

FMLA is unpaid. However, employees may choose to use appropriate leave credits which will run concurrently with FMLA leave.

At the time request for leave is made, an employee must provide written notification to the Plan Administrator of the decision to substitute appropriate leave credits.

Employer Responsibility

It is always the employer's responsibility to designate qualifying absences as FMLA leave, whether or not the employee specifically requests it.

Employee Responsibility

Advance notice and medical certification requirements:

- When leaves are "foreseeable", employees must ordinarily provide 30 days advance written notice to the Plan Administrator in writing. In the case of medical emergencies, notice must provided within 2 workdays of the employee's knowledge of the leave.
- Employees must advise the Plan Administrator "as soon as practicable" of any change in dates of scheduled leave or extension of such leave. Such changes should be confirmed in writing.
- Employees are required to provide:
  - ✓ Medical certification, within 15 days of employer's request, that the leave is needed due to the employee's own serious health condition or that of a family member. (The employer may also, at its own expense, require a second and possibly a third medical opinion.)
  - ✓ Periodic medical certification (every 30 days for a continuous block of leave, and every six months for intermittent leave).
  - ✓ Periodic reports regarding the employee's status and intent to return to work.
  - ✓ Fitness for duty certification in order for the employee to return to work.

What is a Serious Health Condition?

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either:

- Any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical-care facility, and any additional treatment in connection with that inpatient care, or
- Continuing treatment by a health care provider that includes any period of incapacity, i.e., inability to perform work, attend school or perform other regular daily activities due to:
  - ✓ A health condition (including treatment or recovery) lasting more than 3 consecutive days and any later treatment or incapacity (absence from work) relating to the same condition that also includes 2 or more treatments by a health care provider or one treatment with a continuing regimen of

treatment. (Absences for the treatment of substance abuse are covered; absences resulting from use of substances are not.)

- ✓ Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence.
- ✓ A permanent or long-term condition for which treatment may not be effective (e.g., a severe stroke or cancer). Only supervision by a health care provider is required, rather than active treatment.
- ✓ Any absences to receive treatments for restorative surgery or for a condition that would likely result in a period of incapacity if not treated (e.g., radiation treatments or chemotherapy for cancer).

Job Benefits and Protection

- For the duration of FMLA leave, the employer must maintain the employee's health insurance coverage. If the leave is paid, deductions, where applicable, will continue to be made from your pay. If the leave is unpaid, you must make arrangements with the Plan Administrator to pay the employee portion of the premium(s) that would otherwise be deducted from your pay. If an employee voluntarily discontinues coverage during Family and Medical Leave, the employee cannot re-enroll until the annual open enrollment period following your return to work, unless the employee experiences a life event.
- If the employee fails to return to work at the expiration of the maximum twelve-week period, coverage for you and your eligible dependents will terminate on the last day of the month in which the twelve-week maximum leave period is reached. In certain situations, you may arrange for continuation of coverage at your expense. See ***Termination and Extension of Coverage*** or the ***Notice of Federal Continuation Rights*** elsewhere in this document.
- Upon return from FMLA leave, employees must be restored to original or equivalent positions with equivalent pay, benefits and other terms and conditions of employment.
- The use of FMLA cannot result in the loss of benefits that the employee earned or was entitled to before taking the leave.
- The law prohibits an employer from discriminating against individuals who exercise their rights under FMLA.
- Individuals are protected from retaliation for opposing unlawful practices under FMLA.

NOTICE OF FEDERAL CONTINUATION RIGHTS

******VERY IMPORTANT NOTICE******

******CONTINUATION COVERAGE RIGHTS UNDER COBRA******

Introduction

This notice is being provided to you because you are covered under the *Sub-Board I, Inc. Welfare Benefit Plan* for health benefits and dental benefits. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health and/or dental coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health and/or dental coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description, or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan health and/or dental coverage when coverage would otherwise end because of an event know as a "qualifying event". Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under

the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both; or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because and of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for reasons other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or the reduction of hours of

employment, death of the employee, or the employee's becoming eligible for Medicare benefits (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Executive Director of Sub-Board I, Inc., 341 Student Union, University of Buffalo, Amherst, NY 14260. You also may be required to provide documentation of the qualifying event in the case of divorce or legal separation.

How is COBRA Coverage Provided?

Once the Plan Administrator receives the notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming eligible to Medicare benefits (Part A, Part B, or both), your divorce or legal separation, or a dependent's child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became eligible to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts for up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a

total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You may be required to provide documentation from the Social Security Administration verifying the disability determination to the Plan Administrator before the end of the initial 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in you family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes eligible to Medicare benefits (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health and/or dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website a www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

- **Sub-Board I, Inc**
  Executive Director
  341 Student Union
  SUNY at Buffalo
  Amherst, NY 14260-2100

  or

- **Sub-Board I, Inc**
  Chief Accountant
  341 Student Union
  SUNY at Buffalo
  Amherst, NY 14260-2100

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