

Health Reimbursement Account Summary Plan Description

This Summary Plan Description ("SPD") describes the Health Reimbursement Account available under the Franklin & Marshall College Group Insurance Plan and Flexible Spending Account (the Health Reimbursement Account is described herein as the "HRA Plan" or the "Plan"), as in effect on January 1, 2009. The benefits available under this Plan are closely connected to the benefits that you are eligible for under the plan identified as the High Deductible Health Plan (the "High Deductible Health Plan" or "HDHP") and offered under the Franklin & Marshall College Group Health Insurance & Prescription Drug Plan. Copies of the Summary Plan Description for that plan are available upon request, by contacting the Franklin & Marshall Human Resources department. This is not a Certificate of Insurance. It is required by The Employee Retirement Income Security Act (ERISA) of 1974, as amended. The purpose of this Summary Plan Description is to acquaint employees with the provisions of the Plan, the way in which it is administered, and participants' rights under the federal law which applies to employee benefit plans. Every effort has been made to make this SPD as accurate as possible. However, in the event of a discrepancy between this SPD and the Plan Document, the Plan Document shall control. The Plan Document can be viewed by contacting Human Resources, (717) 291-3995. The Plan is established for the benefit of employees and their covered dependents and is administered impartially for the benefit of all eligible participants.

Facts about the Plan

Plan Name: Franklin & Marshall College Group Insurance Plan and Flexible Spending Account

Plan Number: 501 - Plan 501 also includes the Franklin & Marshall College Group Health Insurance & Prescription Drug Plan, the Franklin & Marshall Dental Insurance Plan, the Franklin & Marshall College Group Life Insurance Plan, and the Franklin & Marshall College Flexible Spending Accounts Plan, which are each described in separate Summary Plan Descriptions.

Name, Address, and Telephone Number of Employer/Sponsor: Franklin & Marshall College, Lancaster, PA 17604-3003, (717) 291-3995. Employer shall also include the James Street Improvement District.

Named Fiduciary: Franklin & Marshall College, Lancaster, PA 17604-3003

Plan Sponsor's Employer Identification Number: 23-1352635

Original Plan Effective Date: January 1, 2007

Plan Year: January 1 through December 31

Type of Plan: Welfare plan providing reimbursement for health care expenses

Plan Administrator: Franklin & Marshall College, P.O. Box 3003, Lancaster, PA, 17604-3003

Claims Administrator / Type of Administration: Administration is provided through an independent third party administrator. The third party administrator is Significa Benefit Services, P.O. Box 7777, Lancaster, PA 17604-7777. Significa Benefit Services' telephone numbers are (717) 581-1300 and (800) 433-3746. Significa Benefit Services is appointed by the College to perform certain administrative services with respect to the Plan. Significa Benefit Services does not finance or insure the Plan. Under this type of administration, benefits are not guaranteed under a contract or policy of insurance. In its role as a third party administrator, Significa Benefit Services is not an "administrator" as defined in Section 3(16)(A) of ERISA. The College is the Plan "administrator" as defined in Section 3(16)(a) of ERISA.

Agent for Service of Legal Process: Director, Human Resources, Franklin & Marshall College, P.O. Box 3003, Lancaster, PA, 17604-3003

Funding: Benefits are paid for through the general assets of the employer; participants are not required to contribute to this Plan

Plan Benefits

Health Reimbursement Account

Eligible College employees who elect to participate in the High Deductible Health Plan will participate in this Health Reimbursement Account Plan. The College will make a contribution to each participating employee's Health Reimbursement Account (HRA). Participating employees may then request reimbursement from their Health Reimbursement Account for their, and their covered dependents', eligible health care expenses as described below in the section titled "Eligible Expenses". The maximum amount a participating employee may be reimbursed from the HRA is the full eligible expense incurred by the employee or incurred by the employee's dependent(s) who is enrolled in the High Deductible Health Plan, or the employee's full, current HRA balance, whichever is less.

Funds will be credited to each participating employee's Health Reimbursement Account (HRA) on January 1st of each calendar year. The amount credited to each HRA will be based upon the schedule distributed by the College and communicated to employees each year during the Open Enrollment period, and will be based on the coverage level elected by the participating employee.

At the end of the Plan Year (December 31) any amount remaining in an employee's HRA will carry over to the next Plan Year, as long as the employee remains enrolled in the High Deductible Health Plan with Health Reimbursement Account. As of January 1, each participating employee will be eligible to receive the College's full HRA contribution for that Plan Year, regardless of his/her current HRA balance.

Any unused funds remaining in an employee's HRA upon termination of the employee's participation in this Plan will be forfeited by the employee, except as described below in the "Termination of Coverage" section. Therefore, an employee who elects to discontinue participation in the High Deductible Health Plan with Health Reimbursement Account at the start of a new Plan Year or during the year will forfeit the full balance in his/her HRA.

Plan participants whose College employment terminates, other than as described below in the "Termination of Coverage" section, will forfeit their entire unused HRA balance upon termination of eligibility for participation in this Plan, except as described below in the section titled "Continuation of Coverage through COBRA ". Funds will be retained by the College to offset future expenses.

Eligibility for Coverage

The following classes of employees, and their eligible dependents, are eligible for coverage under this Plan:

Class A:

- full-time faculty and professional staff employees: Franklin & Marshall College employees who are scheduled to work at least 30 hours per week for wages on a regular basis, including visiting, tenured, non-tenured, and tenure-track faculty; full-time employees of the James Street Improvement District; the current, actively employed Spectrometer Technician; the Program Director, Campus Central; and full-time employees of the Centennial Conference and Higher Education Data Sharing Consortium who: (1) are regularly scheduled to work on the Franklin & Marshall College campus and (2) are paid through the College's payroll system, as long as otherwise eligible
- full-time faculty and professional staff employees who are scheduled to work at least 30 hours per week for wages on an approved 9, 10, or 11 month per year appointment
- faculty on an approved joint appointment: one full-time position shared by two College faculty members each working at least 1040 hours annually
- full-time faculty working a reduced schedule under an approved Phased Retirement Agreement
- full-time faculty who have been granted a leave of absence to further their scholarship and/or teaching and who receive a stipend from a competitive grant or fellowship that does not provide health insurance coverage, upon approval of the Provost and Dean of the Faculty (eligibility for coverage may continue for the time period covered by the grant or fellowship, not to exceed 12 months)
- full-time faculty on an approved paid sabbatical or paid Junior Faculty Leave, not to exceed 12 months
- full-time faculty and professional staff employees on an approved paid or unpaid Family & Medical Leave as provided for in the Family & Medical Leave Act, or other approved leave of absence which provides for continued coverage, not to exceed 12 months

To participate in the HRA Plan, the employee and any covered dependents must be eligible for coverage and enrolled in the College's High Deductible Health Plan.

Coverage is provided for the eligible employee; the employee plus one dependent; or the employee plus two or more dependents.

Independent contractors, contracted employees, adjunct faculty, individuals who volunteer their services without compensation, students, student employees, retired members of the College faculty and professional staff, and those not in a covered class are not eligible for coverage through the Plan.

Eligible Dependents

For purposes of the HRA Plan, eligible dependents include any dependents who are enrolled with the employee in Franklin & Marshall College's High Deductible Health Plan as dependents, including a same-sex Domestic Partner as defined by the College's policies. If an employee enrolls his/her same-sex Domestic Partner, the College will deduct from the employee's salary the imputed value of the partner's coverage under this HRA Plan, as required by federal, state, or local law.

Dependents must be enrolled in the College's High Deductible Health Plan to be eligible for coverage under this HRA Plan and to be reimbursed for their eligible expenses.

Employees, spouses / same-sex Domestic Partners, and dependent children who are participating in a Health Savings Account (HSA) are not eligible for coverage under this Plan.

Enrollment

Eligibility for coverage for employees under this HRA Plan coincides with the employee's enrollment in the High Deductible Health Plan sponsored by the employer. College employees are initially eligible to enroll in the High Deductible Health Plan as of the first day of the month coinciding with, or following, appointment to a full-time position in an eligible class as described in the Health Insurance & Prescription Drug Summary Plan Description (available from the Plan Administrator via the Human Resources office). Eligible employees may also elect to enroll in the High Deductible Health Plan during any Open Enrollment period, with coverage effective the next January 1.

Enrollment in this Plan is automatic upon an eligible employee's enrollment in the High Deductible Health Plan and does not require a separate election or enrollment form. The High Deductible Health Plan is the health plan designated by the College to include a high deductible and to include a health reimbursement account. Information regarding the High Deductible Health Plan may be found in the Health Insurance & Prescription Drug Summary Plan Description, or by contacting the Human Resources department, (717) 291-3995.

Changes in Status / Special Enrollment Periods / "Mid-year" Election Changes

Generally, an employee may add a dependent(s) or delete a dependent(s) from coverage only if a corresponding change is made to the employee's coverage under the High Deductible Health Plan. Changes to coverage under this HRA Plan will occur automatically when changes are made to the employee's coverage under the High Deductible Health Plan. The Plan Administrator may modify enrollment elections for administrative purposes or to comply with Plan legal requirements. Employees are permitted to change their health plan elections after January 1 and, hence, elections under this Plan only in limited situations. Employees are encouraged to review the Health Insurance & Prescription Drug Summary Plan Description for information about making changes to coverage after January 1. The Summary Plan Description may also be obtained by contacting the Human Resources department, (717) 291-3995.

If an employee enrolls in the HRA Plan after the start of the Plan Year (as permitted under the terms of this Plan and the High Deductible Health Plan), the entire designated amount will be credited to the employee's HRA for the Plan Year. The amount will not be pro-rated.

If an employee adds dependents to his/her coverage during a Plan Year (as permitted under the terms of this Plan and the High Deductible Health Plan), the HRA will be increased to reflect the contribution amount for the employee's new coverage level. If an employee drops one or more dependents from coverage during a Plan Year (as permitted under the terms of this Plan and the High Deductible Health Plan), his/her HRA balance will not be changed or decreased as a result of the change in coverage level.

College-funded Annual Health Reimbursement Account Contribution

For the 2009 Plan Year, the College will contribute the following amount per participating employee:

- \$420.00 total for employees electing single coverage through the College's High Deductible Health Plan
- \$840.00 total for employees covering self plus one dependent through the College's High Deductible Health Plan, *or*
- \$1,260.00 total for employees covering self plus two or more dependents through the College's High Deductible Health Plan

The amounts above reflect the annual contribution per participating employee, not per covered dependent.

A participating employee's full HRA balance will be available to him/her as of January 1.

The annual College-funded contribution to participants' Health Reimbursement Accounts may vary from year to year, and will be communicated to employees during the annual Open Enrollment period prior to the beginning of each Plan Year.

Each employee participating in the High Deductible Health Plan with Health Reimbursement Account will receive the full applicable College-provided contribution to his/her HRA as of January 1, regardless of his/her current HRA balance.

Eligible Expenses

Health Reimbursement Account funds are provided to participating employees to help off-set the annual **deductible** (and the deductible for covered family members) applicable under the High Deductible Health Plan. Health Reimbursement Account funds are available to reimburse only those expenses incurred to pay the annual deductible under the High Deductible Health Plan.

Eligible expenses must be incurred during the Plan Year (from January 1 through December 31) in which the employee participates in the Plan. An employee may not request reimbursement from his/her HRA balance for expenses incurred during a prior

Plan Year, except that employees have until March 31 of the next Plan Year to submit a claim for reimbursement pertaining to the prior year. Expenses are treated as having been incurred when the employee or eligible dependent is provided with the service that gives rise to the expense, not when the participant is formally billed for, or pays for, the service.

Expenses are only eligible for reimbursement when the employee, spouse or same-sex Domestic Partner, and/or dependent child who incurred the expense is covered under the Franklin & Marshall High Deductible Health Plan with Health Reimbursement Account.

Submitting a Claim for Reimbursement from the Health Reimbursement Account

Each employee will be entitled to receive, upon submitting a claim, reimbursement from the Claims Administrator for incurred expenses pertaining to the annual deductible under the High Deductible Health Plan, up to the amount designated for the employee's Health Reimbursement Account less any prior reimbursements. Therefore, the maximum amount an employee may be reimbursed from the HRA is the lesser of (a) the full eligible expense incurred by the employee or his/her covered dependent, or (b) the employee's current, full HRA balance.

An employee may not "borrow" from his/her future anticipated HRA balance, or be reimbursed for an expense incurred during a previous Plan Year from the current year's HRA balance.

Participants must complete a claim form, available from the Franklin & Marshall College Human Resources department, from the Human Resources public folder in eDisk, and from the Claims Administrator (Erin Group Administrators, Inc.), and submit it directly to the Claims Administrator along with any required documents substantiating the claim, such as the Explanation of Benefits (E.O.B.) from the College's health insurer and the invoice from the health care provider. The Claims Administrator will provide reimbursement to the participating employee for eligible expenses from the employee's current Health Reimbursement Account balance. Reimbursement for eligible expenses will be sent directly to the participating employee, not to the employee's health care provider or the health plan insurance provider.

All claims must be filed within three (3) months after the end of the Plan Year (by March 31 of the following calendar year), or within three (3) months after coverage terminates under this Plan. To receive reimbursement for eligible expenses, a properly completed and substantiated claim must be submitted by the Plan participant to the Plan's Claims Administrator (Significa Benefit Services) no later than by March 31 of the following Plan Year, or within 3 months after coverage under the Plan terminates (i.e., the claim must be postmarked no later than by March 31 of the calendar year following the end of the Plan Year, or submitted via fax or hand-delivered to the Claims Administrator by March 31, or postmarked or submitted via fax within 3 months after coverage terminates).

All claims must be submitted directly to the Claims Administrator (Significa Benefit Services, P.O. Box 7777, Lancaster, PA 17604-7777, fax (717) 581-8379).

Year-end HRA Balances

Any unused funds remaining in an employee's HRA at the end of the Plan Year will remain in the employee's account for as long as the employee remains enrolled in the High Deductible Health Plan. At year end (December 31), all unused funds in an employee's HRA will carry forward to the next Plan Year, *if the employee is eligible and elects to participate in the High Deductible Health Plan with Health Reimbursement Account for that Plan Year.*

Plan Costs

All benefits paid under this HRA Plan are payable directly to the employee out of the general assets of the employer. The employer will not establish a trust or fund for payment of benefits under this Plan. Employees are not required to contribute to the cost of coverage under this HRA Plan (however, employees are required to contribute to the cost of insurance coverage through the High Deductible Health Plan; participants should see the Health Insurance & Prescription Drug Summary Plan Description for contribution rates or contact the Human Resources department).

Coordination of Benefits

This Plan will provide benefits solely for eligible expenses that are not reimbursed or reimbursable elsewhere, except as noted below.

Coordination between the Health Reimbursement Account and the Medical Expense Reimbursement Account-- If a College employee participates in both the Medical Expense Reimbursement Account through the Franklin & Marshall College Flexible Spending Accounts Plan and this HRA Plan, reimbursement to the employee for his/her expenses deemed eligible under the HRA Plan, and/or eligible expenses of a covered dependent, will be provided first from any balance in the employee's Health Reimbursement Account. If the participant does not have enough funds in the HRA to provide full reimbursement for his/her eligible expenses, the remaining amount which cannot be reimbursed from the participant's HRA balance may then be submitted for reimbursement by the participant through his/her Medical Expense Reimbursement Account. **An employee may not be reimbursed for the same expense from both his/her Health Reimbursement Account and the Medical Expense Reimbursement Account.**

Coverage During Leave of Absence

Sabbatical or Research Leave-- A faculty member enrolled in the High Deductible Health Plan with Health Reimbursement Account who takes a sabbatical or paid or unpaid research leave of absence approved through the Office of the Provost will retain his/her Health Reimbursement Account balance if the faculty member temporarily discontinues coverage through the High Deductible Health Plan, as permitted by the terms of that plan, during the period of sabbatical or leave of absence, providing the faculty member re-enrolls in the High Deductible Health Plan immediately upon return from sabbatical or leave of absence. The faculty member's full Health Reimbursement Account balance will be restored when the faculty member re-enrolls in the High

Deductible Health Plan, providing he/she does so as soon as eligible upon expiration of the approved sabbatical or leave of absence.

Family & Medical Leave or Other Medical Leave-- An employee enrolled in the High Deductible Health Plan will not forfeit his/her Health Reimbursement Account balance if the employee temporarily discontinues health insurance coverage during an approved, unpaid leave under the Family and Medical Leave Act of 1993, as amended (FMLA), or other approved, unpaid medical leave and then re-enrolls in the High Deductible Health Plan immediately upon return from leave. The employee's Health Reimbursement Account balance will be restored when he/she re-enrolls in the High Deductible Health Plan, providing the employee re-enrolls immediately upon return to work. If the employee is unable to return to work due to continuing disability, the individual's Health Reimbursement Account balance will be restored if the individual begins receiving long-term disability income benefits through the College's Group Long-term Disability Insurance Plan.

If a covered employee takes a qualifying leave under the Family and Medical Leave Act and the College maintains the employee's group health insurance coverage (as required by the FMLA and upon the terms and conditions described in the Health Insurance & Prescription Drug Summary Plan Description), then the employee's Health Reimbursement Account balance will be available for use during the entire period that the employee remains covered under the High Deductible Health Plan.

Termination of Coverage

An employee's coverage under this HRA Plan will terminate when the employee's coverage under the High Deductible Health Plan terminates. A spouse or dependent's coverage under this HRA Plan will terminate when the employee's spouse's or dependent's coverage under the High Deductible Health Plan terminates. Eligibility for participation in the High Deductible Health Plan and this Plan terminates at the end of the calendar month in which: employment termination occurs; an employee commences a leave of absence that does not provide for continued benefits coverage; and/or an employee is no longer a member of an eligible class. Please see the Health Insurance & Prescription Drug Summary Plan Description for detailed information (available from Human Resources, on the Human Resources web pages, and in the Human Resources public folder in eDisk).

Health Reimbursement Account Balance Upon Termination of Participation

Upon termination of participation in the High Deductible Health Plan and this HRA Plan, an employee's full Health Reimbursement Account balance will be permanently forfeited by the employee, except as described below and as required by "COBRA".

An HRA Plan participant who elects coverage through a College health plan option other than the High Deductible Health Plan, and therefore terminates coverage through the High Deductible Health Plan, will forfeit his/her entire HRA balance. The balance will not be restored if the employee later re-enrolls in the High Deductible Health Plan, except as described above in the "Coverage During Leave of Absence" section of this Summary Plan Description.

Upon termination of Plan participation, an employee may request reimbursement for his/her eligible expenses, as described above in the section titled "Eligible Expenses", and those of covered dependents which were incurred during the Plan Year on or before the date participation in the High Deductible Health Plan terminated.

Eligibility to Retain HRA Balance Upon Employment Termination

All amounts in each employee's Health Reimbursement Account will be forfeited upon termination of an employee's coverage under this Plan, except as required by COBRA as described below, and except that the following employees will retain their full Health Reimbursement Account balance at employment termination:

- (a) eligible employees who retire from the College: employees who terminate their employment after at least ten (10) consecutive years of full-time employment in a benefits eligible class after the age of fifty (50), and who are at least age sixty (60) upon employment termination;
- (b) long-term disability income benefit recipients: College employees whose employment terminates and who are eligible to receive long-term disability income benefits through the Franklin & Marshall College Group Long-term Disability Plan due to total disability; and
- (c) solely for purposes of this Plan, employees who terminate their College employment after at least ten (10) consecutive years of full-time employment in a benefits eligible class, and who are at least age fifty-five (55) upon employment termination.

Eligible expenses for those former employees listed above will include all medical expenses qualified under Section 213(d) of the Internal Revenue Code. These former employees do not have to remain enrolled in the High Deductible Health Plan or other College sponsored health plan to maintain their HRA balance. No additional funds will be deposited into the former employee's Health Reimbursement Account at the beginning of the next or subsequent Plan Years.

Death of a Plan Participant

Upon the death of a current Plan participant, or a former participant who has retained his/her Health Reimbursement Account as described above, the spouse and/or dependents of the individual can continue to use the funds in the HRA for reimbursement of eligible medical expenses. Eligible expenses will include all medical expenses qualified under Section 213(d) of the Internal Revenue Code. No additional funds will be deposited at the beginning of the next or subsequent Plan Years. If there are no covered dependents at the time of the individual's death, the Health Reimbursement Account funds will be forfeited.

Re-hired Employees

An employee who terminates his/her employment for any reason, is re-hired within the same Plan Year (calendar year) in an eligible class, and re-enrolls in the High Deductible Health Plan when first eligible to re-enroll during that calendar year, will have his/her Health Reimbursement Account balance restored to the balance at termination.

If an employee is re-hired during a later Plan Year (calendar year), the employee's Health Reimbursement Account balance will not be reinstated.

Plan Termination

Coverage under this Plan will terminate for all employees on the date this Plan terminates. Upon termination of this HRA Plan by the employer, all participating employees will retain their Health Reimbursement Account balances and can continue to incur eligible expenses under this Plan, but no additional funds will be credited to any Health Reimbursement Account. Eligible expenses after termination of this Plan will include only those expenses included in the section titled "Eligible Expenses". Once all remaining Health Reimbursement Account funds have been paid to employees for eligible expenses, this HRA Plan will terminate.

Temporary Continuation of Coverage / "COBRA"

The information below is intended to provide an explanation of "COBRA" continuation coverage; describe when it becomes available to an employee and/or eligible dependents; and describe what an employee and his/her covered dependents must do to protect the right to elect continued health insurance coverage through COBRA, if coverage through this HRA Plan and the College's Group Health Insurance & Prescription Drug Plan is lost.

Employees of Franklin & Marshall College, and their dependents, who are covered under this HRA Plan have the right to temporary continuation of their health insurance coverage if coverage is lost due to a "Qualifying Event", as required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA coverage is available under this Plan only if the employee, spouse, or dependent also elects COBRA coverage under the High Deductible Health Plan. COBRA guarantees an opportunity to elect temporary continuation of health insurance coverage at group rates. No evidence of insurability is required to choose continuation coverage. Coverage is the same as that for active employees.

Qualifying Events

An **employee** of Franklin & Marshall College enrolled in this Plan has the right to choose continuation coverage for him/herself, his/her covered spouse, and any covered dependent children, if the employee, spouse, or dependent children lose coverage under the Plan due to:

- a reduction in the employee's hours of work that leads to loss of eligibility for coverage under this Plan (such as during a personal leave of absence or a change from full-time to part-time status), or

- termination of the employee's employment (except for termination due to gross misconduct).

An employee who loses coverage under this Plan, due to a Qualifying Event outlined above, becomes a "Qualified Beneficiary" and is entitled to elect temporary continuation of coverage through COBRA if the employee also elects continued coverage under the High Deductible Health Plan.

The **covered spouse** of a College employee has the right to choose continuation coverage for him/herself and his/her covered dependent children, if the spouse or his/her covered dependent children lose coverage under this Plan for any of the following reasons:

- the death of the College employee,
- the reduction of the employee's hours of work,
- the termination of the employee's employment (except for termination due to gross misconduct),
- the employee becomes entitled to Medicare benefits (Medicare Part A, Part B or both), or
- the employee and his/her spouse divorce or legally separate.

A spouse who loses coverage under this Plan, due to a Qualifying Event outlined above, becomes a "Qualified Beneficiary" and is entitled to elect temporary continuation of coverage through COBRA if the spouse also elects continued coverage under the High Deductible Health Plan.

The **covered dependent child** of a College employee has the right to elect COBRA continuation coverage, if coverage under this Plan is lost for any of the following reasons:

- the death of the parent (employee),
- a reduction in the parent's (employee's) work hours,
- termination of the parent's (employee's) employment (except for termination due to gross misconduct),
- the parent (employee) becomes entitled to Medicare benefits (Medicare Part A, Part B or both),
- the parents' divorce or legal separation, or
- the child ceases to be a dependent child eligible for coverage under the terms of this Plan (child reaching his/her age limitation, or any other change in status which effects eligibility for coverage).

A dependent child who loses coverage under this Plan, due to a Qualifying Event outlined above, becomes a "Qualified Beneficiary" entitled to elect temporary continuation of coverage through COBRA if the dependent child also elects continued coverage under the High Deductible Health Plan.

Notification Requirements

Continuation of coverage through COBRA will be offered upon timely and proper notice that a Qualifying Event has occurred or will occur. The covered employee/former

employee, spouse, and/or dependent has the responsibility to inform the Plan Administrator (via Franklin & Marshall College's Human Resources department) of a Qualifying Event that results in loss of coverage under this Plan and the College's Group Health Insurance & Prescription Drug Plan, such as a divorce or legal separation or loss of dependent status. Written notice to the Plan Administrator must be made **within 60 calendar days** of the later of: (1) the date of the Qualifying Event, (2) the date that coverage is lost due to a Qualifying Event, or (3) the date the Qualified Beneficiary is informed, through the Summary Plan Description or initial COBRA notice, of the Plan's procedures for providing notice of loss of coverage due to a Qualifying Event. Written notice must be provided to the Plan Administrator by the employee/former employee who has lost or will lose coverage under this Plan and the College's Group Health Insurance & Prescription Drug Plan, the spouse or dependent who is losing coverage, or a representative acting on behalf of the employee, spouse, or dependent. Such notice must be sent via fax, mail, or hand-delivered to Human Resources, Franklin & Marshall College, P.O. Box 3003, Lancaster, PA 17604-3003, fax: (717) 291-3969. The written notice must include:

1. the full name of the College employee or former employee and his/her social security number and mailing address,
2. the name and mailing address of all dependents who have lost or will lose coverage due to a Qualifying Event,
3. a brief description of the Qualifying Event that has resulted, or will result, in loss of coverage (i.e., divorce, legal separation, child's loss of dependent status, etc.) and, as required, verification of the Qualifying Event,
4. the date the Qualifying Event occurred/will occur,
5. other relevant information necessary for the Plan Administrator to verify that a Qualifying Event has occurred or will occur and the date of the Qualifying Event.

When notice of a Qualifying Event is properly submitted to the Plan Administrator (via Human Resources), the Plan Administrator, or the third party administrator designated by the Plan Administrator, will notify the individual within 14 days of receiving the notice, if the individual is not eligible for continuation coverage through COBRA. The notice of ineligibility will include the reasons for the denial.

Employer Responsibility-- When the Qualifying Event is the termination of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer is responsible for notifying the Plan Administrator of the Qualifying Event.

Birth or Adoption-- If a child is born, adopted, or placed for adoption with a formerly covered employee during the COBRA period, the employee must notify the Plan Administrator **within 31 calendar days of the birth or adoption** in order to elect COBRA coverage for the child.

Notice of Disability-- If the Qualifying Event that resulted in the COBRA election is termination of employment or reduction in work hours, the temporary COBRA continuation period may be extended due to the disability of any Qualified Beneficiary. In the case of disability, **written notice of disability must be provided by the Qualified Beneficiary to the Plan Administrator within 60 days** of the latest of: (a) the date of the Social Security Administration's disability determination; (b) the date of the Qualifying Event: the employee's termination of employment or reduction of hours; (c) the date on

which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the employee's termination of employment or reduction of work hours; or (d) the date on which the individual is informed of the obligation to provide the disability notice, and the procedures for providing such notice, through the Plan's Summary Plan Description or the initial COBRA notice.

If disability status changes, the Plan Administrator must be notified within 30 days after the later of the date of the final determination by the Social Security Administration, or the date the Qualified Beneficiary is informed of the Plan's procedures for providing such notice.

Failure to Provide Timely and Proper Notice of a Qualifying Event

If proper, timely written notice is not made to the Plan Administrator, all rights to continue health and prescription insurance coverage will terminate. If proper notice of a Qualifying Event is not provided, if continuation coverage through COBRA is not elected for both the High Deductible Health Plan and this Plan in a timely manner, or if COBRA premiums are not paid in a timely manner by the employee/former employee or Qualified Beneficiary(ies), all coverage under this Plan will terminate at the end of the calendar month in which the employment termination or other Qualifying Event occurred, in accordance with the provisions outlined in the Plan Document.

Electing COBRA Continuation Coverage

Following a Qualifying Event, and when proper and timely written notification of a Qualifying Event that leads to loss of coverage is provided to the Plan Administrator as required, the Qualified Beneficiary will receive a detailed notice of his/her COBRA rights, and instructions for electing COBRA coverage and paying premiums. Such notice will be sent by the College's third party COBRA administrator. To elect continuation coverage, a Qualified Beneficiary must complete an election form and furnish it **within 60 calendar days** according to instructions on the form. Each Qualified Beneficiary has a separate right to elect continuation coverage. A failure to elect COBRA coverage may affect future rights under federal law, including the right to avoid having pre-existing condition exclusions applied by other group health plans. The guaranteed right to purchase an individual health insurance policy that does not impose pre-existing condition exclusions will also be forfeited. An employee/former employee, spouse, or covered dependent who can obtain other group health insurance coverage may request special enrollment rights within 30 days of loss of coverage.

Coverage Periods

Continuation coverage through COBRA may be elected for a maximum period as follows:

- If the person affected by loss of coverage is the **employee**, and loss of coverage is due to a reduction in the employee's work hours or employment termination for reasons other than gross misconduct, the period of continuation coverage is a maximum of 18 months.
- If the person affected by loss of coverage is an **employee's spouse**, and the reason for loss of coverage is the employee's death, divorce or legal separation, or entitlement to Medicare benefits, the period of continuation coverage is a maximum

of 36 months. If an employee's hours are reduced or employment ends for reasons other than gross misconduct, the period of continuation coverage is 18 months.

- If the person affected by loss of coverage is an **employee's dependent child** and the reason for loss of coverage is the employee's death, divorce or legal separation, entitlement to Medicare benefits, or the dependent child ceases to be a dependent eligible for coverage through the Plan, the period of continuation coverage is a maximum of 36 months. If an employee's hours are reduced or employment is terminated for reasons other than gross misconduct, the period of continuation coverage is 18 months.

The period of continuation coverage described above may be shorter than expected if: (a) the College ceases to provide any group health plan for its employees, (b) the premium for continuation coverage is not paid on time by the covered individual, (c) the individual becomes covered under another group health plan after the date COBRA is elected, unless the other coverage has certain exclusions or limitations with respect to a pre-existing condition of the individual, or (d) the individual becomes entitled to Medicare benefits (under Part A, Part B, or both) after the date COBRA is elected. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage, such as due to fraud.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 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/her employment terminates, COBRA continuation coverage for the spouse and dependent 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. 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.

Extension of COBRA Period Due to Disability-- If an employee loses coverage due to termination of employment or reduction in work hours, he/she may qualify to extend the COBRA continuation period from 18 months to a maximum of 29 months if disabled. This extension applies if all of the following conditions are met: (1) the Qualifying Event was the covered employee's termination of employment or reduction of hours; (2) a Qualified Beneficiary (who may be the covered employee, his/her spouse, or his/her dependent child) has been issued a determination by the Social Security Administration, establishing that he/she was disabled at any time during the first 60 days of COBRA coverage; (3) a Qualified Beneficiary notifies the Plan Administrator, via the Human Resources department, of the Social Security Administration's determination within the 18 month period that begins on the date of the Qualifying Event; and (4) a Qualified Beneficiary notifies the Plan Administrator of the Social Security Administration's determination within 60 days after the latest of: (a) the date of the Social Security Administration's disability determination; (b) the date of the Qualifying Event: the employee's termination of employment or reduction of hours; (c) the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the employee's termination of employment or reduction of work hours; or (d) the date on which the individual is informed of the obligation to provide the disability

notice, and the procedures for providing such notice, through the Plan's Summary Plan Description or the initial COBRA notice. Each Qualified Beneficiary who has elected COBRA continuation coverage will be entitled to the 11 month extension if one of them qualifies.

Extension of COBRA Period Due to Second Qualifying Event-- If a spouse or dependent child experiences a second Qualifying Event while receiving health coverage through COBRA, he/she may be eligible to extend the COBRA period, up to a maximum of 36 months, 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. This extension is available to the spouse and eligible dependent children if the College employee/former employee dies, becomes entitled to Medicare benefits (Part A, Part B, or both), 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. Proper written notice of a second Qualifying Event must be made to the Plan Administrator, as outlined above under "Notification Requirements", within 60 calendar days of the second Qualifying Event.

COBRA Premiums

Year 2009 monthly premiums for continued coverage through the High Deductible Health Plan with Health Reimbursement Account are as follows:

HealthAmerica High Deductible Health Insurance Plan with Health Reimbursement Account—

\$411.17 per month for single coverage, \$820.48 per month for the individual plus one dependent, or \$1,113.70 per month for family coverage

If the COBRA continuation period is extended for up to 29 months due to disability, 150% of the group rate is charged during the 11 month extension.

Making COBRA Payments

When an employee/former employee, spouse, and/or dependent child elects COBRA coverage, he/she, or a third party representing the COBRA recipient, **must make the first payment for such coverage not later than 45 days after the date of his/her election of continued coverage.** If the first payment is not made in full in a timely manner, rights to continued coverage will be lost. Subsequent payments, after the first payment, are subject to a 30 day grace period; continuation coverage will be provided for each coverage period as long as payment is made before the end of the grace period. However, if payment is made later than the first day of the coverage period, but before the end of the grace period, COBRA coverage will be suspended as of the first day of the coverage period and then reinstated, retroactively, when proper payment is received. If a COBRA participant fails to make a periodic payment before the end of the grace period, he/she will lose all rights to COBRA continuation coverage.

The law requires that, at the end of the 18 month, 29 month, or 36 month continuation coverage period, participants be allowed to enroll in an individual conversion health plan if one is available under the terms of the College's Group Health Insurance &

Prescription Drug Plan. In addition, under the Health Insurance Portability & Accountability Act, in certain circumstances, such as when COBRA coverage terminates, an individual may have the right to buy individual health coverage with no pre-existing condition exclusion, and without providing evidence of good health. The College's health insurance carrier must be contacted directly to request conversion to an individual policy.

Questions about COBRA may be directed to Human Resources, (717) 291-3995, Ceridian Benefits Services, the College's 3rd party COBRA administrator, (800) 877-7994, Erin Group Administrators, the claims administrator for the HRA Plan, (717) 581-1300, or the U.S. Department of Labor's Employee Benefits Security Administration, www.dol.gov/ebsa.

Continuation of Coverage under USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") requires employers to provide coverage during qualified service of an employee in the Uniformed Services. This continued coverage, although similar to COBRA, may in certain circumstances provide rights in addition to those under COBRA. If an employee is on a qualified leave of absence under USERRA, when making an election to continue coverage under COBRA, the employee will also be making an election under USERRA. Where COBRA and USERRA provide different benefit protections, the law that provides greater protection will apply. For example, under USERRA if an employee is on a qualified leave of absence that lasts less than 31 days, the employee cannot be required to pay an insurance premium greater than what he/she would have paid if the employee had remained at work during this period.

During a Service leave, a full-time College employee will be eligible for coverage through this Plan for him/herself and covered dependents, at active employee rates, for up to 30 calendar days, if the employee is enrolled in the High Deductible Health Plan. In the case of Service leave exceeding 30 calendar days, USERRA requires the College to extend insurance coverage to the employee and his/her covered dependents, at 102% of the full premium, until the lesser of 24 months from the date the employee's civilian employment ended, or until the end of the period allowed for the individual to apply for reemployment. COBRA rights also apply to the employee and each of his/her covered dependents.

Coverage Under the Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans to notify plan participants and beneficiaries of certain benefits provided under the plan. The College's Group Health Insurance & Prescription Drug Plan, which includes the High Deductible Health Plan, provides the following coverage to any Plan participant or beneficiary who is receiving Plan benefits for a medically necessary mastectomy:

- 1) reconstruction of the breast on which the medically necessary mastectomy was performed;
- 2) any necessary surgery and reconstruction of the other breast to produce a symmetrical appearance;

- 3) the cost of prostheses (such as implants or special bras);
- 4) treatment for physical complications of all stages of mastectomy, including lymph edemas, as determined in consultation with the attending physician and the patient.

This coverage will be subject to the same deductibles and co-payments that apply to mastectomies under the Group Health Insurance & Prescription Drug Plan's terms in effect at the time of treatment.

The Newborns' and Mothers' Health Protection Act of 1996

The Newborns' and Mothers' Health Protection Act of 1996 requires group health plans, insurance companies, and HMO's which provide coverage for hospital stays following childbirth to provide coverage for a minimum period of time. In general, hospital coverage for the mother and newborn must be provided for a minimum of 48 hours following delivery, or 96 hours following a cesarean section. Group health plans may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following delivery, and less than 96 hours following a cesarean section. A group health plan cannot require that a provider obtain authorization from the plan or insurance carrier for a length of stay not in excess of these periods. The College's Group Health Insurance & Prescription Drug Plan, which includes the High Deductible Health Plan, provides coverage in compliance with The Newborns' and Mothers' Health Protection Act.

Health Insurance Portability and Accountability Act of 1996

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before a participant enrolls in a group health insurance plan ("pre-existing conditions"). In addition, HIPAA prevents discrimination against individuals based on their health status, and allows for special enrollment periods under certain circumstances. HIPAA also regulates the use and disclosure of "Protected Health Information".

Pre-existing Condition Exclusions-- Under the law, a pre-existing condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12 month exclusion period is reduced by an individual's prior health coverage. If, at the time an employee enrolls in a new employer's health plan, he/she already has had 12 months of continuous health coverage, without a break in coverage of 63 days or more, the employee will not have to start over with a new 12 month exclusion for any pre-existing medical conditions. If an individual was previously covered, he/she is entitled to a certificate of prior coverage from the insurer. A "Certificate of Creditable Coverage" must be provided to the individual by the plan when coverage is lost. Under HIPAA, pre-existing condition exclusions may not be applied to pregnancy. In addition, pre-existing condition exclusions may not be applied to a newborn, an adopted child, or a child placed for adoption who is under age 18 as long as the child becomes covered under the health plan within 31 calendar days of birth, adoption, or placement for adoption, and provided the child does not incur a subsequent 63 day or more break in coverage.

Health Status Discrimination-- HIPAA prohibits group health plans from establishing eligibility rules based on health status-related factors (such as medical condition, claims experience, medical history, genetic information, or disability). Plans may not require individuals to pay a greater premium based on a health status-related factor. However, plans may establish limits or restrictions on benefits or coverage for similarly situated individuals.

Special Enrollment Provisions-- HIPAA provides for special enrollment periods under certain circumstances. If an employee or retiree declines coverage under the Group Health Insurance & Prescription Drug Plan for him/herself and/or eligible dependents because of other coverage, the individual may be able to enroll him/herself and/or eligible dependents in the Plan, providing the appropriate enrollment form is completed and submitted within 30 calendar days after other coverage, including "COBRA", terminates due to loss of eligibility for such coverage. Under HIPAA, special enrollment rights are also granted when an employer's contributions toward an individual's other health insurance coverage ceases. In addition, if an employee/retiree acquires a new eligible dependent(s) through marriage, birth, adoption, or placement for adoption, such dependent may be enrolled in the Group Health Insurance & Prescription Drug Plan within 31 days of the marriage, birth, adoption, or placement for adoption. Under these circumstances, it is not necessary to wait until the annual Open Enrollment period to enroll in the Plan. The maximum pre-existing condition exclusion period for special enrollees is 12 months, reduced by the special enrollee's creditable coverage. No pre-existing condition exclusions may apply to a child if enrolled within 31 days of birth, adoption, or placement for adoption.

Use and Disclosure of Protected Health Information-- The Group Health Insurance & Prescription Drug Plan will use a participant's Protected Health Information (PHI), in accordance with HIPAA, only for required uses or purposes related to health care treatment, payment for health care, and health care operations. However, if a plan participant provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the authorization.

Further, the Plan will disclose PHI to the Plan Sponsor (Franklin & Marshall College) only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions. With respect to Protected Health Information, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual that is the subject of the PHI;
- Make PHI available to an individual in accordance with HIPAA's access requirements;

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available upon request an accounting of disclosures;
- Make available to the Health and Human Services Secretary internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made.

Security of Protected Health Information-- With respect to Electronic Protected Health Information (ePHI), the Plan Sponsor will:

- Implement administrative, physical, and technical standards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom the Plan Sponsor provides electronic PHI agrees to implement reasonable and appropriate security measures; and
- Report to the Plan any security incident of which the Plan Sponsor becomes aware.

Electronic PHI is health information about a Plan participant that is in an electronic format. Health information includes information about the individual's past, present, or future physical or mental condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.

Benefit Denials and Claims Procedures

The procedures Plan participants are required to follow to file a complaint or grievance pertaining to denial of payment, benefits, or coverage through the Group Health Insurance & Prescription Drug Plan are available to all Plan participants and beneficiaries, at no cost. These procedures are provided with the Certificate of Insurance, which is furnished automatically to employees upon enrollment, and is also available upon request, and at no charge, from the Plan Administrator and the health insurance carrier. Plan participants must follow the procedures described in the Certificate of Insurance to appeal denial of a claim for payment or benefits under the High Deductible Health Plan.

The Plan Administrator shall have the responsibility and authority, in its sole discretion, to decide eligibility for coverage through this Plan. If the Administrator denies a claim for coverage through this Plan, the Administrator promptly and in writing shall notify the individual of such denial. The notification of denial will be made not later than within thirty (30) days of receipt of the individual's claim. This 30 day period may be extended for an additional 15 days due to circumstances beyond the control of the Plan Administrator, including cases in which a claim is incomplete. The individual will receive written notice of any such extension, including the reason for the extension and the date by which a decision by the Administrator can be expected. The Plan Administrator may secure independent information or other advice and require such

other evidence as deemed necessary to decide a claim. A written notice of adverse benefit determination will be provided to the individual, and will include: (1) the specific reason(s) for the denial of benefits, (2) the specific Plan provision on which the denial is based, (3) a description of any additional material or information necessary for the individual to complete a claim and an explanation of why such information is necessary, and (4) an explanation of the right of appeal and the process to appeal the adverse benefit determination, including an explanation of the individual's right to review relevant documents and information, and his/her right to file suit under the Employee Retirement Income Security Act (ERISA) with respect to any adverse determination after appeal of a claim.

If a claim is denied in whole or in part, the individual may appeal to the Plan Administrator for review of the claim. The appeal must be made within one hundred, eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination. If the appeal is not made within 180 days, the individual will lose his/her right to appeal and to file suit in court. The individual's written appeal should state the reasons that he/she believes the claim should not have been denied. It should include any relevant facts and/or documents to support the claim. The individual may ask additional questions of the Plan Administrator, make written comments, and may review (on request and at no charge) documents and other information relevant to the appeal. The Plan Administrator will review and decide the individual's appeal within a reasonable time and, within sixty (60) days after receiving the written appeal, shall render, in writing, a decision. The individual who reviews and decides the appeal will not be the same individual who originally denied the claim for benefits, or that individual's subordinate. The Plan Administrator may require additional relevant information to decide the claim. If the decision on appeal affirms the initial denial of the individual's claim for benefits under the Plan, he/she will be furnished with a notice of adverse benefit determination on review, which includes the following: (1) the specific reason(s) for the denial, (2) the specific Plan provision(s) on which the denial is based, (3) a statement of the individual's right to review (on request and at no charge) relevant documents and other information, (4) a description of any internal rule, guideline, or protocol, if applicable, used to make the benefit determination and a statement that such rule, guideline, or protocol will be provided to the claimant upon request at no charge, and (5) a statement of the individual's right to bring suit under ERISA.

Claims and appeals of adverse benefit determinations are to be addressed to Human Resources, Franklin & Marshall College P.O. Box 3003, Lancaster, PA 17604-3003.

Plan Amendment, Modification, and Termination

This Plan may be amended or terminated by Franklin & Marshall College at any time. No consent of any participant or beneficiary is required to terminate, modify, amend, or change the Plan.

Plan benefits and other costs are subject to change at the sole discretion of the College. Additionally, for COBRA participants and dependents, coverage and costs are subject to change following termination of employment.

Statement of ERISA Rights

Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

Receive information about the Plan and benefits-- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan (including, if applicable, insurance contracts and collective bargaining agreements), and a copy of the latest annual report (Form 5500 Series) filed by the Plan, if the Plan is required to do so, 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, if applicable, insurance contracts and collective bargaining agreements), and copies of the latest annual report (Form 5500 Series), if the Plan is required to file such form, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if the Plan is required to prepare such a report-- The Plan Administrator is required by law to furnish each participant with a copy of any summary annual report.

Continue Group Health Plan coverage-- Continue health insurance coverage for self, and dependent spouse or dependent children if applicable, if there is a loss of coverage under the Plan as a result of a Qualifying Event. A participant and his/her dependents will be required to pay for such coverage. This Summary Plan Description includes rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Group Health Plan, if you have Creditable Coverage for another plan-- You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under a health insurance plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, an individual may be subject to a preexisting condition exclusion for 12 months (up to 18 months for late enrollees) after enrolling in a health insurance plan.

Prudent action by Plan Fiduciaries-- In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an 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 you and other Plan participants and beneficiaries. No one, including your employer or any other person, may terminate your employment 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 a 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 participants can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report (if applicable) from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about this HRA Plan, you should contact the Plan Administrator, via Franklin & Marshall College's Human Resources department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

In no case will a Plan participant, or anyone acting on a participant's behalf, be entitled to challenge a decision of the Plan Administrator in court or in any other administrative proceeding unless and until the claim and appeal procedures described in this Summary Plan Description have been complied with and exhausted.