

Shared Services Group Health Plan Summary Plan Description

This Summary Plan Description describes the health, prescription drug, and vision care coverage available to eligible employees and retired employees of Franklin & Marshall College ("the College") through the Shared Services Health Plan (the "Health Plan" or "Plan"), as in effect on January 1, 2010. This Summary Plan Description ("SPD") is required by The Employee Retirement Income Security Act (ERISA) of 1974, as amended. The purpose of this SPD is to acquaint employees, including retired College 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. The Plan is established for the benefit of employees, their covered dependents, and their beneficiaries, and is administered impartially for the benefit of all eligible participants.

Shared Services Health Plan participants receive a packet of information from the Plan's third party administrator and the vision benefits administrator upon enrollment in the Plan, including a Plan Summary (which includes a Summary of Benefits) and a Summary of Vision Care Benefits. The Plan Summary and Summary of Vision Care Benefits contain important details about the Health Plan, including coverage levels, covered and non-covered services, exclusions, and pre-certification requirements. Some medical services and procedures, as well as prescription medicines and vision services, may not be covered through the Shared Services Health Plan. Plan participants are strongly encouraged to carefully read the Plan Summary and Summary of Vision Care Benefits.

Facts About the Plan

Plan Name: Shared Services Health Plan

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

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

Plan Sponsor's Employer Identification Number: 25-1882792

Original Plan Effective Date: November 1, 2008

Plan Year: January 1 through December 31

Type of Plan: Welfare Plan providing medical, prescription drug, and vision benefits

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

Named Fiduciary for benefits provided to Franklin & Marshall College Plan

Participants: Franklin & Marshall College, Lancaster, PA 17604-3003

Plan Benefits Determined By: The third party administrator for the medical and prescription drug benefits, Highmark Blue Shield (“Highmark”), determines whether services and supplies are eligible for coverage through the group Health Plan, and reviews and processes eligible claims. Vision benefit claims are processed by National Vision Administrators, LLC (“NVA”), 1200 Route 46 West, Clifton, NJ, 07013.

Agent for Service of Legal Process: Shared Services Consortium, LLC, 6 Kacey Court, Mechanicsburg, PA 17055 (717) 796-2200.

Funding: Costs associated with providing group health, prescription drug, and vision coverage through the Shared Services Health Plan are paid by Franklin & Marshall College, through general employer assets; by enrolled College employees, through payroll deductions that can be made, at the employee's election, either pre-tax or after taxes have been withheld from salary; enrolled retired employees; and COBRA participants.

Plan Benefits:

Medical Coverage

Medical coverage is provided for eligible employees, benefits-eligible retired employees, and their eligible dependents enrolled in the group Health Plan. Franklin & Marshall College currently offers the following “Preferred Provider Organization” (PPO) health plan options, administered by Highmark Blue Shield:

1. the High Deductible Health Plan for employees and their eligible dependents (“*HDHP*”),
2. the PPO Health Plan \$250 for employees, retired College employees, and eligible dependents (“*PPO Health Plan \$250*”),
3. the PPO Health Plan \$100 for employees, retired College employees, and eligible dependents (“*PPO Health Plan \$100*”).

Medical and prescription drug benefits as described in the Plan Summary are provided under the group Health Plan. Coverage is provided for eligible services and supplies that are Medically Necessary and Appropriate as described in the Plan Summary.

A copy of the Plan Summary is provided to each participating College employee and retired employee upon enrollment. Additional copies are available to any participant or beneficiary, at no charge, from Franklin & Marshall College, Human Resources, P.O. Box 3003, Lancaster, PA 17604-3003, (717) 291-3995, and from Highmark Blue Shield, (800) 345-3806 or on their website at www.highmarkblueshield.com. Copies of the Plan Summary are also available through eDisk, in the "Groups", "Human Resources" "Public" folder. A listing of Participating Providers can be found by calling Highmark Blue Shield at (800) 345-3806, or via their website at www.highmarkblueshield.com.

The Plan Summary from the third party administrator includes important details about medical and prescription drug benefits, including coverage levels, covered and non-covered services, exclusions, pre-certification requirements, and claims procedures. Some medical services and procedures may not be covered through the Health Plan, even if Medically Necessary and Appropriate (as defined in the Plan Summary). Plan participants are strongly encouraged to read the Plan Summary.

The High Deductible Health Plan includes an employer-funded Health Reimbursement Account. This Account is described in the SPD for that plan, available from Human Resources.

Network Benefits

Each time a Plan participant seeks medical care, the participant decides whether to receive treatment from a "Network" health care provider and receive the highest level of coverage, or seek treatment from an "Out-of-Network" health care provider and receive a reduced level of coverage. A Network provider is a health care provider (including hospital, primary care physician, specialty care physician, and other licensed and accredited health care practitioner) who is contracted with the third party administrator (Highmark Blue Shield) to provide services to Plan participants, and participates in the third party administrator's provider network.

If Medically Necessary and Appropriate treatment is provided by a Network health care provider in accordance with the third party administrator's utilization management policies and procedures, most eligible services are covered at a 100% level, after applicable co-payments and applicable deductibles have been paid by the participant.

Enrolled employees, College retirees, and covered dependents living outside the third party administrator's local service area may receive health care services from providers who participate in their own local Blue Cross Blue Shield PPO network. Medically Necessary and Appropriate covered services will be covered at the Network level of benefits. If a provider is not part of the local Blue Cross Blue Shield PPO network, services will be covered at the lower Out-of-Network level of benefits.

Out-of-Network Benefits

Out-of-Network health care providers are those who are not contracted with the third party administrator (Highmark Blue Shield) to provide services to Plan participants. If a Plan participant receives Medically Necessary and Appropriate treatment from an Out-of-Network health care provider, a lower level of coverage applies. "Coinsurance", or the amount paid by the Health Plan, equals 80% of "Provider's Reasonable Charges" if a participant is enrolled in the PPO Health Plan \$100, or 70% if enrolled in the High Deductible Health Plan or PPO Health Plan \$250. "Provider's Reasonable Charges" are those determined by the third party administrator to be reasonable fees. The "Provider's Reasonable Charge" is used to calculate the payment to a provider and the Plan participant's liability. **The participant is responsible for paying coinsurance charges (20% or 30% based on the health plan option in which the individual is enrolled) plus all charges in**

excess of the "Provider's Reasonable Charges", in addition to applicable co-payments and deductibles. When receiving treatment from an Out-of-Network, non-participating health care provider, a participant may incur substantial costs that will not be reimbursed through the Health Plan.

BlueCard and BlueCard Worldwide – Out-of-Area and Worldwide Care

Most Medically Necessary and Appropriate services that are received from health care providers across the country and worldwide who participate in the "BlueCard" or "BlueCard Worldwide" network (their local Blue Shield PPO network) are covered at 100%, after the participant pays applicable co-payments and deductibles.

If a Plan participant receives covered services from a provider who is *not* part of a BlueCard network, services will be covered at a lower level - 80% if enrolled in the PPO Health Plan \$100, or 70% if enrolled in the High Deductible Health Plan or PPO Health Plan \$250. The amount that a Plan participant will be reimbursed for covered services is a percentage (80% or 70% based on the health plan option in which the individual is enrolled) of the lesser of: (a) the billed charges or (b) the negotiated price that the on-site Blue Cross or Blue Shield Plan ("Host Blue") passes on to Highmark Blue Shield. Please see the Plan Summary for more information on how these charges are calculated. **When receiving treatment from a health care provider who does not participate in the BlueCard network, a Plan participant may incur substantial costs that will not be reimbursed through the Health Plan.**

When receiving health care services abroad, the Plan participant may be required to pay the provider and then complete and submit an international claim form. The claim form may be obtained by calling the third party administrator (Highmark Blue Shield).

As noted below, treatment which is considered emergency medical care, as determined by the third party administrator, is covered at the Network level, whether provided by an in-Network or Out-of-Network health care provider. For participants enrolled in the High Deductible Health Plan or the PPO Health Plan \$250, all emergency room visits are subject to a \$50 co-payment, which must be paid by the participant. This emergency room co-payment is waived if the participant is admitted as an inpatient to a hospital and the applicable inpatient co-payment applies.

Annual Benefit Maximum-- The maximum benefit which will be paid under the group Health Plan per enrolled member is \$20,000,000 per calendar year.

Claim Forms-- Participants who receive treatment from a Network (participating) health care provider are not required to submit claim forms to the third party administrator. Plan participants may be required to submit a claim form to the third party administrator if they receive services from an Out-of-Network (non-participating) health care provider.

Emergency Care-- Treatment which is considered emergency medical care, as determined by the third party administrator, is provided within and outside the provider network, as described in the Plan Summary. Coverage at the Network level of benefits is provided for emergency care received from either a Network (participating)

or Out-of-Network (non-participating) provider. For participants enrolled in the High Deductible Health Plan or the PPO Health Plan \$250, all emergency room visits are subject to a \$50 co-payment, which must be paid by the participant.

Pre-certification Requirements-- The group Health Plan provides coverage for covered services that are Medically Necessary and Appropriate. Pre-certification, through the Plan's third party administrator, is required for all inpatient admissions and certain outpatient procedures to determine medical necessity and appropriateness. Highmark Healthcare Management Services must pre-certify all inpatient admissions. Planned admissions must be pre-certified prior to the admission; emergency and maternity admissions must be certified within 48 hours of the admission.

Some facility providers will obtain pre-certification of the inpatient admission on the Plan participant's behalf. Plan participants should verify through Highmark that the certification has occurred. If the facility does not pre-certify the admission on the participant's behalf, the Plan participant is to contact Highmark Healthcare Management Services directly. Necessary phone numbers are listed on the Highmark health plan ID card. The group Health Plan will not provide coverage for treatment that is not determined to be Medically Necessary and Appropriate.

Pre-existing Condition Exclusions-- There are no pre-existing condition exclusions contained in the Health Plan.

Referrals—A referral from a Plan participant's Primary Care Physician is not required before visiting another provider or specialist. Pre-certification is required for some services in order for coverage to be provided, as explained above and in the Plan Summary.

Prescription Drug Coverage

Prescription drug coverage is provided for employees, retired employees, and their eligible dependents enrolled in the group Health Plan. Coverage is provided for included prescription drugs and supplies which are prescribed by a licensed physician, dentist, or health care provider for use by the Plan participant. Prescription medicines are drugs approved by the FDA for a specific use that may be dispensed only through a prescription order or refill.

To receive coverage, Plan participants must purchase prescription medicines from a Highmark Network - participating - pharmacy and must show their Highmark Blue Shield identification card at the time of purchase. Many prescription medicines used on a regular basis may be purchased through the Medco mail order program.

Coverage is not provided through the Health Plan if prescription medicines are purchased from an Out-of-Network or non-participating provider.

Prescription drug coverage is subject to the exclusions and limitations outlined in the Plan Summary. **The Plan Summary contains important information about prescription drug coverage, including covered and non-covered medicines and exclusions. Some prescription medicines are not covered through the group Health Plan,** including but not limited to experimental/investigative drugs; most vitamin and mineral supplements; most over-the-counter products, medicines, and supplies; hair growth stimulants; blood products; and drugs prescribed for cosmetic purposes. Coverage for some prescription medicines is provided only up to specified quantities

and/or dosages. Plan participants are strongly encouraged to read the Prescription Drug provisions of the Plan Summary or may contact the third party administrator (Highmark).

Generic Substitution Requirement-- The Health Plan provides coverage for generic as well as brand name drugs. However, if a Plan participant purchases a brand name drug when a generic alternative exists, the participant will be required to pay the required brand name co-payment, plus the full difference between the generic drug cost and the brand name drug cost.

Vision Care Benefits

Coverage for certain routine vision care services and eyewear is provided for employees, retired employees, and their eligible dependents enrolled in the Health Plan. Coverage is provided as stated in the Summary of Vision Care Benefits. Annual benefit limits apply.

Coverage Limits

Coverage limits apply to certain services and supplies as listed in the Plan Summary and the Summary of Vision Care Benefits, even if such services are Medically Necessary and Appropriate. Services with coverage or benefit limits include spinal manipulations, physical medicine, speech therapy, occupational therapy, prosthetics, home health services, infertility treatment, private duty nursing, treatment in a skilled nursing facility, and vision services and supplies. Coverage limits also apply to certain prescription medicines.

The above represents only a summary of services and supplies for which calendar year coverage limits or benefit limits apply. The Plan Summary and Summary of Vision Care Benefits contain a listing of services, supplies, and medicines for which limited coverage is provided. A copy of these documents may be obtained by contacting the Plan Administrator (via Human Resources), Highmark Blue Shield, or National Vision Administrators (NVA).

Excluded Services

Coverage for some medical services, treatments, and supplies is not provided through the Health Plan, even if Medically Necessary and Appropriate. Additionally, services that are *not* considered Medically Necessary and Appropriate, as determined by the third party administrator, are not covered. The Health Plan does not provide coverage for any dental or other services except as provided in the Plan Summary. **The Plan Summary includes a full list of Plan benefits, limits, and exclusions, and should be carefully read by each participant.**

Eligibility for Coverage

The following classes of employees, and their eligible dependents, may enroll in the College's group Health Plan:

Class A:

- full-time faculty and professional staff employees: Franklin & Marshall College employees who are appointed to full-time positions and 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; 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 appointed to full-time positions and 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 and per provisions of the College's *Faculty Handbook* (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

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

Class B:

- Medicare-eligible retired employees: full-time College employees who, on the date active employment is terminated, have completed at least ten (10) consecutive full years of full-time employment with Franklin & Marshall College in a benefits-eligible class after the age of 50 (are at least age 60 with at least 10 consecutive years of full-time employment with Franklin & Marshall College after the age of 50), and who are eligible and enrolled through the federal Medicare program

Class C:

- full-time faculty members who meet all criteria for participation in the Phased Retirement Program, and who terminate their employment under an approved Phased Retirement Agreement which provides continued group Health Plan coverage

- full-time professional staff members who terminate their employment under an approved Voluntary Early Retirement Program Agreement which provides continued group Health Plan coverage
- full-time College employees who terminated their employment under an approved Voluntary Separation Agreement which provided continued group Health Plan coverage

Class D:

- non-Medicare-eligible retired employees: full-time College employees who, on the date active employment is terminated, have completed at least ten (10) consecutive full years of full-time employment with Franklin & Marshall College in a benefits-eligible class after the age of 50 (are at least age 60 with at least 10 consecutive years of full-time employment with Franklin & Marshall College after the age of 50); are not eligible, or not yet eligible, for coverage through the federal Medicare program; and did not terminate employment via an approved College early retirement program which provided continued Health Plan coverage at reduced rates

For classes B, C, and D, coverage is provided for the College retiree; the retiree plus one dependent; or the retiree plus two or more dependents.

Retired employees are not eligible for coverage through the High Deductible Health Plan, except on a temporary basis following employment termination as permitted through "COBRA".

A retired College employee who is eligible for coverage through the federal Medicare program, and his/her covered dependent, if applicable, who is eligible for coverage through Medicare, must enroll in Medicare Parts A and B on the earliest possible date following employment termination in order to retain coverage through the College's group Health Plan. Currently, there is no requirement that retired employees enroll in a Medicare Part D prescription plan.

Independent contractors, contracted employees, adjunct faculty, employees appointed to positions classified as "part-time", individuals who volunteer their services without compensation, students, student employees, and those not in a covered class are not eligible for coverage through the Health Plan.

Eligible Dependents

For purposes of the group Health Plan, eligible dependents who can be enrolled through the Plan are:

1. a covered employee's or retiree's legally-recognized spouse, or same-sex Domestic Partner as defined by the College's policies, and
2. dependent children.

A Domestic Partner is defined as the unmarried partner of a College employee or retired employee who is: 1) of the same sex as the employee or retiree, and 2) sharing a long-term, committed relationship of indefinite duration with the employee or retiree, with all of the following characteristics: (a) the partners have an exclusive mutual commitment similar to that of marriage, the partners live together, and the partners intend to maintain their commitment indefinitely, (b) neither partner is legally married to anyone else or has

another domestic partner, (c) the partners are not related by blood closer than would bar marriage in the Commonwealth of Pennsylvania or the state of their residence, (d) both partners are at least 18 years old, (e) the partners are financially responsible for each other's well-being and debts to third parties, and can provide documentation of such responsibility; both partners have entered into a contractual commitment for that responsibility, or both have joint ownership of significant assets (such as home, car, bank accounts) and joint liability for debts (such as mortgages and major credit cards).

Dependent children are defined as a covered employee's or retiree's biological children, legally adopted children, children legally placed for adoption, step children, and children of the employee's or retiree's same-sex Domestic Partner who:

- a) are unmarried,
- b) are *under* age 19 (through age 18),
- c) have the same principal place of residence as the employee-parent or retiree-parent for more than six months of the calendar year (more than 182 days), and
- d) do not provide more than half their own support during a calendar year.

Dependent children for whom the covered employee or retiree or his/her legal spouse or same-sex Domestic Partner is the court-appointed legal guardian, and dependent children for whom the employee or retiree is required to provide health coverage pursuant to a Qualified Medical Child Support Order are also eligible for coverage through the Plan.

A child over age 18 who is otherwise an eligible dependent will continue to be eligible for group Health Plan coverage through age twenty-two (22), provided the child:

- a) is unmarried,
- b) is *under* age 23,
- c) is a *full-time* student at an accredited school (enrolled on a basis considered full-time by the school the child is attending),
- d) has the same principal place of residence as the employee-parent or retiree-parent for more than 6 months of the calendar year, except if away from home to attend school, and
- e) is primarily dependent upon the covered employee or retiree for support (the child does not provide more than one half his/her own support during a calendar year and the employee or retiree provides over half of the child's financial support).

Coverage will be discontinued for a child who does not meet the criteria above, including those over age 18 whose status changes from full-time student to part-time student. However, coverage through the Health Plan will continue for any dependent child who is unable to attend school due to a medically necessary leave of absence related to a serious illness or injury. Coverage will continue for up to one year, unless it would have otherwise terminated under the Plan for reasons not related to the medically necessary leave of absence. A physician's certification may be required for coverage to continue.

An eligible dependent child who is mentally or physically incapable of earning a living and chiefly dependent on the covered employee or College retiree for support (the employee or retiree provides over half of the child's financial support) will continue to be

eligible for coverage through the Health Plan, provided that the onset of incapacity occurred before the age of 19. The Plan Administrator and third party administrator reserve the right to request verification of disability.

Coverage is not provided through the group Health Plan to an employee's or retiree's grandchild(ren) or to other relatives not listed above.

The Plan Administrator and the third party administrator reserve the right to require verification of dependent status (such as a copy of the most recent tax return, a copy of a court order, etc.) before approving coverage for a dependent. Employees and College retirees with children over the age of 18 enrolled in the Health Plan will be required to provide verification of dependent status, as requested, to the Plan Administrator and/or third party administrator.

Enrollment

Eligibility for coverage for employees begins the first day of the calendar month following, or coinciding with, appointment to a regular full-time position in an eligible class as described above. An eligible employee must submit a properly completed enrollment form within 31 calendar days of the first day of eligibility, in order to be enrolled in the Plan.

If an enrollment form is not completed and returned to the Plan Administrator (via the Franklin & Marshall College Human Resources office), the employee will be deemed to have declined coverage through the Health Plan.

If the enrollment form is not submitted to the Plan Administrator (via Human Resources) within 31 calendar days of the first day of eligibility, coverage through the Plan shall become effective no sooner than the next January 1, barring any special enrollment rights and assuming an enrollment form is completed and returned by January 1.

If an eligible employee or College retiree has previously opted-out of the Plan, he/she may enroll by completing and submitting an enrollment form during the annual Open Enrollment period, which begins each November on the date announced by the Plan Administrator and ends each December on the date announced by the Plan Administrator, with coverage effective the next January 1.

Providing a Plan participant and his/her covered dependent(s) remain eligible for coverage, coverage will continue until the participant completes and submits the proper form to terminate coverage. Employees and retired employees will be required to pay their applicable share of premiums, which may vary from year-to-year, to continue their coverage.

An employee or College retiree and each of his/her covered dependents must enroll in the same health plan option.

Before enrolling a same-sex Domestic Partner, and child(ren) of a same-sex Domestic Partner, a Certification of Same-sex Domestic Partnership (available from Human Resources and in the Human Resources public folder in eDisk) must be completed by the employee or retiree and his/her same-sex Domestic Partner, and returned to the Plan Administrator (Human Resources). If an employee's or retired employee's covered Domestic Partner is no longer eligible for coverage because he/she no longer qualifies as

a Domestic Partner per the College's Domestic Partner Policy, the Plan participant may not cover another Domestic Partner as a dependent for a period of 12 months from the date benefit coverage terminated for the previous Domestic Partner.

Failure to Enroll

If an employee who is eligible for health coverage through the Plan fails to complete and return the proper enrollment form to the Plan Administrator (via Human Resources) within 31 calendar days of his/her initial date of eligibility, the employee shall be deemed to have elected not to participate and receive benefits through the Plan.

An employee or retiree may elect not to participate in the Plan by returning the enrollment form stating that he/she elects to "opt-out".

If an employee or retiree fails to re-enroll during the Open Enrollment period and is still eligible to participate, the employee or retiree shall be deemed to have elected to remain enrolled in the same health plan option as in effect for such participant during the immediately preceding Plan Year. The applicable premium for the current calendar year will be required, and benefits and coverage levels will be based on the plan design for the current Plan Year.

An employee or retiree who is not a Plan participant and fails to complete and submit an enrollment form during the Open Enrollment period shall be deemed to have elected not to receive benefits through the Plan.

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

Generally, an employee or College retiree may add a dependent(s) to his/her health coverage through the Plan, or delete a dependent(s) from coverage, and make other election changes only once per year, during the annual Open Enrollment period, with the change effective the next January 1.

Changes to Plan elections may only be made after the start of the Plan Year (January 1), and for the balance of the Plan Year, if:

- a participant experiences a "Change in Status", as defined by the Internal Revenue Service, that affects eligibility for coverage (see below)
- an employee or retiree, spouse, or dependent becomes qualified for, or loses, coverage under Medicare or Medicaid or under the Children's Health Insurance Program (CHIP); or if it is determined that the employee, spouse, or dependent is eligible for premium assistance under Medicaid or CHIP
- an employee or retiree or dependent qualifies for special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA): an individual who is otherwise eligible for health coverage through the College's Health Plan, but declined coverage because he/she had other health insurance coverage, is permitted to enroll in the College's Plan upon loss of eligibility for other coverage or upon termination of "COBRA" coverage under another employer's plan; an eligible individual may enroll in the College's Plan if his/her employer's contributions toward other coverage cease; and an employee or retiree may enroll him/herself and eligible dependents following marriage, birth of a child, adoption, or placement for adoption. Loss of eligibility for coverage may occur (1) when an individual meets the lifetime maximum benefit level under another

employer's health plan, or (2) when the other employer no longer offers any benefits to a class of similarly-situated individuals.

- an employee takes an unpaid leave of absence per the Family & Medical Leave Act
- an employee's or retiree's spouse or dependent child makes permissible election changes under his/her employer's health plan, such as during an Open Enrollment period
- a benefit option is significantly curtailed: when the Plan Administrator determines that the coverage for an employee or retiree, spouse, or dependent child has been "significantly curtailed" with or without a loss of coverage, the employee or retiree can revoke the current election and must elect coverage under a similar benefit option. However, if the employee or retiree, spouse, or dependent experiences a loss of coverage as a result of the curtailment, the participant has the option of not electing replacement coverage under the Plan. Whether there has been a loss of coverage or a significant curtailment in coverage will be determined in the sole discretion of the Plan Administrator, and applied on a consistent basis. A loss of coverage may occur when there is a substantial decrease in the providers who participate in a benefit option or if there is a reduction in benefits for a specific medical condition for which the employee or retiree, spouse, or dependent is currently under treatment. Coverage is considered to be "significantly curtailed" only if there is an overall reduction in coverage.
- a benefit option is added or significantly improved: when the Plan adds a new benefit option or significantly improves an existing option, the Plan Administrator may permit participants to make an election change to participate in the new or significantly improved option, on a prospective basis, and to revoke their elections under any similar benefit option. The Plan Administrator, in its sole discretion and applied on a consistent basis, will determine whether there has been an addition of or significant improvement in a benefit option.
- an employee or retiree, spouse, or dependent or a benefit option under the Plan experiences a relevant, significant change in cost: if the Plan Administrator determines that the cost charged to an employee or retiree for a specific benefit option has significantly increased, the employee or retiree can revoke his/her election for that coverage and elect coverage under another benefit option. If the Plan Administrator determines that the cost charged to an employee or retiree for a specific benefit option has significantly decreased, an employee or retiree may revoke any existing elections and elect coverage under the option with the cost decrease. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether a cost increase or decrease is significant based on IRS guidance.

or

- the Plan receives a court order, such as a Qualified Domestic Relations Order or Qualified Medical Child Support Order, requiring the College's Health Insurance Plan to provide coverage for a dependent(s)

Each of the following qualifies as a "Change in Status" based on current Internal Revenue Service regulations:

- a change in marital status due to marriage, death of a spouse, divorce, legal separation, or annulment

- a change in number of dependents due to birth, death, adoption, or placement for adoption
- a change in employment status due to commencement or termination of employment, commencement of or return from unpaid leave of absence, a change in work site by the employee or dependent, or other change in employment that leads to a loss or gain of eligibility of the employee, spouse, or dependent under a plan
- a change in a dependent's ability to satisfy the requirements for coverage due to attainment of age or full-time student status
- a change in the place of residence or work of the employee or retiree, spouse, or dependent that affects eligibility for coverage

Any mid-year election change(s) must be **on account of and consistent with** the status change experienced by the employee or retiree.

Additional Information Regarding Mid-year Election Changes:

- Except in limited circumstances, benefit election changes made on account of a "Change in Status" as described above must be applied prospectively.
- Other than in the case of birth, adoption, or placement for adoption, changes to benefit plan elections made on account of a status change will be effective the first of the calendar month following the status change. For example, if a College Health Plan participant marries on May 14, coverage for the new spouse will be effective on June 1, assuming the employee properly completes and submits a Health Plan enrollment form within 31 days of the June 1 eligibility date. However, if an employee gives birth on May 14, health coverage for the new dependent through the Plan will be effective as of May 14, if the employee properly completes and submits an enrollment form within 31 calendar days of the birth date (May 14).
- Plan participants' pre-tax Health Plan premiums will automatically be adjusted, through the Insurance Premium Payment Plan, if there is an increase or decrease in the cost of coverage through the group Health Plan. Such adjustments will be made prospectively.
- A Plan participant may not cancel coverage for him/herself or a dependent upon becoming eligible for health insurance coverage through another plan unless the employee or dependent actually becomes covered through the other plan.
- If an employee terminates employment and is then rehired by the College within 30 calendar days, he/she will not be permitted to change previous Health Plan and Flexible Spending Accounts elections, unless the employee has experienced another "Change in Status" or relevant event as described above.
- Health coverage may not be cancelled by a participant if he/she experiences a "significant curtailment" or change in coverage that does not constitute a loss of coverage. Health Plan premiums for retroactive coverage may only be paid on an after-tax basis, except in the case of birth, adoption, or placement for adoption.

Adding or Deleting Dependents

If an employee or College retiree experiences a "Change in Status" or other relevant event as described above, and wants to add an eligible dependent to his/her Health Plan coverage, notification to the Plan Administrator (via the Human Resources office) must be made by the end of the Enrollment Period. The Enrollment Period is within **31 calendar days** of the date an individual is first eligible for coverage, or 60 calendar days in the case of eligibility based on the determination that the Plan participant is eligible for premium assistance under Medicaid or CHIP. The employee or retiree must submit a completed Health Plan enrollment form to the Plan Administrator (via the Franklin & Marshall Human Resources office) within the Enrollment Period.

As noted above, if an employee or retiree wants to add his/her newborn child, newly adopted child, or child placed for adoption to College Health Plan coverage, an enrollment form must be completed and submitted to the Plan Administrator (Human Resources) within 31 calendar days of the birth, adoption, or date of placement for adoption. In the case of birth, adoption, or placement for adoption, the Enrollment Period is within 31 days of the birth, adoption, or placement for adoption. In the event of other changes in status, such as marriage, the Enrollment Period is within 31 calendar days of the 1st of the month following the event.

If an eligible employee or College retiree declines coverage for him/herself or an eligible dependent(s) because of other health insurance coverage, the employee or retiree may be able to enroll him/herself and eligible dependents in the College's Health Plan provided the appropriate enrollment form is completed and submitted within the Enrollment Period. If the form is properly completed and submitted to Human Resources within the Enrollment Period, Health Plan coverage for the dependent will be effective as of the first day of the month coinciding with or following the status change, except when a dependent is added due to birth, adoption, or placement for adoption; coverage in this case will be effective as of the date of birth or adoption. If the enrollment form is not submitted during the Enrollment Period, coverage or election changes will be effective the next January 1 if a proper enrollment form is submitted during the annual Open Enrollment period.

Employees and College retirees are required to notify the Plan Administrator (via Human Resources) of a "Change in Status" or other event that makes a dependent ineligible for coverage through the Plan. To delete a dependent from coverage, the employee or retiree must submit a Health Plan enrollment form to the Plan Administrator **within 31 calendar days** of the status change. The dependent's coverage will be terminated at the end of the calendar month in which the "Change in Status" occurs.

Note: Coverage will terminate at the end of the calendar month in which an event or status change occurs which makes an employee, retiree, or dependent ineligible for coverage, even if proper notice is not provided to the Plan Administrator within the required time period. **Any claims incurred after a Plan participant becomes ineligible for coverage will be the sole responsibility of the former Plan participant.** To be eligible for continued Health Plan coverage through "COBRA", written notice must be provided to the Plan Administrator (via Human Resources) within 60 calendar days of a "Qualifying Event" which results in loss of coverage through the Plan (see below).

Qualified Medical Child Support Order

Procedures for determining whether a medical child support order is a "Qualified Medical Child Support Order" are available from the Plan Administrator (via the Franklin & Marshall Human Resources office) upon request, and at no charge.

Plan Costs

Benefits provided under the group Health Plan, including medical, prescription drug, and vision benefits, are paid for by Franklin & Marshall College and employees, retired employees, and COBRA beneficiaries enrolled in the Plan.

Premiums

Active, full-time faculty and professional staff employees (class A) and retirees in classes B and C pay a portion of an actuarially-determined "premium equivalent" each month for their coverage through the Health Plan, based on the health plan option selected and their coverage level. Retired employees in eligibility class D pay the full (100%) actuarially-determined premium equivalent each month, based on the plan option selected and their coverage level.

Required participant-paid premiums may vary from year-to-year, at the sole discretion of the Plan Administrator, Franklin & Marshall College. The Plan Administrator will determine and communicate required participant-paid premiums each year during the Open Enrollment period.

The Plan Administrator will treat as imputed income to an employee or College retiree the value of health and prescription drug coverage provided to an individual who qualifies for coverage as a dependent through the Plan, but is not considered a legal dependent based on federal or state regulations. Any contribution by the employee or retiree for coverage for the dependent will be subtracted from the value of such coverage. Based on current federal regulations, the College must treat as imputed income to an employee or retired employee the value of coverage for his/her same-sex Domestic Partner and the partner's children, unless the Domestic Partner and children qualify as the employee's or retiree's dependents under the Internal Revenue Code.

Premiums are deducted from a covered employee's pay in equal installments. Active employees are automatically enrolled in the Franklin & Marshall Flexible Spending Accounts Plan upon electing group Health Plan coverage, which means each employee's share of costs is paid on a pre-tax basis through payroll deduction. Employees may elect to pay contributions, through payroll deduction, on an after-tax basis. To do so, an employee must notify the Plan Administrator (via Human Resources), annually and in writing, of his/her desire to make contributions on an after-tax basis. Such notice must be provided upon initial enrollment in the Plan, and during each annual Open Enrollment period.

Retired employees must submit their portion of costs to the Plan Administrator on an annual, semi-annual, quarterly, or monthly basis, no later than by the first day of the month when due.

Calendar year 2010 monthly participant-paid premiums for full-time faculty and professional staff (eligibility class A), retired employees enrolled through Medicare (class B), and employees who retired via the Phased Retirement Program for faculty or an approved early retirement program which provides Health Plan coverage (class C) are:

High Deductible Health Plan--

(available to active employees - eligibility class A - only)

\$36.00 per month for single coverage

\$71.00 per month for the employee and one dependent

\$106.00 per month for the employee and two or more dependents

PPO Health Plan \$250--

\$54.50 per month for single coverage

\$108.80 per month for the employee and one dependent

\$146.41 per month for the employee and two or more dependents

PPO Health Plan \$100--

\$121.79 per month for single coverage

\$243.18 per month for the employee and one dependent

\$326.76 per month for the employee and two or more dependents

Year 2010 monthly participant-paid premiums for College retirees not yet eligible for Medicare benefits, and who did not retire via an approved Phased Retirement or early retirement agreement (eligibility class D) are:

PPO Health Plan \$250--

\$484.36 per month for single coverage

\$787.01 per month for the retiree and one dependent

\$1,293.10 per month for the retiree and two or more dependents

PPO Health Plan \$100--

\$504.22 per month for single coverage

\$819.28 per month for the retiree and one dependent

\$1,345.22 per month for the retiree and two or more dependents

Premiums required of a retired College employee and his/her dependent(s) are based on the eligibility class of the retired College employee, regardless of the Medicare-eligibility status of the retired employee's covered dependent(s).

Retired employees who are eligible for health coverage through Medicare, and their covered dependents who are eligible for coverage through Medicare, must enroll in Medicare Parts A and B on the earliest possible date following employment termination in order to retain coverage through the College's group Health Plan.

Currently, there is no requirement that Medicare-eligible employees or retired employees enroll in a Medicare Part D prescription plan.

Other Costs

In addition to paying premiums, Plan participants pay deductibles, coinsurance, co-payments, and for Out-of-Network treatment, all charges above the “Provider’s Reasonable Charges” as determined by the third party administrator per the provisions of the benefit plan elected.

Retired employees enrolled through Medicare Parts A and B are also required to pay the applicable Medicare premiums per Medicare provisions.

Coinsurance

Coinsurance is the percentage of eligible charges the group Health Plan pays on behalf of a participant, after applicable deductibles and co-payments have been paid by the participant.

High Deductible Health Plan, Network Care-- the coinsurance rate for eligible charges is 100%, meaning the Plan pays 100% of medical care fees for covered services, after the participant has paid applicable deductibles and co-payments

High Deductible Health Plan, Out-of-Network Care-- the Plan pays 70% of “Provider’s Reasonable Charge”, and the Plan participant is responsible for 30%, plus applicable deductibles, co-payments, and all charges above those deemed the Provider’s Reasonable Charge by the third party administrator

PPO Health Plan \$250, Network Care-- the coinsurance rate for eligible charges is 100%, meaning the Plan pays 100% of medical care fees for covered services, after the participant has paid applicable deductibles and co-payments

PPO Health Plan \$250, Out-of-Network Care-- the Plan pays 70% of “Provider’s Reasonable Charge”, and the Plan participant is responsible for 30%, plus applicable deductibles, co-payments, and all charges above those deemed the Provider’s Reasonable Charge by the third party administrator

PPO Health Plan \$100, Network Care-- the coinsurance rate for eligible charges is 100%, meaning the Plan pays 100% of medical care fees for covered services, after the participant has paid applicable deductibles and co-payments

PPO Health Plan \$100, Out-of-Network Care-- the Plan pays 80% of “Provider’s Reasonable Charge”, and the Plan participant is responsible for 20%, plus applicable deductibles, co-payments, and all charges above those deemed the Provider’s Reasonable Charge by the third party administrator

“Provider’s Reasonable Charges”-- Provider’s Reasonable Charges are those determined by the third party administrator to be the reasonable fees received by similar physicians, hospitals, or other health professionals for the same service in the same geographic area. When a Plan participant receives treatment from an Out-of-Network health care provider, the Plan pays the Provider’s Reasonable Charge at the applicable coinsurance level. **All charges above those deemed the Provider’s Reasonable Charge by the third party administrator are the responsibility of the Plan participant.** Such amounts paid by a Plan participant do not count toward meeting deductibles or out-of-pocket maximums.

Deductibles

Participants pay the following deductibles each calendar year before the Plan makes payments. The Health Plan deductible does not apply to / is not charged for physician's office visits (although tests or outpatient procedures performed in conjunction with an office visit are subject to the deductible), prescription drug purchases, routine screening mammograms performed by a Network provider, emergency medical care in an emergency care facility, pediatric immunizations, and covered vision services.

High Deductible Health Plan, Network Care-- \$1,000 per calendar year for an individual and up to \$2,000 per calendar year for the family

High Deductible Health Plan, Out-of-Network Care-- \$3,000 per calendar year for an individual and up to \$6,000 per calendar year for the family

PPO Health Plan \$250, Network Care-- \$250 per calendar year for an individual and up to \$500 per calendar year for the family

PPO Health Plan \$250, Out-of-Network Care-- \$750 per calendar year for an individual and up to \$1,500 per calendar year for the family

PPO Health Plan \$100, Network Care-- \$100 per calendar year for an individual and up to \$200 per calendar year for the family

PPO Health Plan \$100, Out-of-Network Care-- \$250 per calendar year for an individual and up to \$500 per calendar year for the family

Participant-paid co-payments, prescription drug co-payments, payments for vision care, and payments for ineligible services are not applied toward (do not count toward meeting) an individual's Health Plan deductible.

Office Visit Co-Payments

Participants pay the following co-payments per office visit to a health care provider:

High Deductible Health Plan, Network Care-- \$20 per visit to a primary care physician and \$30 per visit to a specialist's office, including a chiropractor. A \$20 office visit co-payment applies to outpatient mental health care.

High Deductible Health Plan, Out-of-Network Care-- \$0 (coinsurance rate applies)

PPO Health Plan \$250, Network Care-- \$20 per visit to a primary care physician and \$30 per visit to a specialist's office, including a chiropractor. A \$20 office visit co-payment applies to outpatient mental health care.

PPO Health Plan \$250, Out-of-Network Care-- \$0 (coinsurance rate applies)

Additionally:

- a \$50 emergency room co-payment (waived if admitted to a hospital) and
- a \$100 inpatient hospital co-payment (\$750 if admitted to an Out-of-Network hospital)

apply to the High Deductible Health Plan and to the Health Plan \$250. These co-payments are in addition to the deductible and applicable coinsurance, and apply to each visit.

PPO Health Plan \$100, Network Care-- \$20 per visit to a primary care physician and \$30 per visit to a specialist's office, including a chiropractor. A \$20 office visit co-payment applies to outpatient mental health care.

PPO Health Plan \$100, Out-of-Network Care-- \$0 (coinsurance rate applies)

Prescription Drug Co-Payments

Participants in the group Health Plan pay the following co-payments when prescription medicine is purchased from a participating pharmacy:

Participating Retail Pharmacy Co-payment for a One Month Supply-

- Formulary Generic Medicine - 15% of the drug cost, with a \$5.00 minimum and \$15.00 maximum co-payment per prescription
- Formulary Brand Name Medicine - 25% of the drug cost, with a \$20.00 minimum and \$50.00 maximum per prescription
- Non-formulary Brand Name Medicine - 35% of the drug cost, with a \$40.00 minimum and \$70.00 maximum per prescription

Mail Order Co-payment for a 90-day Supply (purchased through the Medco mail order program)-

- Formulary Generic Medicine - 15% of the drug cost, with a \$10.00 minimum and \$30.00 maximum per prescription
- Formulary Brand Name Medicine - 25% of the drug cost, with a \$40.00 minimum and \$100.00 maximum per prescription
- Non-formulary Brand Name Medicine - 35% of the drug cost, with a \$80.00 minimum and \$140.00 maximum per prescription

When purchasing prescription medicine from a participating retail pharmacy, a "one month" supply equals a 31-day supply. One co-payment will be charged per "one month" supply of medicine. When purchasing medicine through the mail order program, one co-payment will be charged for an up-to-90-day supply of medicine.

"Formulary" medicines are those included on the Highmark Drug Formulary, which is available upon request and at no charge from the Franklin & Marshall Human Resources office and from the third party administrator (Highmark Blue Shield).

Prescription drugs in selected classifications will only be dispensed through an exclusive pharmacy provider and are limited to the retail cost sharing provisions and the retail days' supply. These selected prescriptions may be order by a physician or other health care provider, or the Plan participant may submit the prescription directly to the exclusive pharmacy provider, which will deliver the prescription. These drugs include:

- Oncology-related therapies

- Interferons
- Agents for multiple sclerosis and neurological related therapies
- Antiarthritic therapies
- Anticoagulants
- Hematinic agents
- Immunomodulators
- Growth hormones

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum amount the Plan participant will be required to pay each calendar year for *coinsurance charges*. The Plan participant may incur additional charges (deductibles, co-payments, amounts over the Provider's Reasonable Charge, and penalty fees) above and beyond the annual out-of-pocket maximum.

High Deductible Health Plan, Network Care-- does not apply

High Deductible Health Plan, Out-of-Network Care-- \$3,500 per individual, up to \$10,500 per family

PPO Health Plan \$250, Network Care-- does not apply

PPO Health Plan \$250, Out-of-Network Care-- \$3,500 per individual, up to \$10,500 per family

PPO Health Plan \$100, Network Care - does not apply

PPO Health Plan \$100, Out-of-Network Care-- \$1,000 per individual, up to \$2,500 per family

The maximum annual (per calendar year) out-of-pocket expense for prescription drugs, applicable to each health plan option, is:

- \$1,500 per individual, up to \$3,000 per family

Prescription drug out-of-pocket maximums are not coordinated with and are in addition to health care out-of-pocket maximums.

Coordination of Coverage with Other Plans

The group Health Plan will coordinate coverage with other plans, including Medicare, as described in the Plan Summary. Generally, the College's Plan is considered the primary plan for active employees and their dependents who are not covered through another employer's plan. The Plan is generally the primary plan for any *active employee* covered through Medicare. The Plan is generally the secondary plan for a spouse covered by his/her employer, and for a retired employee eligible for coverage through Medicare. If two plans cover a dependent child, the plan of the parent whose birthday falls earlier in the calendar year is generally the primary plan (unless a court order requires that the other plan be primary).

A retired College employee who is eligible for coverage through the federal Medicare program, and his/her covered dependent(s), if applicable, who is eligible for coverage through Medicare, must enroll in Medicare Parts A and B on the earliest possible date when first eligible following termination of employment, in order to retain coverage through the College's group Health Plan. Currently, there is no requirement that retired employees enroll in a Medicare Part D prescription plan. Retired College employees and their covered dependents pay premiums, co-payments, coinsurance, and deductibles as outlined above and per the Plan Summary.

Plan participants should refer to their Plan Summary for complete information regarding coordination of benefits.

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 Shared Services Group 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 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 that 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 caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, group health plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. The 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 third party administrator. 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. The Plan includes no pre-existing condition exclusions.

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 Shared Services Health 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 31 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 or retiree acquires a new eligible dependent(s) through marriage, birth, adoption, or placement for adoption, such dependent may be enrolled in the Shared Services Health Plan within 31 days of the birth, adoption, or placement for adoption, or in the case of marriage, within 31 days of the 1st of the calendar month after the date of marriage. 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.

Coverage During Family & Medical Leave

If a covered College employee takes a qualifying leave under the Family & Medical Leave Act of 1993, as amended (FMLA), then to the extent required by the FMLA, the College will continue to maintain the employee's group Health Plan coverage on the same terms and conditions as if the employee were still an active employee. During a paid leave under the FMLA, participation in the group Health Plan will continue for an employee, and his/her covered dependents, who otherwise remains eligible, and who was covered through the Plan immediately prior to commencement of leave. Premium contributions, at active employee rates, will be deducted from the employee's salary on a pre-tax / salary reduction basis as permitted by law, unless the employee previously elected to have premiums deducted on an after-tax basis.

During an unpaid leave under the FMLA, an employee may elect to continue or may discontinue coverage under the group Health Plan, and/or the Medical Expense Reimbursement Account of the Flexible Spending Accounts Plan.

An employee who is entitled to and takes an unpaid leave of absence under the FMLA and elects to continue coverage under the Plan while on FMLA leave must pay his/her share of the premiums for such coverage. Payments are to be made by the employee in one of the following ways:

Pre-payment Option-- an election by the employee to pre-pay all or a portion of the premiums due during the FMLA leave period on a pre-tax basis through salary reduction of not yet available pre-leave compensation, to the extent that such pre-tax payments will not be used to fund coverage during the next Plan Year. If an employee elects this pre-payment option, he/she must notify the Plan Administrator, via the Franklin & Marshall Human Resources office, at least one month in advance of commencement of leave. Pre-payment cannot be required as a condition of remaining in the Plan, nor can it be the only method available for paying premiums for coverage during an FMLA leave.

Pay-As-You-Go Option-- an arrangement under which the employee pays his/her share of health contributions on an after-tax basis by sending the payments to the College. Health premiums, at active employee rates, must be paid by the employee on a monthly basis and submitted to the Plan Administrator, via the Franklin & Marshall Human Resources office. Each monthly payment is due by the last work day of the month. If premium payments are more than 30 calendar days late, College health coverage will be terminated during the remainder of the leave.

If the employee elects to continue his/her coverage while on unpaid leave, the College will continue to pay its share of any premiums. If an employee's coverage ceases while on FMLA leave, upon return from such leave, he/she may elect to be reinstated in the Plan on the same terms that applied prior to the employee's FMLA leave, or as otherwise required by the FMLA.

Termination of an Individual's Group Health Plan Coverage

An employee's or a College retiree's coverage through the group Health Plan, and coverage for each of his/her dependents, will terminate when one or more of the following events occurs. Coverage terminates at 11:59 p.m. on the last day of the calendar month in which the event(s) occurs, unless noted below:

- a) employment termination, other than a bona-fide retirement as defined by Franklin & Marshall College policies
- b) loss of full-time employment status or other event which causes an employee to no longer be a member of an eligible class
- c) death of a covered employee or a retiree
- d) during a medical leave of absence: expiration of employer-paid sick leave benefits (salary continuation) or expiration of Family & Medical Leave, whichever occurs later
- e) a covered employee's last work day prior to commencement of an unpaid leave of absence, including disability leave (other than an approved Family & Medical Leave or other approved leave of absence which provides for continued coverage); coverage for a faculty member commencing a 6- or 12-month unpaid leave of absence will terminate at the end of the month immediately preceding the leave of absence
- f) completion of a 12 month leave of absence which provided continued health coverage
- g) loss of eligibility per provisions outlined in the third party administrator's Plan Summary and/or College policies, and/or loss of dependent status per the College's policies
- h) failure by a covered employee or College retiree to pay the required premium within 30 days of the date the premium became delinquent; coverage will terminate retroactive to the 1st of the calendar month in which the premium became due
- i) for a retired Plan participant and his/her covered dependent(s), coverage will terminate within thirty (30) days of the date the participant is first eligible for Medicare coverage if the Plan participant fails to enroll in Medicare Parts A and B
- j) termination of the Shared Services Health Plan or termination by the College of its participation in the Plan.

A covered dependent will no longer be eligible for coverage through the Health Plan if he/she fails to qualify as an eligible dependent. Coverage terminates at 11:59 p.m. on the last day of the calendar month in which the event(s) occurs which causes the dependent to no longer qualify as a dependent eligible for group Health Plan coverage.

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 or retired College employee and/or eligible dependents; and describe what an employee or retiree and his/her covered dependents must do to protect the right to elect continued health coverage through COBRA, if coverage through the Plan is lost.

Employees and retirees of Franklin & Marshall College, and their dependents, who are covered under the group Health Plan have the right to temporary continuation of their health 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 guarantees an opportunity to elect temporary continuation of health coverage at group rates. No evidence of insurability is required to choose continuation coverage. Coverage is the same as that for active employees or retired employees, and includes prescription drug coverage.

Qualifying Events

An **employee** of Franklin & Marshall College enrolled in the group Health 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 through the group Health 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.

The **covered spouse** of a College employee or retiree 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 through the College's group Health Plan for any of the following reasons:

- the death of the College employee or retiree,
- 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 or retiree becomes entitled to Medicare benefits (Medicare Part A, Part B or both), or
- the employee or retiree and his/her spouse divorce or legally separate.

A spouse who loses coverage under the Plan, due to a Qualifying Event outlined above, becomes a "Qualified Beneficiary" entitled to elect temporary continuation of coverage through COBRA.

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

- the death of the parent (employee or retiree),
- 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 or retiree) 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 the College's 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 the Shared Services Group Health Plan, due to a Qualifying Event outlined above, becomes a "Qualified Beneficiary" entitled to elect temporary continuation of coverage through COBRA.

If a proceeding under Title 11 (bankruptcy) is filed with respect to Franklin & Marshall College, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan. In this case, the Qualified Beneficiary(ies) may elect continued coverage via COBRA.

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 or College retiree, spouse, and/or dependent child 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 the College's group Health 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 or retiree who has lost or will lose coverage through the College's group Health Plan, the spouse or dependent child who is losing coverage through the College's Plan, or a representative acting on behalf of the employee, retiree, spouse, or dependent child. 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, former employee, or retired 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 through the Plan due to a Qualifying Event,
3. a brief description of the Qualifying Event that has resulted, or will result, in loss of health coverage through the Plan (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 that will lead to loss of health coverage through the College's Plan 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 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 reason(s) that continuation coverage is not available.

Employer Responsibility-- When the Qualifying Event is the termination of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to Franklin & Marshall College, 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 or retired employee during the COBRA period, the employee or retiree 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 calendar 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 coverage will terminate. If proper notice of a Qualifying Event is not provided, if continuation coverage through COBRA is not elected in a timely manner, or if COBRA premiums are not paid in a timely manner by the employee/former employee, retired employee, or Qualified Beneficiary(ies), all group health and prescription coverage 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 through the Plan 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.

An employee/former employee, retired 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 through the Health Plan through the other plan.

Coverage Periods

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

- If the person affected by loss of coverage through Plan 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 through the Plan is an **employee's or retiree's spouse**, and the reason for loss of coverage is the employee's/retiree'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 or retiree's dependent child**, and the reason for loss of coverage is the employee's/retiree'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 and/or retirees, (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 through the Plan 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 office, 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, or retired 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

COBRA participants / beneficiaries pay 100% of the group rate premium for continuation coverage (100% of the actuarially-derived premium equivalent), plus a 2% administrative fee. Current monthly premiums are as follows:

High Deductible Health Plan (HDHP)--

\$470.75 per month for single coverage, \$766.70 per month for the individual plus one dependent, or \$1,259.43 per month for family coverage

PPO Health Plan \$250--

\$494.05 per month for single coverage, \$802.75 per month for the individual plus one dependent, or \$1,318.96 per month for family coverage

PPO Health Plan \$100--

\$514.30 per month for single coverage, \$835.67 per month for the individual plus one dependent, or \$1,372.12 per month for family coverage

Temporary Reduced COBRA Premiums-- During the first three (3) months of the normal COBRA continuation period, the following beneficiaries will be eligible to pay reduced monthly premiums for continued group health and prescription coverage, if coverage is lost for the reasons indicated below:

- 1) an **employee's or retiree's child** who has lost eligibility for coverage through the group Health Plan based on reaching age 19, or age 23 if a full-time student
- 2) the **spouse of an employee or retiree** who has lost eligibility for coverage through the group Health Plan due to the employee's or retiree's death

Year 2010 COBRA premiums, applicable only during the first 3 months of the normal COBRA continuation period for beneficiaries and reasons listed above, are:

High Deductible Health Plan-- \$42.72 per month for single coverage

PPO Health Plan \$250-- \$61.59 per month for single coverage

PPO Health Plan \$100-- \$130.23 per month for single coverage

Following the 3 month period, beneficiaries will be required to pay full, normal COBRA rates in order to continue their health and prescription drug coverage. The standard COBRA continuation period will not be extended for the groups identified above.

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 calendar 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 forfeited.**

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.

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.

Questions about COBRA may be directed to the Franklin & Marshall College Human Resources office, (717) 291-3995, Ceridian Benefits Services, the College's 3rd party COBRA administrator, (800) 877-7994, 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 the Plan for him/herself and covered dependents, at active employee rates, for up to 30 calendar days. In the case of Service leave exceeding 30 calendar days, USERRA requires the College to extend 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 and Benefit Denials and Claims Procedures

Benefit Denials-- The procedures Health Plan participants are required to follow to file a complaint or grievance pertaining to denial, by the third party administrator, of payment, benefits, or coverage are available to all Plan participants and beneficiaries, at no cost. These procedures are provided with the Summary of Benefits, which is furnished automatically to employees and retired employees upon enrollment, and is also available

upon request, and at no charge, from the Plan Administrator and the third party administrator. Plan participants must follow the procedures described in the Summary of Benefits, and adhere to time limits, to appeal denial of a claim for payment or benefits.

Adverse Eligibility / Coverage Determinations-- The Plan Administrator shall have the responsibility and authority, in its sole discretion, to decide eligibility for coverage through this Plan. If the Plan Administrator denies a claim for coverage through this Plan, the Plan 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.

Medicare Creditable Coverage Disclosure Notice

Important Notice from Franklin & Marshall College About Prescription Drug Coverage and Medicare

The notice below contains information about current prescription drug coverage through Franklin & Marshall College and prescription drug coverage available for individuals with Medicare coverage. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not to enroll in a Medicare prescription drug plan. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. Please read this notice carefully.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Franklin & Marshall College has determined that the prescription drug coverage offered by the College is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered "Creditable Coverage".

Because your existing prescription drug coverage through the Franklin & Marshall prescription drug plan is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage as long as you are eligible for such coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare prescription drug plan.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare, and each year from November 15 through December 31. Beneficiaries terminating coverage through their employer may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your Franklin & Marshall prescription drug coverage, be aware that you and your dependents may not be able to enroll again in the Shared Services Health Plan until the next Open Enrollment period, with coverage effective the following January 1. To re-enroll, you must complete and submit an enrollment form in a timely manner.

If you terminate your prescription coverage through the Plan, you and your dependents will no longer be eligible for any health or medical coverage through the College. You may, however, re-enroll in the Plan during any Open Enrollment period, with coverage effective the next January 1, providing you and your dependents remain eligible for such coverage.

If you enroll in both the Plan and a Medicare-approved prescription drug plan, the Plan will be the secondary payment provider. You will pay the applicable monthly Medicare premium plus the premium required to be covered through the Plan. Please contact Franklin & Marshall's Human Resource office, at (717) 291-3995, if you would like more information regarding what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Franklin & Marshall College and do not enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage:

Contact the Franklin & Marshall Human Resources office at (717) 291-3995. Note: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if prescription drug coverage through Franklin & Marshall changes. You also may request a copy from the Human Resources office.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is available in the Medicare & You handbook. You will receive a copy of this handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your state Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE - (800) 633-4227. TTY users should call (877) 486-2048.
- For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration, (800) 772-1213 (TTY (800) 325-0778), www.socialsecurity.gov.

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium. You may contact Human Resources if you need another copy.

Plan Amendment, Modification, and Termination

The group Health Plan may be amended or terminated by Shared Services and/or 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, coverage levels, and required participant-paid contributions and other costs and Plan features are subject to change at the sole discretion of the College. Additionally, for retired employees and their dependents and COBRA participants and dependents, coverage and costs (including, but not limited to, participant-paid premiums, deductibles, and co-payments) 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 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 the group Health Plan, you should contact the Plan Administrator, via the Franklin & Marshall College Human Resources office. 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 and the Plan Summary and Summary of Vision Benefits have been complied with and exhausted.