

## Group Dental Summary Plan Description

This Summary Plan Description describes dental coverage available through the Franklin & Marshall College Group Health Plan (the dental coverage is described herein as the "Group Dental Plan" or the "Plan"). This Summary Plan Description is amended and restated as of January 1, 2010. This Summary Plan Description is required by The Employee Retirement Income Security Act (ERISA) of 1974, as amended, and "wraps around" the Evidence of Coverage provided by Delta Dental, the Claims Administrator (the "Evidence of Coverage"). The purpose of this Summary Plan Description is to acquaint employees with the provisions of the Plan, the way in which it is administered, and participants' rights under the federal law which applies to employee benefit plans. Every effort has been made to make this Summary Plan Description as accurate as possible, however, in the event of a discrepancy between this Summary Plan Description 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.

Group Dental Plan participants receive a packet of information from the dental plan administrator upon enrollment into the Plan including the Evidence of Coverage. The Evidence of Coverage, along with this Summary Plan Description, contain important details about the Plan, including eligibility requirements, coverage levels, covered and non-covered services, exclusions, and pretreatment review requirements. Some dental services and procedures may not be covered through the Group Dental Plan. Plan participants are strongly encouraged to carefully read Evidence of Coverage and this Summary Plan Description.

### Facts About the Plan

**Plan Name:** Franklin & Marshall College Group Health Plan

**Plan Number:** 501 - Plan 501 also includes vision coverage, a health reimbursement account and retiree health coverage.

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

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

**Plan Sponsor's Employer Identification Number:** 23-1352635

**Original Plan Effective Date:** May 1, 2006

**Plan Year:** January 1 through December 31

**Type of Plan:** Welfare Plan

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

**Plan Benefits Provided By:** Delta Dental of Pennsylvania, One Delta Drive, Mechanicsburg, PA 17055

The Claims Administrator determines whether services and supplies are eligible for coverage through the group policy, and reviews and pays eligible claims.

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

**Funding:** Dental coverage is funded in part by Franklin & Marshall College, through general employer assets; in part 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; and in part by COBRA participants.

## **Plan Benefits**

### **Dental Benefits**

Franklin & Marshall College offers a self-funded dental plan through Delta Dental of Pennsylvania. The available dental benefits are described in Evidence of Coverage. Coverage is provided for eligible services and supplies that are considered necessary and customary. A copy of the Evidence of Coverage and this Summary Plan Description is provided to each participating College 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. The Evidence of Coverage is also available through eDisk, in the "Groups", "Human Resources" "Public" folder. A listing of Participating Dentists is also furnished to each participant upon enrollment, and additional copies may be obtained, at no charge, by contacting Human Resources, Franklin & Marshall College, Delta Dental, or can be found at [www.midatlanticdeltadental.com](http://www.midatlanticdeltadental.com). The Evidence of Coverage and this Summary Plan Description include important details about dental benefits, including coverage levels, covered and non-covered services, exclusions, and claims procedures. Some medical services and procedures may not be covered through the Group Dental Plan, even if necessary and customary. Plan participants are strongly encouraged to read the Evidence of Coverage and this Summary Plan Description.

**Participating Providers--** The Dental Plan is a preferred provider program. Each time a Plan participant seeks dental care, the participant decides whether to receive treatment from a Participating dental provider and receive the highest level of coverage, or seek treatment from a Non-participating dental provider and receive a reduced level of coverage.

Delta Dental, the dental Claims Administrator, maintains two provider networks - the Delta Dental PPO network and the Delta Dental Premier network. Participants may receive services from a dentist in either network (a "Participating provider"), or a Non-participating dentist (one who does not participate in the Claims Administrator's networks). **Participants will typically pay the lowest costs for dental services when visiting a dentist who participates in the Delta Dental PPO network.** Participants who visit a dentist who does not participate in either network will receive coverage, but will likely experience higher out-of-pocket costs. When receiving services from a provider

who does not participate in one of the Claims Administrator's networks, the Plan participant will be responsible for normal coinsurance, plus all fees charged by the provider in excess of the Claims Administrator's reimbursement rates.

**Emergency Treatment--** Treatment for a dental emergency, as defined by the Claims Administrator, will be paid at the participating provider level in the event the Plan participant cannot be treated by a participating dentist.

**Claim Forms--** Plan participants who receive treatment from a Participating dental provider are not required to submit claim forms. To receive benefits, Plan participants must submit a claim form to the Claims Administrator each time they receive services from a Non-participating dental provider.

**Pre-determination of Benefits--** If charges for services may exceed \$300, the Plan participant may request that the dental provider submit the potential charges for review by the Claims Administrator. The Claims Administrator will review the procedure and charges and notify the provider and the Plan participant as to whether the service is covered and the amount which will be paid by the Claims Administrator and by the Plan participant. The notification will indicate that the procedure must be completed within 60 days of the date of the predetermination notice, as long as the Plan participant is eligible when the services are received and benefit maximums have not been reached.

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

## **Eligibility for Coverage**

The following classes of employees, and their eligible dependents, may enroll in the Group Dental Plan:

### ***Class A:***

- full-time faculty and professional staff employees: Franklin & Marshall College employees who are scheduled to work at least 30 hours per week for wages on a regular basis, including visiting, tenured, non-tenured, and tenure-track faculty; full-time employees of the James Street Improvement District; the current, actively employed Spectrometer Technician; the Program Director, Campus Central; and full-time employees of the Centennial Conference and Higher Education Data Sharing Consortium who: (1) are regularly scheduled to work on the Franklin & Marshall College campus and (2) are paid through the College's payroll system, as long as otherwise eligible
- full-time faculty and professional staff employees who are scheduled to work at least 30 hours per week for wages on an approved 9, 10, or 11 month per year appointment
- faculty on an approved joint appointment: one full-time position shared by two College faculty members each working at least 1040 hours annually
- full-time faculty working a reduced schedule under an approved Phased Retirement Agreement

- full-time faculty who have been granted a leave of absence to further their scholarship and/or teaching and who receive a stipend from a competitive grant or fellowship that does not provide dental coverage, upon approval of the Provost and Dean of the Faculty (eligibility for coverage may continue for the time period covered by the grant or fellowship, not to exceed 12 months)
- full-time faculty on an approved paid sabbatical or paid Junior Faculty Leave, not to exceed 12 months
- full-time faculty and professional staff employees on an approved paid or unpaid Family & Medical Leave as provided for in the Family & Medical Leave Act, or other approved leave of absence which provides for continued coverage, not to exceed 12 months

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

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

### **Eligible Dependents**

For purposes of the Group Dental Plan, eligible dependents are:

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

A dependent child, for purposes of the Group Dental Plan, is a covered employee's unmarried child, from birth through eighteen (18) years of age (under age 19), who has the same principal place of residence as the employee-parent for more than six months of the calendar year (more than 182 days), and does not provide more than half his/her own support during a calendar year.

Dependent children are defined as the employee's biological children, legally adopted children, children legally placed for adoption, stepchildren, and children of the employee's same-sex Domestic Partner. Dependent children for whom the covered employee or his/her legal spouse is the court-appointed legal guardian, and dependent children for whom the employee is required to provide dental 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 dental coverage through age twenty-two (22), provided the child: 1) is a full-time student at an accredited school, 2) is primarily dependent upon the covered employee for support (the child does not provide more than one half his/her own support during a calendar year and the employee provides over half of the child's financial support), 3) has the same principal place of residence as the employee-parent for more than 6 months of the calendar year, except while away from home and attending college, 4) is unmarried, and 5) is under age 23. Coverage will continue for any 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.

Employees with children over the age of 18 enrolled in the Plan will be required to provide verification of dependent status, as requested, to the Plan Administrator and/or dental Claims Administrator.

An eligible dependent child who is mentally or physically incapable of earning a living and chiefly dependent on the covered employee for support (the employee provides over half of the child's financial support) will continue to be eligible for dental coverage, provided that the onset of incapacity occurred before the age of 19. The Plan Administrator and dental Claims Administrator reserve the right to request verification of disability.

The Plan Administrator and group dental Claims 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.

A Domestic Partner is defined as the unmarried partner of a College employee who is: 1) of the same sex, and 2) sharing a long-term, committed relationship of indefinite duration with the employee, 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).

## **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 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 Group Dental 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 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 during an annual Open Enrollment period. Employees will be required to pay their applicable share of premiums, which may vary from year-to-year, to continue their coverage.

Before enrolling a same-sex Domestic Partner, and child(ren) of a same-sex Domestic Partner, a Certification of Same-sex Domestic Partnership must be completed by the employee and his/her same-sex Domestic Partner, and returned to the Plan Administrator (Human Resources). If an 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 dental 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 Group Dental Plan. An employee may elect not to participate in the Plan by returning the enrollment form stating that he/she elects to "opt-out". If an employee fails to re-enroll during the Open Enrollment period and is still eligible to participate, the employee shall be deemed to have elected to continue the same benefits under the Group Dental Plan in effect for such participant during the immediately preceding Plan Year. The applicable premium for the current calendar year will be required. An employee 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**

Generally, an employee may add a dependent(s) to his/her dental 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 Group Dental 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, spouse, or dependent becomes qualified for, or loses, coverage under Medicare, Medicaid or under CHIP; or if it is determined that the employee, spouse or dependent is eligible for premium assistance under Medicaid or CHIP
- an employee takes an unpaid leave of absence per the Family & Medical Leave Act
- an employee's spouse or dependent child makes permissible election changes under his/her employer's dental 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, spouse or dependent child has been "significantly curtailed" with or without a loss of coverage, the employee can revoke

the current election and must elect coverage under a similar benefit option except as follows. If the employee, 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, 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, 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 for a specific benefit option has significantly increased, the employee 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 for a specific benefit option has significantly decreased, an employee 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 Dental 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, 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.**

### **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 Group Dental Plan participant/employee marries on May 14, coverage for the new spouse through the Plan will be effective on June 1, assuming the employee properly completes and submits a Dental Plan enrollment form within 31 days of the May 14 marriage. However, if an employee gives birth on May 14, dental coverage for the new dependent will be effective as of May 14, if the employee properly completes and submits an enrollment form within 31 calendar days of the birth.
- Plan participants' pre-tax dental premiums will automatically be adjusted, through the Flexible Spending Account Plan, if there is an increase or decrease in the cost of coverage through the Group Dental Plan. Such adjustments will be made prospectively.
- A Plan participant may not cancel dental coverage for him/herself or a dependent upon becoming eligible for dental 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 Group Dental Plan and Flexible Spending Accounts elections, unless the employee has experienced another "Change in Status" or relevant event as described above.
- Dental 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.
- Dental 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 experiences a "Change in Status" or other relevant event as described above, and wants to add an eligible dependent to his/her coverage, notification to the Plan Administrator must be made by the end of the enrollment period:

The **enrollment period** is 31 calendar days of the event or 60 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 must submit a completed dental enrollment form to the Plan Administrator (via Human Resources) by the end of the enrollment period. If the form is properly and timely completed and submitted to Human Resources, dental coverage for the affected individual(s) will be effective as of the first day of the month coinciding with or following the event, 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 by the end of 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 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 Group Dental Plan. To remove a dependent from coverage, the employee must also submit a dental enrollment form to the Plan Administrator during the enrollment period. 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 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 Plan participant or dependent, per the policies of the Claims Administrator. To be eligible for continued dental 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 College's Group Dental 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 for dental coverage are paid by Franklin & Marshall College, employees and COBRA recipients enrolled in the Plan. Active employees (class A) pay a portion of the premium equivalent. Required participant-paid contributions may vary from year-to-year, at the sole discretion of Franklin & Marshall College. The Plan Administrator will determine and communicate required participant-paid contributions each year during the Open Enrollment period. Based on IRS regulations, the Plan Administrator will treat as imputed income to an employee the value of dental coverage provided to a same-sex Domestic Partner and his/her children, minus any contribution paid by the employee for this coverage, unless the Domestic Partner and his/her children qualify as the employee's dependents under the Internal Revenue Code. Contributions are deducted from a covered employee's pay in equal installments. Active employees are automatically enrolled in the Flexible Spending Account Plan upon electing group dental coverage, which means each employee's contribution 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 pay contributions on an after-tax basis. Such notice must be provided upon initial enrollment in the Plan, and during each annual Open Enrollment period.

Year 2010 participant-paid contributions for the Group Dental Plan for full-time employees (coverage class A) are:

\$25.44 per month for employee-only coverage

\$44.49 per month for the employee and one dependent

\$66.48 per month for the employee and two or more dependents

## **Coinsurance**

Coinsurance is the percentage of eligible charges the Claims Administrator pays on behalf of a participant, after applicable deductibles have been paid by the participant. The following coinsurance provisions apply to the Plan:

*Diagnostic and Preventive Services - 100%*

Diagnostic services include procedures to assist dentists to evaluate existing conditions and dental care required – such as visits, exams, diagnoses, and x-rays

Preventive services include prophylaxis (cleaning), fluoride treatments (through age 18), space maintainers (through age 13), and sealants (through age 13)

*Basic Restorative Services, Endodontics, Periodontics, and Oral Surgery - 80%*

Basic restorative services include amalgam (silver) and composite (white non-molar) filings.

Endodontics include procedures for pulpal therapy and root canal filling

Periodontics include surgical and non-surgical procedures for treatment of gums and supporting structures of teeth

*Major Restorative Services and Prosthodontics - 50%*

Major restorative services include crowns, inlays, and onlays (where basic restorative materials are not adequate)

Prosthodontics include procedures for construction or repair of fixed bridges, partial or complete dentures

*Orthodontia Services (only covered for dependent children through age 18 – until the last day of the month during which the child turns age 19) - 50%*

When receiving services from a provider who does not participate in one of the Claims Administrator's networks, the Plan participant will be responsible for normal coinsurance as outlined above, plus all fees charged by the provider in excess of the Claims Administrator's contracted provider reimbursement rates.

*Note:* For orthodontia services, the Claims Administrator typically provides half the payment at the time of banding and the remaining payment one year later.

## **Benefit Limitations**

There are a number of limitation on benefits that are provided under the Plan. Please see the Evidence of Coverage for a full list of these limitations.

## **Excluded Services**

Coverage for some dental services, treatments, and supplies is not provided through the Group Dental Plan, even if necessary and customary.

- Services not considered necessary and customary, as determined by the Claims Administrator, are not covered.
- Other services and supplies for which coverage is not provided include:
  - Prescription drugs, premedications, relative analgesia
  - General anesthesia, except with covered oral surgery procedures of one or more simple extractions and/or with surgical extractions for patients under age 19; and except with three or more simple extractions and/or surgical extractions for patients age 19 and over.
  - Charges for hospitalization, including hospital visits
  - Plaque control programs, including oral hygiene and dietary instruction
  - Procedures, appliances or restorations primarily for cosmetic purposes
  - Increasing vertical dimension
  - Replacing tooth structure lost by attrition
  - Periodontal splinting
  - Gnathological recordings
  - Equilibration
  - Treatment of dysfunctions of the temporomandibular joint
  - Implants

## **Maximum Plan Allowance**

The Maximum Plan Allowance is the amount payable for any service as calculated by the Claims Administrator, Delta Dental. The Maximum Plan Allowance for Non-participating providers are the usual fees received by dentists of similar training for the same service in the same geographic area blended by Delta Dental with dentist fee information from a number of other sources. When a Plan participant receives treatment from a Non-participating dental provider, the Claims Administrator bases its payment on the Maximum Plan Allowance. All charges above the Maximum Plan Allowance as determined by the Claims Administrator are the responsibility of the Plan participant. Such amounts paid by a Plan participant do not count toward meeting deductibles.

## **Deductibles**

Participants pay the following deductibles each calendar year before the Claims Administrator makes payments:

\$50 per person per calendar year up to \$150 for a family

The deductible does not apply to diagnostic or preventive services such as routine cleanings and exams, to sealants, and to orthodontics.

### **Benefit Maximum**

The maximum benefit paid through the Group Dental Plan is \$1,000 per person per calendar year.

The Plan also includes a maximum lifetime orthodontia benefit of \$1,000 per covered child.

### **Coordination of Coverage with Other Plans**

The group dental Claims Administrator, Delta Dental, will coordinate coverage with other plans as described in the group contract. 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 College's Plan is generally the secondary plan for a spouse covered by his/her employer. 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). When the College's plan is considered the primary plan, the Claims Administrator will determine coverage levels without regard to coverage under any other plan. When the College's plan is the secondary plan, the Claims Administrator will pay only the amount by which its normal coverage levels exceed benefits payable under another plan or the amount of remaining claims, whichever is less. In no case does the Claims Administrator pay in excess of its total obligation if it were the only Claims Administrator making payments.

### **Coverage During Family & Medical Leave**

If a covered 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 dental 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 Dental 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. Dental premiums, at active employee rates, will be deducted from the employee's salary on a pre-tax / salary reduction basis, 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 Dental 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 dental premiums on an after-tax basis by sending the payments to the College. Dental 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 dental 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 Group Dental Coverage**

An employee's coverage through the Group Dental 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, including retirement as defined by the College's 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 covered dependent
- 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 dental coverage
- g) loss of eligibility per provisions outlined in this Summary Plan Description and/or College policies, and/or loss of dependent status per the College's policies

- h) failure by a covered employee 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) termination by the College of the Group Dental Plan, or failure by the College to pay the required premiums for the group policy

### **Temporary Continuation of Coverage / "COBRA"**

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

Employees of Franklin & Marshall College, and their dependents, who are covered under the College's Group Dental Plan have the right to temporary continuation of their dental 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.

### **Qualifying Events**

An **employee** of Franklin & Marshall College enrolled in the Group Dental 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 Dental 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 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 Dental Plan for any of the following reasons:

- the death of the College employee,
- the reduction of the employee's hours of work,
- the termination of the employee's employment (except for termination due to gross misconduct),

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

A spouse who loses coverage under the College's Group Dental 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 has the right to elect COBRA continuation coverage, if coverage through the College's Group Dental Plan is lost for any of the following reasons:

- the death of the parent (employee),
- a reduction in the parent's (employee's) work hours,
- termination of the parent's (employee's) employment (except for termination due to gross misconduct),
- the parent (employee) becomes entitled to Medicare benefits (Medicare Part A, Part B or both),
- the parents' divorce or legal separation, or
- the child ceases to be a dependent child eligible for coverage under the terms of 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 College's Group Dental Plan, due to a Qualifying Event outlined above, becomes a "Qualified Beneficiary" entitled to elect temporary continuation of coverage through 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, 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 Dental Plan, such as a divorce or legal separation or loss of dependent status. Written notice to the Plan Administrator must be made **within 60 calendar days** of the later of: (1) the date of the Qualifying Event, (2) the date that coverage is lost due to a Qualifying Event, or (3) the date the Qualified Beneficiary is informed, through the Summary Plan Description or initial COBRA notice, of the Plan's procedures for providing notice of loss of coverage due to a Qualifying Event. Written notice must be provided to the Plan Administrator by the employee/former employee who has lost or will lose coverage through the College's Group Dental Plan, the spouse or dependent child who is losing coverage through the College's Plan, or a representative acting on behalf of the employee, 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 or former employee and his/her social security number and mailing address,

2. the name and mailing address of all dependents who have lost or will lose coverage through the College's Group Dental Plan due to a Qualifying Event,
3. a brief description of the Qualifying Event that has resulted, or will result, in loss of dental coverage through the College's 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 dental 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 third party administrator designated by the Plan Administrator, will notify the individual within 14 days of receiving the notice, if the individual is not eligible for continuation coverage through COBRA. The notice of ineligibility will include the 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 during the COBRA period, the employee must notify the Plan Administrator **within 31 calendar days of the birth or adoption** in order to elect COBRA coverage for the child.

**Notice of Disability--** If the Qualifying Event that resulted in the COBRA election is termination of employment or reduction in work hours, the temporary COBRA continuation period may be extended due to the disability of any Qualified Beneficiary. In the case of disability, written notice of disability must be provided by the Qualified Beneficiary to the Plan Administrator **within 60 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 dental 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 or Qualified Beneficiary(ies), all group dental 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 College's Group Dental 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.

### **Coverage Periods**

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

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

The period of continuation coverage described above may be shorter than expected if (a) the College ceases to provide any dental plan for its employees, (b) the premium for continuation coverage is not paid on time by the covered individual, (c) the individual becomes covered under another group dental 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 College's Group Dental 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 continued dental coverage through COBRA, he/she may be eligible to extend the COBRA period, up to a maximum of 36 months, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. This extension is available to the spouse and eligible dependent children if the College employee/former employee dies, becomes entitled to Medicare benefits (Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. Proper written notice of a second Qualifying Event must be made to the Plan Administrator, as outlined above under "Notification Requirements", within 60 calendar days of the second Qualifying Event.

### **COBRA Premiums**

COBRA participants pay 100% of the group rate premium for continuation coverage, plus a 2% administrative fee. Current monthly premiums are as follows:

\$31.02 per month for coverage for one individual

\$54.22 per month coverage for two individuals

\$81.04 per month for coverage for three or more individuals

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

### **Making COBRA Payments**

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

Questions about COBRA may be directed to Human Resources, (717) 291-3995, Ceridian Benefits Services, the College's 3rd party COBRA administrator, (800) 877-7994, or the U.S. Department of Labor's Employee Benefits Security Administration, [www.dol.gov/ebsa](http://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 a premium greater than what he/she would have paid if the employee had remained at work during this period. During a leave of absence for military service, a full-time College employee will be eligible for coverage through the College's Group Dental 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.

## **Benefit Denials and Claims Procedures**

**Benefit Denials--** The dental Claims Administrator, Delta Dental, administers all claims in accordance with the terms of the Dental Plan. Payment is made for approved claims. If a claim for coverage is denied in whole or in part, the Claims Administrator will notify the Plan participant of the denial, in writing, within thirty (30) days after the claim is filed, unless special circumstances require an extension of up to fifteen (15) days. The Plan participant will be notified, within thirty (30) days, if an extension is necessary. The Plan participant or his/her participating dentist will be afforded at least forty-five (45) days from the date of notice to provide any additional information to the Claims Administrator pertaining to the claim. A notice of denial of payment of a claim will explain the specific on which the denial is based, a description of any additional material or information necessary for the Plan participant to resubmit the claim, and an explanation of why such information is necessary. The notice of denial will also include an explanation of the Claims Administrator's claim review and appeal process and the applicable time limits, including the Plan participant's right to bring a civil action under the Employee Retirement Income Security Act (ERISA) upon the Claims Administrator's completion of its second level of review.

If a Plan participant and/or his/her dental care provider wishes to have a denial of a claim reviewed, the Plan participant or his/her dental care provider must write to the Claims Administrator, Delta Dental, within one hundred eighty (180) days of the date of the denial notice. The Plan participant or his/her dentist should state why the claim should not have been denied and include any documents, data, or other information which may have bearing on the claim. The Plan participant or dentist is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information regardless of whether such information was submitted or considered during the initial claim determination.

The review shall be conducted on behalf of the Claims Administrator by a person who is neither the individual who made the original claim denial nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a clinical judgement in applying the terms of the group contract, the Claims Administrator shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Claims Administrator's dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Claims Administrator's dental consultant will be made available to the Plan participant or his/her dentist upon request.

If after the review the Claims Administrator continues to deny the claim, the Claims Administrator will notify the Plan participant and his/her dental care provider, in writing, of the decision within thirty (30) days of the date the request for review is received by the Claims Administrator. The Claims Administrator's notice will include the specific reason(s) for the second denial and reference to the contract provision on which it is based. The notice will state that the Plan participant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents relevant to the participant's claim for benefits. The notice shall also state that the Plan participant has

a right to bring an action under ERISA upon completion of the Claims Administrator's second level of review.

If the Plan participant wishes the claim to be reviewed further, he/she or the participant's dentist should advise the Claims Administrator in writing as soon as practical. The matter will then be referred to a committee of the Claims Administrator for review, which may include a clinical exam and a hearing before the committee. The Claims Administrator's committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Claims Administrator's committee will be final. If the Plan participant then wishes to pursue the claim further, he/she may contact the appropriate state regulatory agency or review board, file an action under ERISA, or file a civil action.

Claims and appeals of adverse benefit determinations are to be addressed to Delta Dental of Pennsylvania, One Delta Drive, Mechanicsburg, PA 17055.

**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 Administrator denies a claim for coverage through this Plan, the Administrator promptly and in writing shall notify the individual of such denial. The notification of denial will be made not later than within thirty (30) days of receipt of the individual's claim. This 30 day period may be extended for an additional 15 days due to circumstances beyond the control of the Plan Administrator, including cases in which a claim is incomplete. The individual will receive written notice of any such extension, including the reason for the extension and the date by which a decision by the Administrator can be expected. The Plan Administrator may secure independent information or other advice and require such other evidence as deemed necessary to decide a claim. A written notice of adverse benefit determination will be provided to the individual, and will include: (1) the specific reason(s) for the denial of benefits, (2) the specific Plan provision on which the denial is based, (3) a description of any additional material or information necessary for the individual to complete a claim and an explanation of why such information is necessary, and (4) an explanation of the right of appeal and the process to appeal the adverse benefit determination, including an explanation of the individual's right to review relevant documents and information, and his/her right to file suit under the Employee Retirement Income Security Act (ERISA) with respect to any adverse determination after appeal of a claim.

If a claim is denied in whole or in part, the individual may appeal to the Plan Administrator for review of the claim. The appeal must be made within one hundred eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination. If the appeal is not made within 180 days, the individual will lose his/her right to appeal and to file suit in court. The individual's written appeal should state the reasons that he/she believes the claim should not have been denied. It should include any relevant facts and/or documents to support the claim. The individual may ask additional questions of the Plan Administrator, make written comments, and may review (on request and at no charge) documents and other information relevant to the appeal. The Plan Administrator will review and decide the individual's appeal within a reasonable time and, within sixty (60) days after receiving the written appeal, shall render, in writing, a decision. The individual who reviews and decides the appeal will not be the same individual who originally denied the claim for benefits, or that

individual's subordinate. The Plan Administrator may require additional relevant information to decide the claim.

If the decision on appeal affirms the initial denial of the individual's claim for benefits under the Plan, he/she will be furnished with a notice of adverse benefit determination on review, which includes the following: (1) the specific reason(s) for the denial, (2) the specific Plan provision(s) on which the denial is based, (3) a statement of the individual's right to review (on request and at no charge) relevant documents and other information, (4) a description of any internal rule, guideline, or protocol, if applicable, used to make the benefit determination and a statement that such rule, guideline, or protocol will be provided to the claimant upon request at no charge, and (5) a statement of the individual's right to bring suit under ERISA.

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

### **Plan Amendment, Modification, and Termination**

This Plan may be amended or terminated by Franklin & Marshall College at any time. Termination will also occur if the Policyholder fails to pay the required dental premiums. No consent of any employee, participant, or beneficiary is required to terminate, modify, amend, or change the Plan. Plan benefits and participant-paid premiums and other costs are subject to change at the sole discretion of the College.

### **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 Dental coverage--** Continue dental 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 Dental Plan, if you have Creditable Coverage for another plan--** You should be provided a Certificate of Creditable Coverage, free of charge, from the Group Dental Plan or dental issuer when you lose coverage under a dental 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 dental 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 Plan, you should contact the Plan Administrator, via Franklin & Marshall College's Human Resources Department. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee

Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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