

Flexible Spending Accounts Plan Summary Plan Description

This Summary Plan Description describes the Flexible Spending Accounts available under the Franklin & Marshall College Group Insurance Plan and Flexible Spending Account (described herein as the "Flexible Spending Accounts Plan", the "Plan", or the "Section 125 Plan") as in effect as of January 1, 2007. It is required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The purpose of this Summary Plan Description (SPD) is to acquaint employees with the provisions of the Section 125 Plan, the way in which it is administered, and participants' rights under the federal law which applies to employee benefit plans. This SPD describes the election process and the tax effect of participation in the Section 125 Plan. Every effort has been made to make this SPD as accurate as possible, however, in the event of a discrepancy between the SPD and the Plan Document, the Plan Document shall control. The Plan Document can be viewed by contacting Human Resources. The Section 125 Plan is intended to qualify as a cafeteria plan under the Internal Revenue Code. The Section 125 Plan is established for the exclusive benefit of participants, their covered dependents, and their beneficiaries, and is administered impartially for the benefit of all eligible employees.

Facts About the Plan

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

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

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

Plan Sponsor's Employer Identification Number: 23-1352635

Plan Year: January 1 to December 31

Type of Plan: Section 125 cafeteria plan arrangement with premium conversion feature and medical and dependent care reimbursement accounts.

Name, Address and Telephone Number of Plan Administrator: Franklin & Marshall College, Lancaster, PA 17604-3003, (717) 291-3995

Type of Administration: Administration is provided through an independent third party administrator. The third party administrator is Significa Benefit Services, P.O. Box 7777, Lancaster, PA 17604-7777. Significa Benefit Services' telephone numbers are (717) 581-1300 and (800) 433-3746. Significa Benefit Services is appointed by the College to perform certain administrative services with respect to the Plan. Significa Benefit Services does not finance or insure the Plan. Under this type of administration, benefits are not

guaranteed under a contract or policy of insurance. In its role as a third party administrator, Significa Benefit Services is not an "administrator" as defined in Section 3(16)(A) of ERISA. The College is the Plan "administrator" as defined in Section 3(16)(a) of ERISA.

Agent for Service of Legal Process: The plan sponsor at the above address.

Plan Benefits

The Flexible Spending Accounts Plan

The Flexible Spending Accounts Plan allows each eligible College employee to reduce his/her salary and direct contributions to:

1. the Insurance Premium Payment Plan, to pay the employee's share of health and/or dental insurance premiums
2. a Medical Expense Reimbursement Account, and/or
3. a Dependent Care Reimbursement Account

Insurance Premium Payment Plan-- Eligible employees may pay for their portion of the cost of coverage under the Franklin & Marshall Group Health Insurance & Prescription Drug Plan and/or the Franklin & Marshall College Group Dental Insurance Plan with "pre-tax" dollars. (Based on current IRS regulations, the portion of the premium paid to cover a same-sex domestic partner may not be paid on a pre-tax basis.) The benefits a participant elects through the Insurance Premium Payment Plan are non-taxable, so the participant does not pay Social Security or federal income taxes on his/her portion of the cost of coverage under the Group Health Insurance & Prescription Drug Plan or Group Dental Insurance Plan. Eligible, active full-time employees are automatically enrolled in the Insurance Premium Payment Plan upon electing group health insurance and/or dental insurance coverage, which means each employee's share of premiums is paid on a pre-tax basis through payroll deduction. Employees may elect to pay premiums, 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 premiums on an after-tax basis. Such notice must be provided upon initial enrollment in the Group Health Insurance & Prescription Drug Plan and/or the Group Dental Insurance Plan, and during each annual Open Enrollment period. The benefits provided under the Group Health Insurance & Prescription Drug Plan and the Group Dental Insurance Plan are described in greater detail in a separate Group Health Insurance & Prescription Drug Summary Plan Description and the Group Dental Insurance Plan Summary Plan Description and the Certificate of Insurance for each plan, available from Human Resources.

An employee's election through the Insurance Premium Payment Plan may vary from year to year depending upon the required rate of contribution for coverage under the Group Health Insurance & Prescription Drug Plan and the Group Dental Insurance Plan. The Plan Administrator reserves the right to select the insurer(s) which will offer group medical coverage and group dental coverage, the policy terms under which benefits will be offered, and the amount of premium contribution required by

participants. The Plan Administrator may alter, amend, or terminate the Group Health Insurance & Prescription Drug Plan and/or the Group Dental Insurance Plan in its sole discretion. If an employee does not choose any of the benefits offered under the Group Health Insurance & Prescription Drug Plan and/or the Group Dental Insurance Plan, the employee will be considered to have elected a "cash" benefit in the form of taxable salary equal to the amount of the applicable participant-paid insurance premiums.

Medical Expense Reimbursement Plan and Dependent Care Reimbursement Plan-- The Flexible Spending Accounts Plan also gives eligible employees the ability to participate in the Medical Expense Reimbursement Plan and/or Dependent Care Reimbursement Plan. Under these Plans, an eligible employee may elect to have a portion of his/her salary deducted on a pre-tax basis and designated to a Medical Expense Reimbursement Account and/or a Dependent Care Reimbursement Account. After paying for eligible medical expenses which are not reimbursed through any insurance plan or eligible dependent care expenses, the employee may be reimbursed from the money in his/her Account(s).

Eligibility for Participation

Insurance Premium Payment Plan-- Full-time employees of Franklin & Marshall College are eligible to participate in the Insurance Premium Payment Plan as of the date they satisfy the eligibility requirements for the Group Health Insurance & Prescription Drug Plan and the Group Dental Insurance Plan.

Medical Expense Reimbursement Plan and Dependent Care Reimbursement Plan-- Employees who work or are expected to work for wages for the College at least 1,000 hours per Plan Year are eligible to participate in the Medical Expense Reimbursement Plan and/or Dependent Care Reimbursement Plan, including:

- faculty and professional staff employees, including visiting, tenured, non-tenured, and tenure-track faculty; the current, actively employed Spectrometer Technician; the Program Director, Campus Central; employees of the Centennial Conference and the 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; and employees of the James Street Improvement District who are paid through the College's payroll system.
- faculty on an approved joint appointment: one full-time position shared by two College faculty members each working at least 1,000 hours annually
- full-time faculty working a reduced schedule under an approved Phased Retirement Agreement
- full-time faculty on an approved paid sabbatical or paid Junior Faculty Leave
- 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 paid leave of absence which provides for continued coverage

Independent contractors, contracted employees, adjunct faculty, individuals who volunteer their services without compensation, students, student employees, and retired College employees are not eligible to participate in this Section 125 Plan.

The Election Process

Initial Election

College employees are eligible to make elections under the Section 125 Plan at the same time they are eligible to enroll in the Group Health Insurance & Prescription Drug Plan and the Group Dental Insurance Plan. Eligible College employees may enroll as of the first day of the calendar month coinciding with or following appointment to a full-time position. 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 Flexible Spending Accounts 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 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.

Full-time employees who elect benefits under the Group Health Insurance & Prescription Drug Plan and/or the Group Dental Insurance Plan will automatically be enrolled in the Insurance Premium Payment Plan.

Employees who do not wish to participate in the Insurance Premium Payment Plan, and, therefore, elect to pay their portion of health insurance premiums and dental insurance premiums on an after-tax basis, must notify the Plan Administrator (via Human Resources), in writing, upon enrollment in the Group Health Insurance & Prescription Drug Plan or Group Dental Insurance Plan.

College employees are eligible to enroll in the Medical Expense Reimbursement Plan and/or Dependent Care Reimbursement Plan as of the first of the calendar month coinciding with or following appointment to a position expected to work at least 1,000 hours per Plan Year. When a participant is eligible to enroll in the Plan, he/she will be asked to complete and submit an enrollment form. The proper enrollment form must be completed and submitted to Human Resources within 31 calendar days of the 1st day of eligibility.

Subsequent Elections

During each Open Enrollment period, eligible employees will be asked to complete an election form to select the benefits to be provided on their behalf for the next Plan Year. If an eligible employee elects to participate in the Section 125 Plan, his/her compensation will be reduced by the amount of his/her elections.

An employee who elects to participate in the Medical Expense Reimbursement Account and/or Dependent Care Account will receive a letter from the Plan's third party administrator, confirming his/her election. This confirmation letter must be signed by the participant and returned to the third party administrator (Significa Benefit Services) before the third party administrator will process claims for the participant.

When Participation Ends

Insurance Premium Payment Plan-- Participation in the Insurance Premium Payment Plan will continue in effect from year to year, until a participant elects, in writing, to cease participation in the Insurance Premium Payment Plan. Premiums required for participation in the Group Health Insurance & Prescription Drug Plan and the Group Dental Insurance Plan may vary from year to year. The contributions of participants through the Insurance Premium Payment Plan will automatically be adjusted by the Plan Administrator as participant-paid health insurance premiums and dental premiums are adjusted.

Medical Expense Reimbursement Account and Dependent Care Reimbursement Account-- Any salary reductions relating to coverage under the Medical Expense Reimbursement Account and Dependent Care Reimbursement Account shall cease at the end of the Plan Year, unless a participant elects to participate in one or both accounts before the start of each calendar year, during the Open Enrollment period. Elections under the Medical Expense Reimbursement Plan and Dependent Care Reimbursement Plan do not automatically carry over into the next Plan Year (calendar year), even if a participant wishes to keep his/her contribution amount(s) the same. A new enrollment form must be submitted each year, during the Open Enrollment period, to continue elections for the Medical Expense Reimbursement Plan and Dependent Care Reimbursement Plan.

Participation in the Section 125 Plan will end on the date a participant is no longer an eligible employee, or on the date a participant elects to end participation, although special rules apply for purposes of changing elections during the year (as described below in the section entitled "Changing Elections"). Special rules apply to participants who return from leaves of absence covered under the Family & Medical Leave Act and for payments for coverage for participants who are on unpaid leaves of absence.

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

After an employee has selected benefits under this Plan, the employee may not change his/her elections until the next Open Enrollment period, with changes effective the next January 1. The only exception to this rule is if there is a relevant change in status. If a Plan participant experiences a relevant change in status, he/she may be permitted to change benefit elections for the balance of the Plan Year after the change, provided the change in elections **is on account of and consistent with a change in status** that affects eligibility under the terms of a plan.

Changes to Group Health Insurance & Prescription Drug Plan, Group Dental Insurance Plan, and/or Medical Expense Reimbursement Plan elections may be made after the start of the Plan Year (January 1) if:

- an employee experiences a "Change in Status", as defined by the Internal Revenue Service, that affects eligibility for coverage (see below)
- an employee, his/her spouse, or dependent(s) becomes qualified for, or loses, coverage under Medicare or Medicaid
- an employee/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 insurance coverage through the College's 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 Health Insurance & Prescription Drug Plan if his/her employer's contributions toward other coverage cease; and an employee/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
- 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 & Prescription Drug Plan to provide coverage for a dependent(s) (Plan Participants and beneficiaries may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.)

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

- a change in legal 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 an 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/retiree, spouse, or dependent that affects eligibility for coverage

A corresponding, prospective change to Group Health Insurance & Prescription Drug Plan and Group Dental Insurance Plan elections and elections through the Insurance Premium Payment Plan (but not Medical Expense Reimbursement Plan elections) are also permitted if:

- an employee's spouse or dependent child makes permissible election changes under his/her employer's health or dental plan or Section 125 cafeteria 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.

Changes to Dependent Care Reimbursement Plan elections may only be made after the start of the Plan Year (January 1) if:

- an employee experiences a "Change in Status" as described above
- a dependent care provider is replaced by another provider, resulting in a change in the cost of care
- an employee experiences a decrease in dependent care costs due to a coverage change, such as a reduced need for care
- an employee experiences a significant increase in dependent care costs, as long as the dependent care provider is not a relative of the employee

All mid-year election changes must be on account of and consistent with the status change experienced by the employee.

If a change in status affecting an employee or his/her spouse or dependent(s) occurs, the employee must notify the Plan Administrator (via Human Resources) and submit a new Flexible Spending Accounts Plan enrollment form **within 31 calendar days** of the event (along with a new Group Health Insurance & Prescription Drug Plan enrollment form and/or a Group Dental Insurance Plan enrollment form, as applicable). If the form(s) is not properly submitted within 31 calendar days of the status change or other event, changes to benefit elections may not be made until the following January 1. The Plan

Administrator will determine whether a requested change is permissible and on account of and consistent with a change in status.

Additional Information Regarding Mid-year Election Changes:

- Except in limited circumstances, benefit election changes 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.
- Employees' pre-tax health insurance premiums and pre-tax dental insurance 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 College's Group Health Insurance & Prescription Drug Plan and/or Group Dental Insurance Plan. Such adjustments will be made prospectively.
- 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 Health Insurance & Prescription Drug Plan, Group Dental Insurance Plan, or Flexible Spending Accounts Plan elections, unless the employee has experienced another "Change in Status" or relevant event as described above.
- Health insurance coverage and dental insurance 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. For example, if an employee moves out of the area, he/she may enroll in the College's Indemnity (out-of-area) Plan, but may not cancel coverage or change his/her Medical Expense Reimbursement Plan election.
- Health insurance premiums and dental insurance premiums for retroactive coverage may only be paid on an after-tax basis, except in the case of birth, adoption, or placement for adoption.

Tax Advantages of the Plan

As a participant in the Insurance Premium Payment Plan, the amount contributed toward Group Health Insurance & Prescription Drug Plan premiums and Group Dental Insurance Plan premiums will be deducted from pay before federal taxes are calculated. Since participants do not pay federal taxes on the money used to pay their portion of health and dental insurance premiums, their take-home pay will be higher. By paying their share of health and/or dental insurance premiums on a pre-tax basis, participants lower their taxable income.

Through the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan, participants can reduce the amount of their income subject to taxes and save money by paying for certain eligible medical and dependent care expenses on a pre-tax basis. When an employee participates in the Medical Expense Reimbursement Plan and/or Dependent Care Reimbursement Plan, the College sets up an account on the employee's behalf. The account is funded solely by the employee's contributions, and is used to reimburse the employee for eligible expenses using pre-tax dollars.

When an employee elects to participate in one or both of these plans, he/she contributes money to an account in his/her name each pay period before taxes are withheld from the employee's pay. The funds which accumulate in the accounts are then used to reimburse the employee for eligible medical or dependent care expenses that are incurred by the employee. Although the participant must pay for medical expenses and/or dependent care expenses, the participant saves money because contributions to these accounts are exempt from federal and Social Security taxes.

For state income tax purposes, the Commonwealth of Pennsylvania does not exclude contributions under Section 125 Plans except for those pertaining to medical expenses. Please note, participants will not pay Social Security taxes on their share of contributions to the Section 125 Plan. As a result, the earnings used to calculate Social Security benefits at retirement will not include these payments. This could result in a small reduction in the Social Security benefit the participant receives at retirement. However, savings on current taxes will normally be greater than any eventual reduction in Social Security benefits.

Medical Expense and Dependent Care Reimbursement Plans

Participation in either of the reimbursement accounts is optional. Employees who anticipate incurring medical and/or dental care expenses that their insurance plan(s) will not cover, or will cover only in part, may want to participate in the Medical Expense Reimbursement Plan. An employee who pays for child or elder care so that he/she (and his/her spouse, if married) can work or attend school may want to participate in the Dependent Care Reimbursement Plan.

When an employee enrolls in one or both plans, he/she elects to participate for the full calendar year (or the remainder of the calendar year, if eligible to enroll during the year). The amount an employee chooses to contribute to the Medical Expense Reimbursement Plan and/or Dependent Care Reimbursement Plan will be deducted from paychecks in equal installments throughout the year and credited to an account(s) in the employee's name. If an employee enrolls mid-year, he/she may still contribute the annual maximum to the account(s) for that year. In this case, the amount an employee elects to contribute will be divided by the number of pay periods remaining in the year. As a participant incurs eligible medical or dependent care expenses, he/she pays for these services and then requests reimbursement from his/her Medical Expense Reimbursement Account and/or Dependent Care Reimbursement Account, as described below. Reimbursement Accounts do not earn interest during the year. Each type of plan has specific guidelines regarding which expenses are eligible for reimbursement. Please note that not all expenses are eligible for reimbursement.

Internal Revenue Service (IRS) rules require that an employee elects to participate in one or both plans before the start of each calendar year. **A previous election will not automatically carry over into the next calendar year**, even if a participant wishes to keep his/ her contribution the same.

To participate in the Medical Expense Reimbursement Account and/or Dependent Care Account during a calendar year, an enrollment form must be completed and submitted during the Open Enrollment period that begins prior to January 1.

Amount that May Be Contributed to the Plan(s)

Each participant decides the amount he/she wants to contribute to the Medical Expense Reimbursement Plan and/or Dependent Care Reimbursement Plan by estimating out-of-pocket health care and/or dependent care expenses during the upcoming calendar year. There are maximum amounts that may be contributed each Plan Year (calendar year), as follows:

- Maximum Medical Expense Reimbursement Plan Election: \$2,500 per Plan Year (\$3,500 effective January 1, 2010)

This amount will be determined prior to the start of each Plan Year by the Plan Administrator. If an employee's spouse is also a full-time College employee, each employee may contribute up to \$2,500 per year to the Medical Expense Reimbursement Plan.

- Dependent Care Reimbursement Account: \$5,000 per Plan Year, or up to \$2,500 if married and filing separate tax returns

Additional Limitations on Contributions

The amount which may be contributed to the Dependent Care Reimbursement Plan cannot exceed the participant's compensation for the year. If a participant is married and his/her spouse's compensation is less than the participant's compensation, the participant's contribution amount cannot exceed the spouse's income. For example, if an employee's income is \$40,000 per year and her spouse's income is \$4,000 per year, the maximum the employee may contribute to the Dependent Care Reimbursement Plan is limited to \$4,000 for that year. If an employee's spouse is a full-time student or is incapable of self-care, his/her income is assumed to be:

- \$250 per month, if there is one person for whom eligible dependent care expenses are incurred, or
- \$500 per month, if there are two or more persons for whom eligible dependent care expenses are incurred.

An employee's and spouse's combined maximum contribution to a Dependent Care Reimbursement Plan cannot exceed \$5,000 per year (if the spouse also participates in a dependent care reimbursement plan through his/her employer and a joint federal tax return is filed). If an employee's spouse or other dependent participates in a Medical Expense Reimbursement Plan through his/her employer, both may not claim reimbursement for the same medical expenses.

Making Changes to Elections

Other than during the annual Open Enrollment period, an employee may only make a change to his/her elections if the employee experiences a qualified change in status, as described above. At that time, an employee may choose to begin or end participation, or increase or decrease the amount contributed to one or both plans. Employees must

request a change, and submit the appropriate enrollment form to the Plan Administrator (via Human Resources), **within 31 calendar days** of the qualified change in status.

If an employee starts or ends participation in the Medical Expense Reimbursement Plan during the year due to a qualified change in status, participation in that account starts or ends as of the date of the change in status. An employee may not be reimbursed for expenses that were incurred before his/her participation began or after it ended.

If an employee starts or ends participation in the Dependent Care Reimbursement Plan during the year, he/she may submit expenses incurred during the Plan Year (January 1 to December 31), whether incurred before participation began or after it ended.

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 health insurance 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 Insurance & Prescription Drug Plan, the Group Dental Insurance Plan, and the Flexible Spending Accounts Plan will continue for an employee who otherwise remains eligible, and who was covered through the plans immediately prior to commencement of leave. Health insurance premiums and 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 for group insurance deducted on an after-tax basis. An employee's contributions to the Medical Expense Reimbursement Account and/or Dependent Care Account will be deducted from the employee's salary on a pre-tax / salary reduction basis.

During an *unpaid* leave under the FMLA, an employee may elect to continue or may discontinue coverage under the Group Health Insurance & Prescription Drug Plan, the Group Dental Insurance Plan, and Insurance Premium Payment Plan, and/or the Medical Expense Reimbursement Account.

An employee who is entitled to and takes an *unpaid* leave of absence under the FMLA and elects to continue coverage under the plans while on FMLA leave must pay his/her share of the premiums and contributions 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 / contributions 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 offered 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 premiums / contributions on an after-tax basis. Premiums for

group health insurance coverage and/or dental insurance coverage, at active employee rates, must be sent to the Plan Administrator, via the Franklin & Marshall Human Resources office, by the last work day of each month for which coverage is provided. Medical Expense Reimbursement Account contributions must be submitted by the employee on a monthly basis, in the manner described by the Plan Administrator at commencement of leave. If premium payments are more than 30 calendar days late, College health insurance and dental insurance coverage and participation in the Medical Expense Reimbursement Account will be terminated during the remainder of the leave.

If an 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 plans on the same terms that applied prior to the employee's FMLA leave, or as otherwise required by the FMLA.

Key Restrictions / Important Information

While reimbursement accounts can reduce the amount of taxes a participant must pay, participants should be aware of these restrictions before enrolling in one or both plans:

- Once enrolled in one or both plans, contributions cannot be changed or stopped unless the participant has a qualified change in status, such as marriage, divorce, or the birth or adoption of a child. (For more information about qualified changes in status, refer to the “Changes in Status / Special Enrollment Periods / “Mid-year” Election Changes” section above.)
- If a participant enrolls in both the Medical Expense Reimbursement Plan and the Dependent Care Reimbursement Plan, money may **not** be transferred between the two accounts established for the participant under the plans.
- If a participant does not incur enough eligible expenses during the year to use all the contributions he/she made to the account(s), **the IRS requires the participant to forfeit any remaining balance in his/her account(s).**
 - With the Medical Expense Reimbursement Account, eligible expenses must be incurred between January 1 of the current year and March 15 of the following calendar year.
 - With the Dependent Care Account, eligible expenses must be incurred between January 1 and the next December 31 (i.e., during the calendar year).
- A participant cannot receive a refund, carry balances over to pay for the next year's expenses, or transfer money from one account to another. Forfeited money is used to help offset the cost of administering the Plan.
- A participant cannot claim an expense on his/her federal income tax return if the participant has been reimbursed for that expense through the Medical Expense Reimbursement Plan or the Dependent Care Reimbursement Plan.
- Effective for elections made on or after January 1, 2004, participants will have until March 31 of the next year to submit claims for reimbursement for expenses

incurred during the previous year. **Any money left in a participant's account(s) after that date must be forfeited.**

- If a Medical Expense Reimbursement Account participant also participates in the College's High Deductible Health Plan with Health Reimbursement Account, reimbursement to the employee for medical expenses deemed "eligible" through the Health Reimbursement Account will be provided **first from any balance in the employee's Health Reimbursement Account (HRA)**. If the participant does not have enough funds in the HRA to provide full reimbursement for his/her eligible medical expenses, the remaining amount which cannot be reimbursed from the participant's HRA balance may then be submitted for reimbursement by the participant through his/her Medical Expense Reimbursement Account. An employee may not be reimbursed for the same incurred medical expense from both the Health Reimbursement Account and the Medical Expense Reimbursement Account. However, if the balance in an employee's HRA is not sufficient to provide full reimbursement for an eligible medical expense, the employee may then request reimbursement of the remaining eligible expense through his/her Medical Expense Reimbursement Account, if a balance remains in this account and if the expense is an "eligible" expense under the Medical Expense Reimbursement Account.
 - Currently, only expenses a participant in the High Deductible Health Plan with Health Reimbursement Account incurs to pay the health plan deductible may be reimbursed from the participant's Health Reimbursement Account.
 - Medical Expense Reimbursement Account participants who also participate in the College's High Deductible Health Plan with Health Reimbursement Account should plan carefully when determining their annual salary reduction election to the Medical Expense Reimbursement Account. Such participants are advised to take into account that they will be reimbursed first for eligible medical expenses from their Health Reimbursement Account balance to the extent a balance is available.

Medical Expense Reimbursement Account

Participants may use a Medical Expense Reimbursement Account to pay for eligible health care expenses that their health insurance plan(s) do not cover or cover only in part, such as deductibles, co-payments, eligible dental expenses, and vision care. Expenses must be incurred by the participating employee or his/her eligible dependents.

Eligible Dependents—For purposes of the Medical Expense Reimbursement Account, eligible dependents are the participant's (employee's) legal spouse, or the participant's other eligible dependents. An eligible dependent is someone the participant can claim as a dependent on his/her federal income tax return for the current year (the year during which the employee is a participant in the Medical Expense Reimbursement Account Plan).

Medical expenses must be incurred from January 1 of the calendar year in which the employee is participating in the plan through March 15 of the following calendar year. **Expenses are treated as having been incurred when the participant or eligible dependent is provided with the medical care that gives rise to the medical expenses, not when the participant is formally billed for, or pays for, the medical care.**

Eligible Health Care Expenses

A Medical Expense Reimbursement Account may be used to provide reimbursement for a wide variety of eligible medical care expenses, if such expenses are not covered or are covered only in part under the participant's health insurance plan(s). To be considered eligible, an expense must be incurred while the employee is a participant in the Medical Expense Reimbursement Plan. An employee may not be reimbursed during the current Plan Year for expenses incurred during a different Plan Year.

Eligible expenses recognized by the IRS include but are not limited to:

- acupuncture
- ambulance transportation
- audio display television for the deaf
- birth control pills
- Braille books and magazines, limited to the difference between the cost of the Braille items and the cost for regular items
- cancer insurance premiums
- chiropractic expenses in excess of health plan limits
- contact lenses and solutions
- costs for keeping a mentally disabled person in a halfway house or special home (not the home of a relative), when recommended by a psychiatrist to help the person adjust from life in a psychiatric hospital to community living
- costs for medical services provided by physicians, surgeons, specialists, or other medical practitioners
- costs for services by Christian Science practitioners
- crutches
- deductible, co-pay, and coinsurance amounts (excludes insurance premiums)
- dental examinations and services
- expenses for medical care in a nursing home
- eyeglasses, including lenses, frames, and exams
- hearing expenses, including examinations, hearing aids, and batteries required to operate a hearing aid
- hospitalization charges in excess of the usual and customary fees, including private room coverage
- laboratory fees
- medical expenses for therapy received as medical treatment, such as speech, occupational, physical, or cardiac therapy
- medical expenses paid to a special school if the main reason for using the school is relieving a medical or physical disability medicine prescribed by a doctor
- nursing services when provided by a registered nurse or licensed practical nurse for medical care
- orthodontia / braces
- over-the-counter drugs and medicines recommended by a physician to treat a medical condition (the cost of vitamins, supplements, diet foods or drinks merely beneficial to general health are not eligible expenses)

- oxygen or oxygen equipment to relieve breathing problems caused by a medical condition
- psychiatrist/psychologist fees
- purchase of a guide dog for a blind or deaf individual
- purchase or rental of special medical equipment, if the primary purpose is medical care
- tuition fees for a special school for a learning disabled child who has severe learning disabilities caused by mental or physical impairments, including nervous system disorders, when recommended by a doctor; tutoring fees for a teacher specially trained and qualified to work with children with severe learning disabilities are also eligible when recommended by a doctor
- services by an optometrist
- smoking cessation programs and medicines, including over-the-counter drugs or medicines
- special car controls for the handicapped
- special telephone for the deaf
- sterilization fees
- surgery (legal operations), including experimental procedures
- vaccinations
- vision correction surgery, including laser eye surgery
- weight loss programs, if the patient is participating in the program as treatment for a specific disease, including obesity, diagnosed by a physician

Ineligible Health Care Expenses

In general, health care expenses that do not qualify as medical deductions for federal income tax purposes are not eligible for reimbursement.

Examples of ineligible expenses include but are not limited to:

- any expenses incurred in connection with an illegal operation or treatment
- automobile insurance premiums, including any portion of the premium providing medical coverage for persons injured through an accident in or with the covered individual's vehicle
- bottled water
- cosmetics, such as toiletries and toothpaste
- cosmetic surgery, except to correct congenital abnormality, bodily injury, or disfiguring disease
- costs for sending a child with behavioral or disciplinary problems to a special school for benefits the child may receive from the course of study and disciplinary methods
- custodial care in an institution
- dancing or swimming lessons, even when recommended by a qualified physician for health improvement

- expenditures for the general health of an individual, including expenses related to exercise, fitness, nutrition, recreation, vacation, or membership in a spa or health club
- expenses that are filed on a federal tax return for a tax credit or for which a deduction is taken
- funeral and burial expenses
- hair removal (electrolysis)
- hair transplants
- health club dues, YMCA dues, steam bath, etc., even if recommended by a physician
- health insurance premiums, including premiums for employer-provided medical and dental coverage and for contact lens insurance
- household and domestic help, even if recommended by a qualified physician due to an individual's inability to perform physical housework
- life insurance premiums or premiums for policies taken to provide repayment for loss of earnings or accidental loss of life, limb, sight, etc.
- long-term care insurance premiums and expenses
- marriage counseling fees
- maternity clothes, diaper service, etc.
- over-the-counter drugs or medicines (including vitamins, dietary supplements, diet foods or drinks) when taken for general health purposes, even if recommended by a physician
- transportation expenses to and from work, even if a physical condition requires a special means of transportation
- vacation or travel, even when taken for general health purposes, improvement of morale, or to relieve physical or mental discomfort
- weight loss programs, except when the patient is being treated for a specific disease, including obesity, diagnosed by a physician

Dependant Care Reimbursement Account

A Dependent Care Reimbursement Account may be used to reimburse a Plan participant for the cost of care for eligible dependent(s), as described below. Expenses must be incurred during the calendar year in which the employee participates in the plan.

Eligible Dependents-- Effective January 1, 2007, an eligible dependent under the Dependent Care Reimbursement Account is any of the following individuals, *if the College employee claims the individual as a dependent on his/her federal tax return:*

- The employee's child or step-child (or his/her descendent) or sibling or step-sibling (or his/her descendent) under age 13, if the child or sibling does not provide over half of his/her own support during the calendar year and if the dependent shares your (the employee's) principal residence for more than six months of the calendar year (more than 182 days).
- The legal spouse of an employee who is physically or mentally incapable of caring for him/herself.

- An employee's child, grandchild, sibling, parent, grandparent, aunt, uncle, niece, or nephew who is physically or mentally incapable of caring for him/herself, and depends on the employee for at least half of his/her financial support.
- An individual who is physically or mentally incapable of caring for him/herself, depends on the employee for at least half of his/her support, and is a member of the employee's household for the entire taxable year.
 - For purposes of the Dependent Care Reimbursement Account, an individual shall be considered physically or mentally incapable of self-care if, as a result of a physical or mental impairment, the individual is incapable of caring for his/her hygiene or nutritional needs, or requires the full-time attention of another person for his/her own safety or the safety of others.

If an employee is a divorced or separated parent, he/she may be eligible to use the Dependent Care Reimbursement Account if the employee must have day care services in order to work, even if the child does not reside with the employee-parent. In the situation where a child received over one-half of his/her support during the year from his/her parents who are separated, divorced, or have lived apart for the last six months of the year, and was in the custody of one or both parents during more than one-half of the year, the child will be eligible under the Dependent Care Reimbursement Account even if the child did not live with the employee-parent for more than one-half of the year, if there is a written agreement that allows this or if the custodial parent agrees that he/she will not claim the child as a dependent. Employees are encouraged to consult a qualified tax advisor if this situation applies.

Acceptable verification of dependent status must be provided to the Plan Administrator before claims will be reimbursed for a dependent.

Eligible Dependent Care Expenses

Eligible dependent care expenses include, but are not limited to:

- amounts paid to a dependent care center, baby-sitter, or nurse in order to allow the participant and his/her spouse to work
- amounts paid to a housekeeper or cook if part of the services are provided to a person who qualifies for dependent care
- amounts paid for services performed outside the home for the care of the participant's dependent or spouse
- amounts paid to a relative who provides dependent care services, provided the relative is not the employee's or his/her spouse's: (1) dependent for whom a personal exemption deduction is allowed for federal income tax purposes, or (2) child or stepchild who is under age 19 at the end of the calendar year
- expenses for after-school programs
- expenses for a summer day camp
- the full amount paid to a nursery school, even when the school provides lunch and educational services

Ineligible Dependent Care Expenses

Certain expenses are not eligible for reimbursement through a Dependent Care Reimbursement Account.

Examples of ineligible expenses include but are not limited to:

- child care expenses when such expenses are incurred to allow an employee to participate in non-work activities
- child care expenses incurred while not actively working, such as when on leave of absence
- care in a convalescent nursing home
- cost of food, clothing, and educational expenses
- custodial care for a dependent who resides outside the participant's home
- dependent care that allows the participant or his/her spouse to do volunteer work
- expenses for which a dependent care tax credit is taken or that are reimbursed under a health care reimbursement account
- services provided by one dependent to care for another
- the cost of transportation between the employee's home and the place where dependent care services are provided
- tuition for kindergarten and schooling for first grade or higher

Submitting a Claim for Reimbursement

After a Plan participant (College employee), or his/her eligible dependent(s), has incurred eligible health care or dependent care expenses not covered / paid for through any plan, the employee must complete a Flexible Spending Accounts Plan Claim Form, available in the Human Resources office, via eDisk (Human Resources public folder), and from Significa Benefit Services. The properly completed Claim Form must be submitted to Significa Benefit Services along with other documentation as follows:

- For **health / medical care expenses**, the completed Claim Form must be submitted along with an itemized bill and "Explanation of Benefits" (EOB) indicating the name and address of the health care provider, the name of the individual receiving services, date of services, type of services, and the amount charged for services.
- For **prescription drug expenses**, the Claim Form must be submitted along with an itemized bill including the pharmacy name and address, the patient's name, date of service, description of item, prescribing physician's name, and the amount charged for the prescription medicine. The name of the prescription drug may be "blacked out" by the participant if the bill clearly shows that the requested reimbursement is limited to the co-payment amount.
- To request reimbursement for the cost of **over-the-counter medications**, the Claim Form must be submitted along with an itemized receipt that includes the name of the pharmacy or store where the medicine was purchased, name of the medicine, date of purchase, and the dollar amount of the expense.

- For **dependent care expenses**, the completed Claim Form must be submitted along with a receipt from the dependent care provider showing the name of the provider, the Federal Tax ID Number or Social Security Number of the dependent care provider, the name of the dependent(s) to whom care was provided, and the amount charged for care.

Cancelled checks presented without other required documentation are not an acceptable form of claims substantiation.

The Claim Form and additional information listed above must be submitted directly to Significa Benefit Services, P.O. Box 7777, Lancaster, PA 17604-7777, fax (717) 581-8379.

Reimbursement to the participant from the participant's account will generally be made within 14 days of when a proper claim is received by the third party administrator. The participant must have a minimum of \$25.00 in receipts to request reimbursement. The participant may request reimbursement for an amount less than \$25.00 only when he/she makes the final reimbursement request for the year. Acceptable verification of dependent status must be provided to the Plan Administrator and/or third party administrator before claims will be reimbursed for a dependent. The Plan Administrator, or the third party administrator on its behalf, reserves the right to require evidence that an individual for whom a participant is claiming expenses is a dependent as defined by the Internal Revenue Code.

Medical Expense Reimbursement Account-- Eligible medical expenses must be incurred between January 1 of the calendar year in which an employee is a participant in the Medical Expense Reimbursement Account, and March 15 of the following calendar year. If an employee participates in the Medical Expense Reimbursement Account, any claims submitted for expenses incurred between January 1 and March 15 will automatically be applied first to any remaining account balance from the previous calendar year. If there is no remaining balance from the previous calendar year or if the employee did not participate during the previous calendar year, claims will be applied against his/her current year balance.

Dependent Care Account—Eligible dependent care expenses must be incurred during the calendar year (January 1 through December 31) for which the employee is requesting reimbursement.

Expenses are treated as having been incurred when the employee or eligible dependent is provided with the service that gives rise to the expense, not when the participant is formally billed for, or pays for, the service.

In addition, the following guidelines apply to reimbursement requests:

Medical Expense Reimbursement-- A participant may request reimbursement for an amount that is greater than his/her account balance if the participant's contributions for the remainder of the year will cover the amount being reimbursed. Eligible health care expenses are only reimbursed if they are incurred while a participant in the Medical Expense Reimbursement Account Plan.

Dependent Care Reimbursement-- A participant may only be reimbursed up to the current balance in his/her Dependent Care Reimbursement Account. If a participant submits a request that exceeds his/her current account balance, the participant will be reimbursed when the funds become available in the account. Eligible dependent care expenses are only reimbursed if they are incurred in the same calendar year as contributions are withheld from pay.

Participants have until March 31 of the following calendar year to request reimbursement from their accounts for expenses incurred during the plan (calendar) year (or through March 15 for the Medical Expense Reimbursement Account).

Please note: To receive reimbursement for eligible expenses, a properly completed Claim Form plus substantiating document(s) as outlined above must be hand-delivered, submitted by fax, or mailed and postmarked to the Plan's third party administrator (Significa Benefit Services) no later than by March 31.

***Please note:* Any amounts remaining in a participant's account(s) after this date must be forfeited by the participant.**

Coordination between the Health Reimbursement Account and the Medical Expense Reimbursement Account-- As noted above, if a Medical Expense Reimbursement Account participant also participates in the College's High Deductible Health Plan with Health Reimbursement Account, reimbursement to the employee for his/her eligible medical expenses will be provided first from any balance in the employee's Health Reimbursement Account (HRA). If the participant does not have enough funds in the HRA to provide full reimbursement for his/her eligible medical expenses, the remaining amount which cannot be reimbursed from the participant's HRA balance may then be submitted for reimbursement by the participant through his/her Medical Expense Reimbursement Account. An employee may not be reimbursed for the same incurred medical expense from both the Health Reimbursement Account and the Medical Expense Reimbursement Account. However, if the balance in an employee's HRA is not sufficient to provide full reimbursement for an eligible medical expense, the employee may then request reimbursement of the remaining eligible expense through his/her Medical Expense Reimbursement Account, if a balance remains in this account and if the expense is an "eligible" expense under the Medical Expense Reimbursement Account.

Important Information About Taxes

In some cases, an employee may be able to deduct certain medical care expenses from income, and receive a tax credit for certain dependent care expenses when filing the federal tax return, as described below. The College acts only as the Plan Administrator and sponsor for the Medical Expense and Dependent Care Reimbursement Plans and bears no responsibility for any employee's tax obligations. Employees remain fully accountable to the IRS to prove the eligibility of any expense that was submitted for reimbursement. Employees are encouraged to consult their tax or financial advisor to determine what is best for their personal financial situation.

Medical Care Expenses-- If an employee decides to reimburse him/herself for eligible medical care expenses through his/her Medical Expense Reimbursement Account, the participant cannot claim those same expenses as deductions on his/her income tax return. In most cases, a medical care reimbursement account is more advantageous than

the tax deduction. Current IRS regulations require that out-of-pocket expenses exceed 7.5% of adjusted gross income in order to be eligible for deduction on the federal tax return. In addition, regulations only allow individuals to deduct those expenses that exceed 7.5% of adjusted gross income. By using pre-tax dollars to pay for eligible expenses, through the Medical Expense Reimbursement Account, the tax advantage begins immediately.

Dependent Care Expenses-- Current IRS regulations allow individuals to take a dependent care tax credit when they file their taxes. A taxpayer may claim credit on qualified expenses up to \$3,000 for one dependent and up to \$6,000 for two or more dependents. If an employee chooses to reimburse him/herself on a pre-tax basis through his/her Dependent Care Reimbursement Account, those reimbursed expenses will reduce the amount of federal tax credits available. For each dollar reimbursed from the Dependent Care Reimbursement Account, one less dollar of expenses may be claimed for a federal tax credit. Employees may wish to consult a tax advisor to determine whether their tax advantages will be greater by participating in the Dependent Care Reimbursement Plan or claiming a dependent care tax credit.

Coordination of Benefits

Health Insurance Portability and Accountability Act of 1996

The Flexible Spending Accounts Plan will use a participant's Protected Health Information (PHI), in accordance with HIPAA, only for required uses or purposes related to treatment, payment, and Plan operations. However, if a Plan participant provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the authorization. Further, the Plan will disclose PHI to the Plan Sponsor (Franklin & Marshall College) only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions:

Use and Disclosure of Protected Health Information-- With respect to PHI, the Plan Sponsor agrees to:

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

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

Security of Protected Health Information-- With respect to Electronic PHI, the Plan Sponsor agrees to:

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

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

Termination of Coverage / When Plan Participation Ends

Participation in the Reimbursement Account(s) and pre-tax contributions will end on the earliest of:

- For the Medical Expense Reimbursement Plan, the last day of the month in which employment terminates.
- For the Dependent Care Reimbursement Plan, the date employment ends.
- For both types of plans:
 - the date of retirement,
 - the date an employee is no longer eligible for the plan, or
 - the date the plan is terminated.

When employment is terminated, pre-tax contributions (salary reductions) for both accounts end. An individual may continue to request reimbursement for medical care expenses incurred prior to his/her termination date. Eligible medical care expenses will be reimbursed to the full extent of the individual's unused annual contribution amount. Eligible dependent care expenses will be reimbursed to the full extent of the individual's unused account balance as of his/her termination date for qualified dependent care expenses incurred during the remainder of the calendar year in which termination occurs.

The balance in an individual's Reimbursement Account(s) will be maintained until March 31 of the following year, so that the individual can submit claims for any unreimbursed expenses.

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 coverage through COBRA, if coverage is lost. This section describes COBRA continuation rights if coverage through the Group Health Insurance & Prescription Drug Plan and/or Group Dental Insurance Plan is lost, and continuation rights if coverage through the Medical Expense Reimbursement Account is lost.

Employees and retirees of Franklin & Marshall College, and their dependents, who are covered under the College's Group Health Insurance & Prescription Drug Plan and/or Group Dental Insurance Plan have the right to temporary continuation of their health insurance or dental insurance coverage if coverage is lost due to a "Qualifying Event", as required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA guarantees an opportunity to elect temporary continuation of health and dental insurance 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 continued health coverage includes prescription drug coverage.

Participants who lose coverage through the Medical Expense Reimbursement Account may elect to temporarily continue their coverage, through the remainder of the Plan Year, via COBRA.

Qualifying Events

An **employee** of Franklin & Marshall College enrolled in the Group Health Insurance & Prescription Drug Plan, Group Dental Insurance Plan, and/or Medical Expense Reimbursement Account has the right to choose continuation coverage for him/herself, his/her covered spouse, and any covered dependent children as applicable, if the employee, spouse, or dependent children lose coverage under the Plan(s) due to:

- a reduction in the employee's hours of work that leads to loss of eligibility for coverage through the Group Health Insurance & Prescription Drug Plan and Group Dental Insurance 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

Insurance & Prescription Drug Plan or Group Dental Insurance 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 this Plan, due to a Qualifying Event as 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 College's Group Health Insurance & Prescription Drug Plan and Group Dental Insurance 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(s) (child reaching his/her age limitation, or any other change in status which effects eligibility for coverage).

A dependent child who loses coverage under this Plan, due to a Qualifying Event as 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 Group Health Insurance & Prescription Drug 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 Insurance & Prescription Drug Plan, Group Dental Insurance Plan, and/or Medical Expense Reimbursement Account. 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 relevant 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 Plans, the spouse or dependent child who is losing coverage through the College's Plans, 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 College's Group Health Insurance & Prescription Drug Plan and/or Group Dental Insurance Plan due to a Qualifying Event,
3. a brief description of the Qualifying Event that has resulted, or will result, in loss of coverage through the College's plans (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 coverage through the College's plans 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 or retired employee during the COBRA period, the employee/retiree must notify the Plan Administrator **within 31 calendar days of the birth or adoption** in order to elect health insurance and prescription drug coverage and/or dental insurance coverage through COBRA 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 health insurance and prescription drug and dental insurance 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 plans 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 coverage through COBRA 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 coverage will terminate effective when the employment termination or other Qualifying Event occurred, in accordance with the provisions outlined in the Plan Documents.

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 Health Insurance & Prescription Drug Plan, Group Dental Insurance Plan, and/or Medical Expense Reimbursement Account 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 as applicable.

A failure to elect COBRA coverage may affect future rights under federal law, including the right to avoid having pre-existing condition exclusions applied by other group health plans. The guaranteed right to purchase an individual health insurance policy that does not impose pre-existing condition exclusions will also be forfeited.

An employee/former employee, 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 College's Health Insurance & Prescription Drug Plan through the other plan.

Coverage Periods

Group health insurance and prescription drug continuation coverage and/or dental insurance coverage through COBRA may be elected for a maximum period as follows:

- If the person affected by loss of coverage through the College's Health Insurance & Prescription Drug Plan and/or Dental Insurance 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 Health Insurance & Prescription Drug Plan and/or Group Dental Insurance 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 and/or group dental 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 and/or 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 Health Insurance & Prescription Drug Plan and/or Group Dental Insurance 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 and/or 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, 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.

Medical Expense Reimbursement Account-- A Medical Expense Reimbursement Account participant who terminates his/her employment with the College, or becomes ineligible for coverage through the Flexible Spending Accounts Plan, may submit claims for reimbursement for eligible medical expenses incurred through his/her termination date or date he/she becomes ineligible for participation. A participant may elect to continue to participate in the Medical Expense Reimbursement Account, via COBRA, through the remainder of the Plan Year, but may not change his/her previous salary reduction election. If COBRA continuation coverage is elected, monthly contributions to the Medical Expense Reimbursement Account are made by the participant on an after-tax basis following employment termination or the Qualifying Event which resulted in loss of coverage. Claims for reimbursement of eligible medical expenses incurred during the Plan Year in which the employment termination or other Qualifying Event occurs may be submitted.

COBRA Premiums

COBRA participants pay 100% of the health insurance and dental insurance group rate premium for continuation coverage, plus a 2% administrative fee. Current monthly premiums can be found in the Summary Plan Description for the Group Health Insurance & Prescription Drug Plan and the Summary Plan Description for the Group Dental Insurance Plan, available from the Plan Administrator (via the Human Resources office).

If the COBRA health insurance and/or dental insurance 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.

The law requires that, at the end of the 18 month, 29 month, or 36 month health insurance continuation coverage period, participants be allowed to enroll in an individual conversion health plan if one is available under the terms of the College's Group Health Insurance & Prescription Drug Plan. In addition, under the Health Insurance Portability & Accountability Act, in certain circumstances, such as when COBRA coverage terminates, an individual may have the right to buy individual health coverage with no pre-existing condition exclusion, and without providing evidence of good health. The College's health insurance carrier must be contacted directly to request conversion to an individual policy.

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

Circumstances Which May Affect Benefits

The College believes the Section 125 Plan is fully qualified as a "cafeteria plan" under the Internal Revenue Code and that the benefits it provides are therefore tax-free. However, there can be no assurance that the intended tax benefits will be available. Participants

will be liable for any tax plus interest that would be imposed in the unlikely event that benefits are ruled unqualified by the Internal Revenue Service. Federal law makes it necessary to sometimes limit or restrict contributions or elections under the Section 125 Plan which discriminate in favor of officers and highly compensated employees of the College. A participant will be notified in the event any such limit may apply.

Nothing in the Section 125 Plan gives an employee a right to continued employment and the College retains the right to discharge an employee at any time, except for the purpose of denying the employee any benefits for which he/she would otherwise be entitled.

Benefit Denials and Claims Procedures

Benefit Denials-- If a College employee or his/her dependent claims benefits under the Group Health Insurance & Prescription Drug Plan and/or Group Dental Insurance Plan offered through this Section 125 Plan, and the claim for benefits is denied, an appeal process will be provided under the terms of the Group Health Insurance & Prescription Drug Plan and the Group Dental Insurance Plan. This Section shall apply only to the extent that a claim for benefits is not governed by a provision of a benefit plan available under this Plan. Any claim governed by a provision of a benefit plan available under this Plan shall be subject to review under such benefit plan and not under this Plan.

The Plan Administrator is responsible for establishing and maintaining reasonable procedures for: 1) filing claims, 2) providing notification of benefit decisions, and 3) appealing negative benefit decisions (collectively referred to as "claims procedures"). The Plan Administrator is also responsible for making certain that the procedures comply with ERISA and that claims are considered consistently for participants in similar situations.

The College assigned responsibility for processing claims under this Plan to Significa Benefit Services, an independent third party administrator. Participants are to contact Significa Benefit Services with questions about requesting benefits and filing claims. By filing a written request with Significa Benefit Services, a participant may designate a representative to act on his/her behalf in pursuing a benefit claim or appealing a negative benefit decision. The request must identify who and to what extent a person is authorized to act on the participant's behalf. The Plan will then recognize the level of authority granted to the representative by the participant. Significa Benefit Services' mailing address is P.O. Box 7777, Lancaster, PA 17604-7777. Significa Benefit Services' telephone numbers are (717) 581-1300 and (800) 433-3746.

Significa Benefit Services' authority is limited to processing claims according to the claims procedures established and maintained by the Plan Administrator. Significa Benefit Services may not make independent decisions involving claims that are different from the rules established by the Plan Administrator.

Incorrectly and incompletely filed claims cannot be paid or reimbursed. A claim is incorrectly filed if a participant or participant's representative does not follow the Plan Administrator's claims procedures. A claim is incompletely filed if a participant or participant's representative submits a claim that omits any information considered necessary by the Plan Administrator.

The time for making an initial claims decision begins to run when a claim is filed according to the Plan Administrator's claims procedures, regardless of whether the Plan has all of the information necessary to decide the claim at the time of the filing. The Plan will be deemed to have received a claim for benefits under this Plan if a participant or a participant's representative makes a written communication reasonably calculated to bring a request for a claim to the attention of Significa Benefit Services.

If Significa Benefit Services denies any claim for benefits under this Plan, Significa Benefit Services promptly and in writing will notify the participant of such denial. The notification of a denial of a claim for benefits will be made not later than 30 days after receipt of the claim by Significa Benefit Services. However, if a written extension notice is provided to the participant or the participant's representative before the end of that 30-day period, the time to consider a claim may be extended for an additional 15 days, as long as the circumstances necessitating the extension are beyond the control of the Plan. The extension notice will include the reason for the extension, as well as the date by which a decision by Significa Benefit Services can be expected. Significa Benefit Services may secure independent medical or other advice and require such other evidence as deemed necessary to decide a claim for benefits.

Written notice of a negative benefit decision will include: 1) the specific reason(s) for the denial of benefits, 2) the specific Plan provision(s) on which the denial is based, 3) a description of any additional material or information necessary for the participant or participant's representative to perfect 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 negative benefit decision, including an explanation of the participant's or his/her representative's right to review relevant documents and information, and the participant's right to file suit under ERISA with respect to any negative benefit decision after appeals of a claim have been exhausted.

If a claim is denied in whole or in part, the participant or his/her representative may appeal to Significa Benefit Services for review of the claim. The appeal must be made within 180 days of Significa Benefit Services' notice of the negative benefit decision. If the appeal is not made within 180 days, the participant will lose his/her right to appeal and bring a civil action under section 502(a) of ERISA. The participant's or representative'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 participant or participant's representative may ask additional questions of Significa Benefit Services, make written comments, and may review (on request and at no charge) documents and other information relevant to the appeal. Neither the participant nor the participant's representative will be provided access to or copies of files of other participants.

Significa Benefit Services will review and decide the participant's or representative's appeal within a reasonable time and, within 30 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. Significa Benefit Services may require additional relevant information to decide the claim. If the decision on appeal affirms the initial denial of the participant's claim for benefits under the Plan, the participant or his/her representative will be furnished with a notice of negative benefit decision 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 participant's or representative'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 decision and a statement that such rule, guideline, or protocol will be provided to the participant or his/her representative upon request at no charge, and 5) a statement of the participant's right to bring suit under ERISA.

If the initial appeal of a participant's benefit claim is denied, the participant or representative may then appeal to the Plan Administrator for review of the denial. The second appeal must be made within 60 days of the date of receipt of Significa Benefit Services' notice of a denial of the first appeal. If the second appeal is not made within 60 days, the participant will lose his/her right to appeal and bring a civil action under section 502(a) of ERISA.

The participant's or representative's second written appeal may include comments, documents, records, and any other information relating to the participant's claim. During the period that the claim is being reconsidered, upon request and free of charge, the participant or participant's representative will also have access to, and the right to obtain copies of all documents, records, and information relevant to the participant's claim. Neither the participant nor the participant's representative will be provided access to or copies of files of other participants.

The Plan Administrator will review the full record of the claim within a reasonable time and, within 30 days after receiving the written appeal, shall render, in writing, an independent decision about the participant's or representative's second appeal. The notice will include the same information that was included in the notice of negative benefit decision at the first level of appeal. Neither the reviewer of the first appeal nor a subordinate of that individual will be involved in the decision about the second appeal. The Plan Administrator will not give deference to the first level appeal decision.

The Plan Administrator may require additional relevant information to decide the second appeal. All medical information supplied to the Plan Administrator is to be kept confidential and protected from unauthorized use. However, a second appeal involving certain claims for benefits may require the use of a special, written authorization form. If Significa Benefit Services sends a participant or participant's representative one of these forms, it must be signed and returned to Significa Benefit Services as soon as possible so there is no delay in the Plan Administrator considering the second appeal.

If the Plan Administrator denies the claim on second appeal, the decision will be final and binding on all parties.

Funding

All benefits under the Section 125 Plan are paid directly from the general assets of the College. Unless required by federal law, no assets will be set-aside in a separate trust to provide benefits.

Amendment and Termination of The Section 125 Plan

While it is intended that the Section 125 Plan will be continued indefinitely, the College reserves the right to amend or terminate the Section 125 Plan at any time and for any

reason. If the Section 125 Plan is amended or terminated, the College will notify employees. No consent of any participant or beneficiary is required to terminate, modify, amend, or change the Plan.

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Group Health Plan and Group Dental 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 and group dental plan or insurance carrier when you lose coverage under a health or dental 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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