Welfare Benefit Plan
SUMMARY PLAN DESCRIPTION
for
Franklin Pierce University

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No provisions of any of your benefit plans are considered a contract of employment between you and Franklin Pierce University nor does your participation in any plan provide any guarantee of continued employment.

ABOUT THIS BOOK

This document, along with the materials sent with it (such as insurance booklets, certificates or provider contracts) is the summary plan description ("SPD") for the Franklin Pierce University Welfare Benefit Plan (the "Plan"). These documents describe the Plan as in effect on 07/01/2010. The Plan may be changed from time to time.

For additional information about the Plan, you should refer to the official plan documents and the full insurance contracts. Copies are available from Franklin Pierce University upon request. If the terms of this SPD conflict with the Plan documents, the Plan documents shall govern.

Franklin Pierce University expects to maintain the Plan indefinitely but reserves the right to amend or terminate the Plan if Franklin Pierce University believes the situation so requires. If you have elected to participate in the Plan, you will be notified in writing if there is any significant amendment or if the Plan is terminated. If the Plan is terminated, Franklin Pierce University will cease deducting any applicable contributions from your salary to pay for Welfare Programs. However, all previous salary deductions will be used to pay for Welfare Programs that you have elected.

This booklet contains a summary in English of your Plan rights and benefits under the Plan. If you have any difficulty understanding any part of this booklet, please contact the Plan Administrator during standard business hours.

PLAN INFORMATION

Franklin Pierce University	
Plan Name	Franklin Pierce University Group Medical Insurance HMO and PPO
Plan Number	502
Plan Sponsor	Franklin Pierce University PO Box 60 Rindge, NH 03461 603-899-4077 www.franklinpierce.edu
Plan Sponsor Employer Tax ID Number	02-0263136
Plan Administrator	Franklin Pierce University PO Box 60 Rindge, NH 03461 603-899-4077 www.franklinpierce.edu
Agent for Legal Process	Franklin Pierce University PO Box 60 Rindge, NH 03461 603-899-4077 www.franklinpierce.edu
Plan Type	Medical Welfare programs, including the following: • **Harvard Pilgrim HMO 3V Medical Insurance** • **Harvard Pilgrim HMO 14 Medical Insurance** • **Harvard Pilgrim PPO XI Medical Insurance**
Plan Year	July 1, 2010 to June 30, 2011
Plan Funding	Fully Insured

CLAIMS ADMINISTRATORS

Welfare Program	**Claims Administrator's Name, Address and Telephone Number**
Medical	Harvard Pilgrim Health Care of New England **Claims for Mental Health/Drug & Alcohol Rehab:** Behavorial Health Access Center - C/O PacifiCare PO Box 31053 Laguna Hills, CA 92654-1053 **Pharmacy Claims:** MedImpact - DMR Department 10680 Treena Street, 5th Floor San Diego, CA 92131 **All other claims:** HPHC-NE Claims PO Box 699183 Quincy, MA 02269-9183 888-333-4742 www.harvardpilgrim.org

ELIGIBILITY & ENROLLMENT

You are eligible to participate in the Plans if:

Eligible Employees: employees working a minimum of 40 hours per week are eligible to participate in the Harvard Pilgrim health plans.

Eligible Spouse: The legal spouse of the employee, including a partner in a legal civil union. Please note that a divorced or separated spouse of the employee may be eligible for coverage under New Hampshire law in accordance with RSA 415:18 XVI (c)(5) (see section J.4.b.2. for more information). In the event of a divorce or legal separation, the former spouse of the employee may remain eligible for coverage under the employee's policy until the earliest of one of the following events:

1. The remarriage of the employee
2. The remarriage of the divorced spouse
3. The termination of the employee's policy
4. The three-year anniversary of the final decree of divorce or legal separation
5. Such earlier time as provided by the final decree of divorce or legal separation

Eligibility will not be granted if the decree of divorce expressly disallows coverage.

Eligible Child(ren): 1) An unmarried child (including an adopted child) of the employee or spouse of the employee under 26 years of age, who:

(a) resides within the Enrollment Area or is enrolled as a student in an accredited institution of higher education; and

(b) is not covered under any other public or private medical plan or entitled to benefits under Medicare.

Notwithstanding the above requirements, an eligible dependent who is unable to remain in an accredited educational institution on a full time basis due to a medically necessary leave of absence shall be eligible for continued enrollment under the Plan. Eligibility for continued enrollment shall extend up to the earlier of:

(i) 12 months from the date the dependent's leave of absence began,

(ii) age 26, or

(iii) the date on which the child's dependent status would otherwise end under the Plan. The Plan must be provided with documentation from the dependent's attending physician certifying that the leave of absence is Medically Necessary.

2) An unmarried child (including an adopted child) of the employee or spouse of the employee, who is no longer eligible under paragraph above, and meets each of the following requirements:

(a) is currently totally disabled;

(b) became totally disabled while enrolled as a dependent under paragraph above; and

(c) remains chiefly financially dependent on the employee.

An individual will be determined to be "totally disabled" by HPHC-NE only if he or she:

(i) is unable to perform all of the substantial and material duties of his or her regular occupation;

(ii) is unable to engage in any other employment or occupation for which he or she is qualified by reason of education, training or experience; and

(iii) is not in fact engaged in any employment or occupation for wage or profit other than a sheltered workshop or similar program for persons with disabilities.

3) An unmarried child under 19 years of age, for whom the employee or employee's spouse is the court appointed legal guardian. Proof of guardianship must be submitted to HPHC-NE prior to enrollment.

4) The child of an eligible dependent of the employee until such time as the parent is no longer a Dependent.

ENROLLING IN THE PLAN

The Plan Administrator will let you know the process for enrolling yourself, your spouse and/or your dependents, including what forms you may need and any applicable deadlines.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for a group health plan to provide coverage to an employee's child or children. The Plan provides health care coverage for your child under the terms of a QMCSO—even if you do not have legal custody of the child and the child does not depend on you for support—and whether or not any enrollment restrictions might otherwise apply for dependent coverage. If the Plan receives a valid QMCSO and you do not enroll the dependent child, the custodial parent or a state agency may enroll the child.

Federal law requires that a QMCSO meet certain form and content requirements in order to be valid. If you have any questions or you would like a copy of the written procedures for determining whether a QMCSO is valid, please contact the Human Resources Department at 603-889-4077.

Effective Dates

When Coverage Begins

Once you enroll, the date coverage begins depends on why and when you are enrolling. As long as you enroll within the timeframes required by the Plan, your coverage will begin as follows:

Event	**Coverage Begins**
New Hire – if you are a new hire, your coverage begins:	first of the month following 30 days of employment
Newly Eligible – if you are newly eligible to participate in the plan, your coverage begins:	first of the month following date of eligibility
Open Enrollment – if you enroll during open enrollment, your coverage begins:	on the first of the month that begins the new plan year
Mid-Year Enrollment – if you enroll during the year (other than during open enrollment) coverage begins:	first of the month following date of qualifying event
Marriage – if you enroll within 31 days after marriage, coverage begins:	first of the month following date of marriage
Birth – if you enroll your dependent within 31 days after his or her birth, coverage begins:	first of the month following date of birth
Adoption/Placement for Adoption - if you enroll your dependent within 31days after his or her adoption or placement, coverage begins:	first of the month following date of adoption or placement.
Loss of Coverage – if you enroll within 31 days after your loss of coverage (60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage), coverage begins:	date of loss of coverage
Eligibility for Medicaid or CHIP contributions – if you become eligible for employee contribution subsidies from Medicaid or CHIP you may enroll within 60 days after eligibility. Plan coverage begins:	the date of the effective date of the subsidy

If you are reinstating coverage and your previous coverage under the Plan ended due to a period of service covered under the Uniformed Services Employment and Re-employment Rights Act of 1994, your coverage is effective on the day you return to work. Waiting periods and pre-existing condition limits will be imposed only to the extent they applied before your coverage ended.

CHANGING YOUR ELECTION

(Plans with Pre-Tax Contributions or After-Tax Using Pre-Tax Guidelines—if Adopted by plans). Participants in any Welfare Programs listed in this document may not enroll or change their election until the next annual enrollment—unless there is a qualified status change.

Qualified status changes include:

- Marriage, divorce, legal separation, or annulment of a marriage,
- Birth, adoption, or placement for adoption of a child,
- Death of an eligible dependent
- Loss of your dependent's eligibility (for example, a dependent child who no longer meets the age limitations under the plan),
- Changes in your dependent's employment status that affect the individual's coverage under a plan,
- Changes in place of residence that could affect the availability of coverage under the service area
- Changes in your or your eligible dependent's coverage (including coverage changes under Medicare, CHIP or another employer's plan). This would include changes due to an annual enrollment change, significant change in cost or coverage, or significant change in level of benefits.

Your enrollment or change in benefits must be consistent with your qualified status change and you must notify the plan administrator of any change in status within 30 days of the status change. For information on how to change your benefit election, contact the Plan Administrator.

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) in a group health plan listed in Appendix A because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April, 1, 2009, if you or your spouse or dependents are eligible, but not enrolled, in a group health plan listed in Appendix A you may enroll when:

- Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and you request coverage under a group health plan within 60 days after termination of such coverage, or
- You or your spouse or dependent become eligible for a premium assistance subsidy under Medicaid or CHIP and you request coverage under a group health plan within 60 days after eligibility is determined.

The special enrollment rules do not apply to limited scope dental or vision benefits or certain health care flexible spending accounts (e.g., spending accounts that limit benefits to employee salary reduction amounts). To request special enrollment or obtain more information, contact the Plan Administrator.

STATE MEDICAID PROGRAMS

With the exception of the previously mentioned Special Enrollment rules, eligibility for coverage or enrollment in a State Medicaid Program will generally not affect your eligibility or a dependent's in this Plan. Payment of benefits shall be in accordance with any assignment of rights as required by any State Medicaid Program.

If a Welfare Program available under this Plan contains provisions regarding coordination of benefits with State Medicaid Programs, the language in the written materials for such Welfare Program will govern unless the language fails to comply with applicable laws and regulations.

COST

You and Franklin Pierce University share the cost of medical coverage for you and your family. You will be notified of the cost when you enroll for the first time and during annual enrollment. You may opt to pay your share of the cost on a Pre-tax basis. This means your contribution would be taken before most federal, state, and local taxes are taken from your paycheck. Therefore, this Pre-tax deduction would lower your taxable income.

SPECIAL RULE FOR WOMEN'S HEALTH COVERAGE

The Women's Health & Cancer Rights Act of 1998 requires group health plans that provide coverage for mastectomies to provide mastectomy-related benefits to Plan participants. Specifically, the legislation requires that when a covered individual receives benefits for a mastectomy and decides to have breast reconstructive surgery, the Plan must provide coverage in a manner determined in consultation with the attending physician and the patient, for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce symmetrical appearances; and
- prostheses and physical complications at all stages of the mastectomy, including lymphedemas.

These procedures will be covered the same as any other medical/surgical benefit under the Plan. Certain general coverage limitations may apply including, but not limited to, deductibles, co-insurance, co-payments and reasonable and customary charges.

SPECIAL RULES FOR MATERNITY AND INFANT COVERAGE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

CLAIM PROCEDURES

For instructions on how to file a claim for benefits under a specific plan, contact the Claims Administrator listed above. Except as noted below, benefit claims under each plan will be reviewed in accordance with procedures contained in the policies, contracts, or other written materials for such Plan benefits. All other general claims or requests should be directed to the Claims Administrator.

A claim for benefits is a request for benefits made by you, your dependent or your representative that complies with the Plan's reasonable procedures for claims.

Claims are divided into four categories:

- Pre-Service Claims, which are claims for benefits where approval is required before you get care. Benefits will not be denied if it is not possible to get advance approval or if the process would jeopardize your life or health.
- Urgent Care Claims, which are claims for care or treatment, as determined by the Plan, that would:
    - Seriously jeopardize your life, health or ability to regain maximum function if normal pre-service standards were applied; or

- Subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a physician with knowledge of your condition.

- Concurrent Care Claims, which are claims that are reconsidered after initially approved (such as recertification of the number of days of an inpatient stay) and the reconsideration results in reduced benefits or a termination of benefits.
- Post-Service Claims, which are claims for benefits where you have already received the services for which the claim is being submitted.

Filing a Claim

Many providers will file claims for you. If your provider does not, follow the steps listed in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed.

Be sure to show your ID card to your provider so they will know where to submit the claim. If your provider does not submit your claim for you, then you must do so. When you need to submit a claim, follow the steps listed below to make sure your claim is processed as quickly as possible.

Step 1: When you receive covered services or supplies, be sure your bill or statement shows the:

- Provider's name and address;
- Full name of the patient (no nicknames);
- Date of service;
- Charges, listed separately for each service;
- Description of services;
- Diagnosis; and
- Nine digit identification number from your ID card.

Step 2: Obtain the appropriate claim form from your employer or the Plan.

Step 3: Complete the claim form.

- Make sure to provide all requested information.
- Use a separate claim for each individual.
- Review the form to ensure accuracy. Incomplete forms will be returned to you, which will cause a delay in payment.
- Make a copy of the claim for your records; originals cannot be returned to you.
- Be sure to sign and date the form.

Step 4: Submit the form to the address listed on the form.

- Be sure to enclose the original bill or statement with the form; cash register receipts, cancelled checks and money order stubs are not acceptable.
- If you or your dependent have coverage under another plan (including Medicare), be sure to include information on the other coverage, including any Explanation of Benefits (EOB) if the other plan paid first.

Claim Filing Deadlines

Claims can be filed by you, your dependent, your beneficiary or someone authorized to act on your or their behalf. However, claims should be submitted as soon as possible. If a claim is not submitted by 12 months from the date of service, it will be denied.

Assignment of Benefits

"Assigning" benefits means that you authorize the Plan to pay a provider directly. You must provide a written, signed authorization to assign benefits. Once benefits are assigned, all payments will then be made directly to the provider, unless you or dependent later notify the Plan, in writing, to make payment directly to you.

Explanation of Benefit (EOB)

Whenever a claim is processed, you will receive a printed summary, called an Explanation of Benefits or EOB. An EOB is an itemized statement that shows what action has been taken on a claim; it is not a bill. It is provided to help you understand how expenses were paid and that the information received by the Plan was correct. An EOB is for your information and files. When you receive an EOB, you should review it to verify that it is accurate; be sure to report any inaccuracies. If you receive an EOB from other coverage, be sure to provide it along with your related claim.

Claim Decisions

Generally, the following claims procedures apply to claims made under this Plan. However, to the extent that these procedures are inconsistent with the claims procedure contained in the policies, contracts or other written materials of the Plan, the claims procedure in those materials supersede these procedures as long as the other claims procedures comply with government regulations.

Once your claim is submitted, it will be reviewed to determine if you are eligible for benefits and the amount of benefits payable, if any, will be calculated. All claims are processed promptly, when complete claim information is received. Generally, determinations are made as soon as administratively possible as follows:

- Pre-Service Claims. An initial determination will be made within 15 days after your claim is received.
    - If more time is needed due to matters beyond the Plan's control, you will be informed, within this 15-day deadline, that an extension of up to 15 additional days is needed.
    - If more information is needed to process your claim, you will be notified within 15 days of receipt of the claim. You will then have up to 45 days to provide the requested information. You will be notified of a determination within 15 days after this additional information is received.
- Urgent Care Claims. A determination will be made within 72 hours from receipt of the claim. Notice of a decision on an urgent care claim may be provided orally within 72 hours and then confirmed in writing within three days after the oral notice. If more information is needed to process the claim, you will be notified within 24 hours of receipt of the claim. You will then have up to 48 hours to respond. You will be notified of a determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.

- Concurrent Care Claims. A determination will be made as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated if possible.
    - If you ask for an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as the claim is received at least 24 hours before the approved treatment ends.
    - If a concurrent care claim does not involve urgent care treatment or is filed less than 24 hours before the previously approved period or number of treatments runs out, the claim will be processed according to the type of claim involved.
- Post-Service Claims. An initial determination will be made within 30 days of receipt of the claim.
    - If more time is needed due to matters beyond the Plan's control, you will be informed, within this 30-day deadline, that an extension of up to 30 additional days is needed.
    - If more information is needed to process your claim, you will be notified within 30 days of receipt of your claim. You will then have up to 45 days to provide the requested information. You will be notified of a determination within 15 days after this additional information is received.

If an extension is needed, the extension notice will include the reason(s) for the extension and the date a decision is expected.

If a Claim Is Denied

If a claim is denied (in whole or in part), you (or your beneficiary) will receive a written notice, within the timeframes described above, that includes:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process the claim and an explanation of why it is needed;
    - A copy of the Plan's review procedures and the periods that you must comply with to request an appeal decision, including:
    - A description of the expedited review process for urgent care claims, if applicable; and
    - A statement that you may bring a lawsuit under ERISA after appealing the denial; and
- If applicable, a statement that a copy of:
    - Any rule, guideline, protocol or similar criteria on which the claim is denied is available at no cost upon request, if applicable; and
    - Any scientific or clinical judgment relating to medical necessity, experimental treatment or similar exclusion or limit on which the claim is denied is available at no cost upon request.

Appealing a Denied Claim

If a claim is denied or you disagree with the amount of the benefit, you may have the initial decision reviewed. You must follow and exhaust the Plan's appeals procedure before you file a lawsuit under ERISA (the federal law governing employee benefits) or initiate proceedings before any administrative agency.

In general, written requests for an appeal should be sent as soon as possible. If a claim is denied or if you are otherwise dissatisfied with a Plan determination, a written appeal must be filed within 180 days from the date of the decision. For urgent care claims, the appeal may be made orally or sent by fax.

Your written appeal should explain the reason(s) you disagree with the decision and any other information requested in the denial notice. When filing an appeal you may:

- Submit additional materials, including comments, statements or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on medical necessity, experimental treatment or similar exclusion or limitation.

Appeal Decisions

If an appeal is filed on time, following the required procedures, a new, full and independent review of the claim will be made. The new decision will not consider the initial decision. An appropriate Plan fiduciary will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information provided. If the request for review involves a claim for benefits that are provided by an insurance company, that company will make the review and final decision.

A determination on appeal will be made within certain timeframes for the different types of claims as follows:

- **Pre-Service Claims.** A determination will be made within 15 days of receipt of the appeal.
- **Urgent Care Claims.** A determination will be made within 72 hours of receipt of the appeal.
- **Concurrent Care Claims.** A determination will be made, if possible, before termination or reduction of the benefit.
- **Post-Service Claims.** A determination will be made within 30 days of receipt of the appeal.

Written notification of the decision will be provided within five days after a determination is made. However, oral notice of a determination on an urgent care claim may be provided sooner. The written notice will include all required information, including information on how to request a second level appeal, if applicable, and a statement indicating that you may bring a lawsuit under ERISA after the denial of an appealed claim.

Final Appeal

If you are dissatisfied with the Claims Administrator’s decision on your initial appeal, you may request a second and final review. The final review follows the same process as the initial appeal.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing. All necessary information, including the Plan’s benefit determination on review, will be transmitted between the Claims Administrator and the claimant by telephone, facsimile or other available similarly expeditious method. In general, urgent care guidelines apply when you

need to have the process expedited to prevent serious risk to your health, life or ability to regain maximum functionality, or in the opinion of your physician to prevent severe pain that cannot be managed without the requested services. The decision on expedited appeals will be communicated orally within 72 hours and will be followed up in writing.

Authorized Representatives

You may designate another person as your authorized representative for filing a claim. Except in the case of an urgent care claim, this designation must be in writing. Unless your authorization states otherwise, all notices regarding your claim will be sent to your authorized representative and not to you. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide written notification authorizing this representative, and comply with the Plan procedures. Written notification must be received before a determination is made. You or your representative may review the pertinent records and documents.

You may have, at your own expense, legal representation at any stage of the review process. If any Plan provision is determined to be unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other Plan provisions.

Medical Judgments

If a claim or appeal is denied based on a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the judgment; and
- Was not consulted (or does not report to the person who was consulted) in connection with the original denial of the claim.

You may ask for the identity of any medical experts the Claims Administrator consulted when deciding your claim.

Incompetence

If the Plan determines that a person entitled to benefits is unable to care for his or her affairs because of illness, accident or incapacity (either physical or mental), payment that would otherwise be made to that person will be made to that person's duly appointed legal representative. If no legal representative has been appointed, payment will, at the discretion of the Plan, be made to that person's spouse, child or such person who has care and custody of that person.

Release of Information

By participating in the Plan, you authorize physicians, hospitals and other providers to provide the Plan, upon request, with information relating to services that you are or may be entitled to under the Plan for treatment, payment and health care operations. This authorization allows the Plan to examine records with respect to the services and to provide information requested. All information related to treatment remains confidential, except for the purpose of determining rights and liabilities under the Plan.

Coordination of Benefits (COB)

Benefits under the Plan are coordinated with benefits provided by other plans under which you are also covered. For the purpose of coordinating benefits, a plan is one that covers medical or dental expenses and provides benefits or services. Each plan will determine what is an allowable expense according to its own provisions.

Effect on Benefits

One of the plans involved will pay benefits first. This called the primary plan. All other plans are called secondary plans. When this Plan is the secondary plan, the benefit payable under this Plan will not exceed the cost of the service less the amount paid by the primary plan.

For example, assume you incur a $100 expense. The primary plan pays 80% of this charge, or $80. This Plan will pay the remaining 20%, or $20.

Order of Benefit Determination

If you have health coverage under a group health plan or Medicare in addition to your coverage under this Plan, there are rules that determine which plan pays benefits first. These rules help avoid duplication of benefits. Contact the Plan Administrator for details.

Right of Recovery

The Plan has the right to reimbursement for benefits provided or paid for which you were not eligible under Plan terms. Reimbursement is due and payable immediately upon Plan request. In addition, the Plan has the right to reduce or refuse payment of future benefits to recover any reimbursement. The acceptance of premiums or other fees or the providing or paying of benefits by the Plan does not constitute a waiver of the Plan's rights to enforce this provision in the future. This provision is in addition to, and not instead of, any other remedy available to the Plan at law or in equity.

Subrogation/Reimbursement

If you file a claim for benefits for medical expenses you have incurred which may be the responsibility of a third party, you may be required to reimburse the Plan from any recovery you receive. For example, if you are injured in an automobile accident which is not your fault, you may have to repay the Plan for the health benefits you collect from the third party responsible for the accident, or from his insurance company, or anyone else from which you receive payment for the accident. You must notify the Plan of any claim you may have against any third party as soon as you become aware of the claim, you must sign any subrogation/reimbursement agreement requested by the Plan, and you must cooperate with the Plan in all attempts to collect from the third party. This means that the Plan has the right to act on your behalf in pursuing payment from the third party. For additional information about subrogation/reimbursement, contact the Plan Administrator.

WHEN COVERAGE ENDS

CIRCUMSTANCES THAT MAY CAUSE LOSS OF BENEFITS

The Plan restricts the type and amount of benefits payable and the circumstances when benefits are paid. You may lose coverage under the Plan if Franklin Pierce University terminates the Plan or amends it to reduce or eliminate your coverage. Your coverage under this Plan generally ends when you terminate employment with Franklin Pierce University or if you are not actively at work.

You should review the insurance booklets or other materials for further information, such as the specific date(s) coverage ends.

When group health plan coverage ends, you will automatically be issued a Certificate of Creditable Coverage by the Plan Administrator. You may also request a Certificate of Creditable coverage within 24 months of the date your coverage terminates. This certificate will describe the period during which you were a plan participant. If you (or your dependent) coverage ends and you obtain coverage under a new group health plan, the new plan must reduce any pre-existing condition exclusion period by the length of your creditable coverage.

CONTINUATION OF HEALTH CARE BENEFITS – COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, you and your dependents may be eligible to temporarily extend group health care coverage under the Plan. Both you and your dependents should take the time to read this section carefully. Your rights and obligations under the law are summarized below.

In general, to elect continued coverage, you and your dependents must have been covered under the Plan on the day before the event that caused coverage to terminate. However, any children born to or placed for adoption with you while you are covered through COBRA will automatically be covered under the Plan you elect.

To continue coverage, you or your covered dependents must pay the full cost of that coverage (your share, if any, plus the company's share). Your contributions must be made on an after-tax basis and will be subject to an additional 2% administrative fee.

COBRA Qualifying Events

Continued coverage under the Plan can be purchased as follows:

- If you are an active employee covered by the Plan, you may elect COBRA continuation coverage if your coverage under the Plan is lost because:
    - Your hours of employment are reduced; or
    - Your employment terminates (other than for gross misconduct).
- If you are a covered spouse of a covered active or former employee, you may elect COBRA continuation coverage for yourself if your coverage under the Plan through your spouse is lost for any of these reasons:
    - The covered employee dies;
    - The covered employee's hours of employment are reduced or employment terminates (other than due to gross misconduct);
    - You are divorced or legally separated from your spouse; or
    - The covered employee becomes entitled to Medicare.
- If you are a covered dependent child of a covered active or former employee, you may elect COBRA continuation coverage if coverage under the Plan is lost for any of these reasons:
    - The covered employee dies;
    - The covered employee's hours of employment are reduced or employment terminates (other than due to gross misconduct);
    - Your parents divorce or legally separate;
    - You cease to be a dependent child as defined by the Plan; or
    - The covered employee becomes entitled to coverage under Medicare.

If you or your dependents purchase COBRA continuation coverage, it will be the same as the coverage you lost because of one of these events. However, if the Plan covering similarly situated employees changes, those changes will also apply to your COBRA continuation coverage.

COBRA Eligibility

The Company is responsible for notifying the COBRA or Plan Administrator—within 30 days of the event—of your right to purchase continued coverage through COBRA following a change in your employment status with the Company, your entitlement to Medicare or your death.

If you become disabled or there is a change in your spouse's or dependent's status because you become divorced or legally separated or your child no longer meets the eligibility requirements, you are responsible for notifying the COBRA or Plan Administrator within 60 days of the event.

Within 14 days after the COBRA or Plan Administrator is notified in writing that a COBRA qualifying event has occurred, you will be notified of your right to elect COBRA continuation coverage. You then have 60 days from the later of the day the COBRA or Plan Administrator mails notice of your COBRA election rights to you and the day your regular coverage ends to return your written COBRA election. If you elect to continue coverage, you have 45 days from the date of your election to make your first payment. Once your continuation coverage begins, the Claims or Plan Administrator must receive your monthly payments before the start of each month.

You do not have to provide evidence of good health to elect COBRA continuation coverage. If applicable under state insurance law, you may also be eligible to enroll in an individual conversion health plan, if otherwise generally available under the Plan and if coverage ends because of the expiration of the 18-month or 36-month COBRA period. If you change your marital status or if you, your spouse or your dependent change addresses, notify the COBRA or Plan Administrator immediately.

COBRA Continuation Coverage Period

COBRA allows you to keep your coverage for up to:

- 18 months if your coverage is lost because your employment terminates or your work hours are reduced (plus, if applied for and approved, an 11-month disability extension, as described below); or
- 36 months if coverage is lost because of death, divorce, legal separation or when a child ceases to be a dependent child.

If you have an 18 month qualifying event and the Social Security Administration determines that you (or your spouse or dependent child, if applicable) are disabled at any time during the first 60 days of the COBRA continuation coverage period, then your COBRA continuation coverage period as well as your spouse's and any dependent's periods may be extended from 18 months to 29 months.

If you recover (are no longer disabled), you must notify the COBRA or Plan Administrator within 30 days. If you recover within the initial 18-month period, you may keep your COBRA continuation coverage for the remainder of the 18-month period. If you recover in the 19th through the 28th month, your COBRA continuation coverage will cease at the end of the month in which you are determined to no longer be disabled. You may be charged up to 150% of the total cost of coverage for the 11-month extension period.

If during an 18 month event a second qualifying event takes place that entitles your spouse or dependent child to COBRA continuation coverage, your spouse's and/or dependent child's COBRA continuation coverage may be extended by another 18 months. You must make sure that the COBRA or Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Your spouse's and/or your dependent child's COBRA continuation coverage cannot extend for more than a total of 36 months from the date of the initial event.

Ending COBRA Continuation Coverage

Your COBRA continuation coverage will end for any of the following reasons:

- The Company no longer provides group health coverage to any of its employees;
- You do not pay the premium for your coverage;
- You become entitled to Medicare;
- In the case of a 29-month extension due to disability, a determination is made that the individual is no longer disabled (after the first 18 months); or
- You become covered under another group health plan, unless there is a pre-existing condition exclusion as explained below.

If you become covered under another group health plan that excludes coverage for pre-existing conditions, you may keep your COBRA continuation coverage until the earlier of:

- The date the pre-existing condition exclusion expires; or
- The date your COBRA continuation coverage period ends.

When COBRA continuation coverage ends, you will automatically be issued a Certificate of Creditable Coverage. A Certificate of Creditable Coverage may also be requested within 24 months of when your coverage terminates. This Certificate will describe the period during which you were a participant and the length of your coverage. If you (or your dependent, if applicable) participate in another group health plan within 63 days after your coverage ends, the new plan must reduce any pre-existing condition exclusion period by the length of your creditable coverage.

When COBRA continuation coverage ends, you will also be given the opportunity to enroll in an individual conversion plan, if provided by the Company.

CERTIFICATES OF CREDITABLE COVERAGE

Certificates of creditable coverage are documents provided by a group health plan (or another source that offers health care coverage) to show the type of health care coverage a person had (e.g., employee only, family, etc.) and how long the coverage lasted. Under federal law, most group health plans must provide these certificates automatically when your coverage terminates. However, if you do not receive a certificate, you have the right to request one. Certificates apply to both you and your dependents.

The primary purpose of the certificates is to show the amount of "creditable coverage" that you had under a group health plan or other health insurance coverage, because this can reduce or eliminate the length of time that any preexisting condition clause in a new plan otherwise might apply to you. The Plan will automatically give you a certificate after you lose health coverage (whether regular coverage or COBRA continuation coverage) and will make reasonable efforts to provide on the certificate the names of your dependents who were also covered. The Plan will automatically provide certificates for your dependents when it has reason to know that they are no longer receiving health coverage. In addition, the Plan will provide a certificate of health coverage for you (or your dependents) upon request if you make the request within 24 months after your coverage terminates.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

UNIFORMED SERVICES REEMPLOYMENT RIGHTS

Your right to continued participation in a group health plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). Accordingly, if you are absent from work due to a period of active duty in the military you may elect to continue your group health plan coverage. If you are absent for less than 31 days, you will pay the regular employee share of the cost of the health coverage. If the absence is for 31 or more days, the cost of continuation coverage may not exceed 102% of the full cost of your health coverage.

Continuation coverage will terminate on the earlier of:

- The last day of the 24 month period beginning on the first day of military leave, or
- The date you fail to apply for reemployment, as required under USERRA, after returning from military leave.

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available.

Benefits during a period of military leave must be as generous as benefits available to similarly situated employees on other employer-approved leaves of absence (*e.g.*, family and medical leave).

Premium Payment

If you elect to continue Plan coverage under USERRA, you must pay the applicable cost of coverage. If you are absent for 30 days or less, the cost will be the amount you would otherwise pay for coverage as an active employee. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes your share and any portion previously paid by Franklin Pierce University.

FAMILY AND MEDICAL LEAVE ACT

The FMLA applies if the Plan Sponsor has 50 or more employees. If you have been employed at least one year and worked at least 1,250 hours within the previous 12 months, you may continue coverage for up to 12 weeks of unpaid leave for:

- The birth of your own child.
- The placement of a child with you for the purpose of adoption or foster care.
- To care for a "seriously ill" spouse, child or parent.
- A serious health condition rendering you unable to perform your job.
- A "qualified exigency" as defined by a the Department of Labor caused by a spouse, son, daughter or parent being on active duty or notified of an impending call to active duty status in support of a contingency operation.

In addition, an employee who is a spouse, child, parent or nearest blood relative of a service member may take up to 26 weeks of FMLA leave to care for that service member if he or she has a serious illness or injury

If you take an approved FMLA leave, you may coverage for yourself and your covered dependents under the Plan. Coverage will terminate at the end of your FMLA leave period if you do not return from leave, or on the date you give notice that you will not be returning from FMLA leave, and you will be eligible for COBRA continuation coverage (as described above). To continue Plan coverage during unpaid FMLA leave, you must continue to pay your share of the premium. You should contact the plan administrator to make arrangements for premium payments during unpaid FMLA leave. If you do not continue your Plan coverage during unpaid FMLA leave, your coverage will be reinstated when you return from FMLA leave. For more information about Plan coverage during FMLA leave, contact the Plan Administrator.

If you choose to continue coverage during the leave, you will be given the same health care benefits that would have been provided if you were working, with the same premium contribution ratio. If your payments are more than 30 days late, the Plan Administrator will send written notice to you. The notice will state that coverage will be terminated. It will also give the date of the termination if payment is not received by that date. This notice will be mailed at least 15 days before the termination date.

If your coverage under this health plan is discontinued during FMLA leave for any reason, your coverage will be restored when you return to work to the same level of benefits as those you would have had if the leave had not been taken and the premium payment(s) had not been missed. This includes coverage for eligible dependents. You will not be required to meet any initial qualification requirements when returning to work. This includes: new or additional waiting periods; waiting for an open enrollment period; or passing a medical exam to reinstate coverage.

For additional information about health plan benefits during FMLA leave, contact the Plan Administrator.

SUMMARY OF HIPAA PRIVACY RIGHTS

A federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to protect the confidentiality of your private health information. The Plan and Franklin Pierce University will not use or further disclose information that is protected by HIPAA ("protected health information") except as necessary for treatment, payment, health plan operations and plan administration, or as otherwise permitted or required by applicable law. By law, the Plan requires all of their business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Franklin Pierce University.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Plan Administrator. If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you should contact the insurer or Franklin Pierce University Privacy Officer.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan 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 operations of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, your spouse, and your dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. You should review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation of coverage rights under COBRA. Same-sex spouses are not considered qualified beneficiaries under COBRA.

Exclusionary periods of coverage for preexisting conditions may be reduced or eliminated, if you have previous creditable coverage under another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan when:

- you lose coverage under that plan,
- you become entitled to elect COBRA continuation coverage,
- 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, any pre-existing condition exclusions would apply.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. However, if the Plan fails to comply with a plan provision in a single situation, this will in no way waive the Plan's ability to enforce that provision in the future.

Enforce Your Rights

If your 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 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. 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 Your 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 Benefit Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. Contact information for local EBSA offices can be found at www.dol.gov/ebsa.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration at 1-800-998-7542.

RESPONSIBILITY FOR GOODS/SERVICES

Franklin Pierce University does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program.

NO GUARANTEE OF EMPLOYMENT

The Plan is not an employment contract. Nothing contained in this document nor the insurance booklet gives you the right to be retained in the service of Franklin Pierce University or interferes with the right of Franklin Pierce University to discharge you or to terminate your service at any time.

APPENDIX A – LIST OF WELFARE PROGRAMS IN WRAP

Welfare Program
Medical Welfare programs, including the following: • **Harvard Pilgrim HMO 3V Medical Insurance** • **Harvard Pilgrim HMO 14 Medical Insurance** • **Harvard Pilgrim PPO XI Medical Insurance**

APPENDIX B – LIST OF PARTICIPATING EMPLOYERS

Franklin Pierce University