Northeast Delta Dental Plan
Summary Plan Description
for
Franklin Pierce University

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HOW YOUR DENTAL PLAN WORKS

Under the Northeast Delta Dental Plan, you may obtain care from any dentist you choose. However, if you choose a provider who participates in the dental PPO network, your out-of-pocket costs will be lower.

That's because providers in the network have agreed to accept a negotiated rate as payment in full. If you receive care outside of the PPO network, Plan benefits are based on Reasonable and Customary Charges (R&C). A Reasonable and Customary charge is the most common charge made by dentists and other providers for similar procedures in a particular geographic area. You must pay any coinsurance identified by the Plan and any amount billed over the R&C limits.

You can get a copy of the participating provider directory by calling 1.800.832.5700 or visiting www.nedelta.com. Specific coinsurance amounts are identified in the "Benefit Summary" section of this booklet.

ELIGIBILITY & ENROLLMENT

To participate in the Plan, you must belong to one of the following groups:

Eligible Employees: employees are eligible for the Northeast Delta Dental plan if they work a minimum of 40 hours per week.

Eligible Spouses: the legal spouse or civil union partner of a subscriber is eligible to enroll. Former spouses are eligible subject to the terms and limitations of New Hampshire law, for a maximum of three (3) years from the date of the divorce, or until the Subscriber or the Ex-spouse remarries, whichever comes first.

Eligible Child(ren): Delta Dental defines a child as one of the following dependents of a subscriber or of the subscriber's enrolled spouse:
·A natural or legally adopted child
·A child for whom one or both of the above mentioned adults has been appointed legal guardian
·A step-child who is a dependent on the subscriber for support
·A child placed with the subscriber or subscriber's enrolled spouse, and for which legal obligation for total or partial support is retained in anticipation of adoption, and such child has not reached age 18 as of the date of the adoption or placement (foster children are not included).
·Less than 26 years of age

Note: Coverage is available for dependent student's medically necessary leave of absence from school for a period not to exceed 12 months or the date on which coverage would otherwise end pursuant to the terms and conditions of the employer's group policy, whichever occurs first.

If your spouse or eligible dependent also works at Franklin Pierce University and is eligible for dental coverage, he or she can enroll as an employee or as your dependent, but not both. If you and your spouse are both employees of Franklin Pierce University and eligible for dental coverage, only one of you may enroll your eligible children.

Contact the Plan Administrator for enrollment instructions and 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 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 Human Resource Department at 603-899-4077.

Effective Dates

Coverage Begins

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, coverage begins:	first of the month following 30 days of employment
Newly Eligible - If you are newly eligible to participate, coverage begins:	first of the month following qualifying event
Open Enrollment - If you enroll during open enrollment, 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:	within 30 days of the qualifying event
Marriage - If you enroll within 30 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 will begin:	children are eligible first of the month following their 2nd birthday or at open enrollment
Adoption/Placement for Adoption - If you enroll your dependent within 30 days after his or her adoption or placement, coverage will begin:	first of the month following date of adoption or placement
Loss of Coverage - If you enroll within 30 days after your loss of coverage, (60 days if you lose Medicaid or Children's Health Insurance Program (CHIP) coverage) is effective, coverage will begin:	first of the month following date of loss of coverage

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.

Pre-Existing Condition Rules

The Plan does not have a pre-existing condition exclusion clause.

CHANGING YOUR ELECTION

You may not enroll or change your election until the next annual enrollment—unless you have 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 or 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 in the service area; and
- Changes in your or your eligible dependent's coverage 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.

COST

You and Franklin Pierce University share the cost of 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/before tax basis. This means your contribution is taken before most federal, state and local taxes are taken from your paycheck. Therefore, this pre-tax/before tax deduction lowers your taxable income.

BENEFIT SUMMARY

The chart below highlights the coverage available for many common services. This summary is intended to be an overview of the services covered under the Northeast Delta Dental Plan. If you have questions about coverage under the Plan, contact the claims administrator.

The Plan pays the same percentage for both in-network and non- network services. However, non-network benefits are based on reasonable and customary charges (R&C). Non-network providers may bill for amounts more than the R&C charges; if so, you must pay these amounts. In-network benefits are calculated based on a negotiated rate, Network providers accept the negotiated rate as payment in full, which means using a network provider lowers your out-of-pocket expense.

Benefit Item	**Plan Benefit**
Annual Deductible*	
Individual	$50 per member per calendar year
Family	$150 per family per calendar year
Annual Benefit Maximum**	
Individual	$1,000 per member per contract year for coverages A, B and C combined
Family	$1,000 per member per contract year for coverages A, B and C combined
Preventive and Diagnostic Services	
Periodic Oral Exams	covered 100%, twice in a 12-month period
Full Mouth X-rays	covered 100%, once in a 3-year period
Bitewing X-rays	covered 100%, once in a 12-month period
Single tooth X-rays	covered 100%, as necessary
Teeth Cleaning	
Cleanings	covered 100%, four cleanings are covered in a 12-month period; this can be routine (coverage A) or Periodontal (coverage B), in any combination
Periodontal Cleaning	covered at 60%, four cleanings are covered in a 12 month period; this can be Routine (coverage A) or Periodontal (coverage B), in any combination
Fluoride Treatments	covered 100%, fluoride treatment provided twice in a 12-month period to age 19
Basic Restorative	
Silver Fillings	covered at 60%
White Fillings	covered at 60%, white fillings for anterior teeth only
Temporary Fillings	not a covered benefit in most cases, contact customer service for benefit coverage, limitations and exclusions.
Stainless Steel Crowns	covered at 50%
Oral Surgery	covered at 60% for surgical and routine extractions
Periodontal Surgery	covered at 60%
Scaling and Root Planing	covered at 60%
Root Canal Treatment	covered at 60%
Vital Pulpotomy	not a covered benefit
Bridge or Denture Repair	covered at 60%

Benefit Item	Plan Benefit
Rebase or Reline of Dentures	covered at 50%
Recement of Crowns and Onlays	covered at 50%
Emergency Minor Treatment of Pain Relief	covered at 60%
Emergency General Anesthesia	covered at 60%, general anesthesia or intravenous sedation, when administered in conjunction with an extraction; tooth reimplantation; surgical exposure of tooth; surgical placement of implant body (only when implantology is specified as a benefit on the Outline of Benefits); biopsy;transseptal fiberotomy; alveoloplasty; vestibuloplasty; incision and drainage of an abscess; frenulectomy and or frenuloplasty. General anesthesia is covered when administered in conjunction with procedures performed in the dental office for the following covered patients: (a) A child under the age of six (6) who is determined by a licensed dentist in conjunction with a licensed primary care physician to have a dental condition of significant complexity which requires the child to receive general anesthesia for the treatment of such condition or; A person who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician, which place the person at serious risk.
Major Restorative	
Dentures	covered at 50%
Fixed Bridges and Crowns	covered at 50%
Crowns	covered at 50%
Endosteal Implant	covered at 50%
Orthodontia Coverage (Annual plan maximum does not apply)	
Coinsurance	50% per member per calendar year
Limiting Age	children to age 19
Individual Lifetime Maximum	$1,500 per member
Family Maximum	$1,500 per member
Other Covered Services	
Space Maintainers	covered 100%, to age 16
Sealants	covered 100%, sealant application to permanent molars, once in a three year period per tooth for children to age 19
Chlorhexidine mouth rinse	prescription drugs or premedications are not covered, please refer to you Group Contract for further details or contact Customer Service for benefit coverage, limitations and exclusions.
Fluoride toothpaste	prescription drugs or premedications are not covered, please refer to you Group Contract for further details or contact Customer Service for benefit coverage, limitations and exclusions.

*The deductible is based on calendar year

**The benefit maximum is based on the calendar year

WHAT IS NOT COVERED

Not all services are covered by the Plan. Limitations and exclusions apply even if a qualified practitioner has performed or prescribed the services that are limited or excluded under the Plan. The following is a list of services that are not covered. This is not intended to be an all inclusive list. If you have a question about a particular service, you should contact the claims administrator for information.

The Plan does not provide benefits for the following:

- Services received before your coverage took effect.
- Missed appointments.
- Prescription drugs.
- Work in progress before the effective date of your coverage under this Plan.
- Expenses that are covered by your previous dental or medical plan.
- Expenses incurred while you were committing a crime or attempting to commit a criminal act.
- Any loss caused by or contributed to by war or any act or war, whether declared or not; insurrection or any act of armed conflict or any conflict involving armed forces of any authority.
- Services furnished for a sickness or bodily injury connected to military service or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs.
- Any services received outside of the United States, except for emergency services as required by law.
- Services not furnished by a qualified practitioner or treatment facility as determined by the Plan.
- Services not authorized as required by Plan guidelines.
- Charges in excess of Plan maximums.
- Services for which no charge is made, or for which you would not be required to pay if you were not covered under this Plan unless charges are received from and reimbursable to the United States.
- Services performed as a result of a complication arising from a service that is not covered under this Plan.
- Services for sickness or bodily injury that are covered by any automobile, homeowner, marine, aviation, premise or any other similar coverage up to the limit under the other coverage.
- Services for sickness or bodily injury that is payable under any workers' compensation or occupational disease act or law, or would be payable under any workers' compensation or occupational disease act or law regardless of whether such coverage was actually purchased.
- Services that are not provided.
- Services provided by a family member.
- Services required by a third party such as a school or employer.

CLAIMS

A claim for benefits is a request for Plan benefits made by a covered employee, dependent or their representative that complies with the Plan's reasonable procedure for making benefit 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 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, if applicable; 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 member.
- Review the form to insure 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 has coverage under another plan, 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 24 months from the date of service it will be denied.

Assignment of Benefits

If you do not want the Plan to pay your provider directly, you should contact the Claims Administrator. The Claims Administrator will let you know the process necessary to make this request.

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

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, 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 such materials will supersede these procedures as long as such other claims procedure complies with government regulations.

- **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.
- **Pre-Service Urgent Care Claims.** A determination will be made within 72 hours from receipt of the claim. Notice of a decision on an urgent care claims 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 and you 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 reasons 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; or
    - 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 (including if the claim is denied based on eligibility) 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 reasons 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 with 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 obtain a second level appeal, if applicable, and a statement indicating that the participant may bring a lawsuit under ERISA after the denial of an appealed claim.

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 your 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 about 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 its own provisions.

Effect on Benefits

One of the plans involved will pay benefits first. This is 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 dental coverage under a group health plan 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.

The primary plan pays before the secondary plan. The first rule that applies to you will determine which plan is primary and which is secondary.

- **No coordination of benefits provisions.** If one plan does not have coordination of benefits provisions, then that plan is primary, and the plan with a coordination of benefits provision is secondary.
- **Dependent/non-dependent.** The plan covering the person as an employee is primary over the plan covering that person as a dependent.
- **Child of parents not separated or divorced.** In this case, the birthday rule applies. Under the birthday rule, benefits are paid first by the plan of the parent whose birthday is earlier in the year. If both parents have the same birth date, then the plan of the parent who has been covered longer pays first.
- **Child of separated or divorced parents.** If a court order specifies that one of the parents is responsible for the child's coverage, the plan of that parent is primary. If the court decree awards joint custody without determining who is responsible for the child's coverage, the birthday rule applies. If the parents do not share custody and no court order allocates responsibility for the child's coverage, the plan of the custodial parent pays first, the plan of the spouse of the custodial parent (if any) pays second, the plan of the non-custodial parent pays next and the plan of the spouse of the non-custodial parent (if any) pays last.
- **Active or inactive employee.** The plan that covers the person as a former employee or leased employee (or dependent of a former employee or leased employee) is secondary to a plan that covers the person as an active employee or leased employee (or a dependent of an active or leased employee). If the other plan does not have this rule, and the plans do not agree on the order of benefits, this rule will not apply.
- **Continuation coverage.** COBRA continuation coverage is secondary to the plan covering the person as an employee or retiree.
- **Length of coverage.** If none of the rules above determine order of payment, the plan that has covered the person longer will be primary.
- **Other rules don't apply.** If none of the above rules apply, expenses are shared equally between the plans.

You must notify Franklin Pierce University any time you obtain or lose other dental coverage. If you or a covered dependent has primary coverage under another dental plan, you must file a claim for benefits under that coverage before your claim under this plan will be processed.

Right of Recovery

The Plan may have the right to reimbursement for benefits provided or paid for which you were not eligible under Plan terms. Reimbursement may be due and payable immediately upon Plan request. In addition, the Plan may have 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 would be in addition to, and not instead of, any other remedy available to the Plan by law or in equity.

Subrogation/Reimbursement

If you file a claim for benefits for expenses you have incurred that 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 that 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

Coverage terminates on the earliest of the following:

For Employees

- The date the Plan terminates.
- The end of the month for which any required contribution is due and not paid.
- The end of the month after the date you are no longer a member of an eligible class of employees.
- The end of the month in which you terminate employment with your employer.
- The end of the month in which you retire.

For Dependents

- The date your coverage terminates.
- The end of the month in which he or she no longer meets the definition of a dependent as defined in the Plan or required under Federal law.

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 coverage under 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 an eligible dependent child, under the terms of the Plan; or
    - The covered employee becomes entitled to coverage under Medicare.

If you or your dependents purchase COBRA continuation coverage, the coverage will be the same as the coverage you had on the day before the qualifying event. However, if the Plan covering similarly situated active employees change, those changes will also apply to your COBRA continuation coverage.

COBRA Eligibility

The company is responsible for notifying the 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 Plan Administrator within 60 days of the event.

Within 14 days after the Plan Administrator is notified in writing that a COBRA qualifying event has occurred, the Plan Administrator will notify you and/or your dependents of your rights to elect COBRA continuation coverage. You then have 60 days from the later of the day the Plan Administrator mails notice of your COBRA election rights to you and the day your regular coverage ends to return your written COBRA election to the Plan Administrator. If you elect to continue coverage, you have 45 days from the date of your election to make your first payment. Once your COBRA continuation coverage begins, the 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. The law also requires that you be allowed to enroll in an individual conversion health plan, if otherwise generally available under the Plan, if coverage ends because of the expiration of the 18-month or 36-month continuation period, as applicable under state law. If you change your marital status or if you, your spouse or your dependent change addresses, notify the 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, your work hours are reduced or, if applied for, an approved 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, 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 Plan Administrator within 30 days. If you recover within the initial 18-month COBRA 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, if applicable) to COBRA continuation coverage, your spouse's COBRA continuation coverage (or dependent child's COBRA continuation coverage, if applicable) may

be extended by another 18 months. You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of that event.

COBRA continuation coverage for your spouse (or your dependent child if applicable) can not 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 medical conditions, you may keep your COBRA continuation coverage until the earlier of:

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

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

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

Federal law requires the Plan to offer to continue coverage for you and/or your dependents if you are absent due to service in the uniformed services. Coverage may continue for up to 24 months after the date you are first absent due to uniformed service.

Eligibility

You are eligible for continuation under USERRA if you are away from work because of voluntary or involuntary service in the Armed Forces, Army National Guard, Air National Guard, commissioned corps of the Public Health Service or any other category of persons designated by the President of the United States in a time of war or national emergency. Service includes absence for active duty, active duty training, initial active duty training, inactive duty training, full-time National Guard duty and for the purpose of an examination to determine fitness for duty. Any of your dependents who are covered under the Plan immediately before the date your military service begins may also elect continuation under USERRA.

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.

Duration of Coverage

Elected continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after you do not apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA will run concurrently with the COBRA continuation coverage period available to you and/or your eligible dependents.

FAMILY AND MEDICAL LEAVE ACT

You may be able to continue coverage under the Plan as provided by the Family and Medical Leave Act (FMLA). 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; and
- 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 continue Plan coverage for yourself and your covered dependents. 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. You will then be eligible for COBRA continuation coverage (as previously described).To continue Plan coverage during unpaid FMLA leave, you must continue to pay your share of the premium, if any. 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 applicable. 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 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 Plan coverage during FMLA leave, contact the Plan Administrator.

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 are 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, 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, 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 Dental Plan Coverage

You are entitled to continue dental care coverage for yourself, your spouse and your dependents if there is a loss of group dental 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 dental plan when:

- You lose coverage under that plan;
- You become entitled to elect COBRA continuation coverage; and
- Your COBRA continuation coverage ceases, if you request it before losing coverage up to 24 months after losing coverage.

Without evidence of creditable coverage, pre-existing condition exclusions may 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 Plan Administrator. If you have a claim for benefits that 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 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 Your Questions

If you have any questions about the 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.

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 private health information. The Plan and your employer, 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 will require 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 the employer.

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, if applicable, or the Plan’s Privacy Officer.

PLAN INFORMATION

Franklin Pierce University	
Plan Name	Northeast Delta Dental Plan
Plan Number	507
Plan Sponsor	Franklin Pierce University PO Box 60 Rindge, NH 03461 603-899-4077 www.franklinpierce.edu
Plan Sponsor Tax ID Number	02-0263136
Plan Administrator	Franklin Pierce University PO Box 60 Rindge, NH 03461 603-899-4077 www.franklinpierce.edu
Claims Administrator	Northeast Delta Dental PO Box 2002 Concord, NH 03301 800-832-5700 www.nedelta.com
Agent for Legal Process	Franklin Pierce University PO Box 60 Rindge, NH 03461 603-899-4077 www.franklinpierce.edu
Plan Fiduciary	Franklin Pierce University is the named fiduciary for the Plan, as defined by ERISA. The fiduciary acts on your behalf to make sure the Plan is administered fairly, honestly and in accordance with legal standards and the terms of the Plan document.
Plan Type	This Plan is an employee welfare plan offering medical coverage.
Plan Year	7/1/10-6/30/11
Plan Funding	Self Funded – General Assets: Claims and covered benefits are from the company's general assets. The company has an administrative services contract with a third-party administrator to decide on and process claims.

The Plan Administrator

The Plan Administrator, or the Plan Administrator's designated representative ("designee," such as the Claims Administrator), is responsible for interpreting Plan provisions, resolving issues of fact and making determination regarding eligibility for benefits. The decisions of the Plan Administrator (or designee) in all matters relating to the Plan will be final and binding.

No person may bring an action against the Plan Administrator in a court of law unless the claim and appeal procedures have been exhausted and the Plan Administrator (or designee) makes a final determination. A review by a court of law will be limited to the facts, evidence and issues presented during the appeal procedure. Facts and evidence that become known to you, your dependent, your beneficiary or another interested person after having exhausted the appeals procedure will be brought to the Plan Administrator's (or designee's) attention for reconsideration of the appeal. Issues not raised during the initial appeal will be deemed waived. Likewise, the Plan Administrator's (or designee's) decision will be upheld unless it is found to be arbitrary and capricious.

While the company intends to continue the benefits and policies described in this booklet, the Plan Sponsor and/or Plan Administrator (or designee) reserves the right to change, modify or discontinue the Plan, or any portion of the Plan, at its discretion and at any time. You will be notified in writing if there is any significant amendment or if the Plan is terminated.

In addition, 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 the Plan provide any guarantee of continued employment.

Plan Documentation

This Summary Plan Description (SPD) for the Northeast Delta Dental Plan describes the Plan in effect on July 1, 2010.

This document together with any descriptive materials received from or on behalf of the Plan Administrator, as required, represents the Plan as a whole and supersedes any previous versions of this document.

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

DEFINITIONS

The list of definitions below is a general list of commonly used terms and not intended to be specific to this Summary Plan Description (SPD) only. Therefore, certain terms listed here may not be used in this SPD.

Annual Benefit Maximum
The highest amount a plan will in a year for covered expenses.

Prescription Drug
A medication or drug for which a physician's written direction is required to purchase.

Claims Administrator
The administrator that reviews and pays claims on behalf of a plan. Claims administrators are typically insurance companies or third party administrators.

Coinsurance
The percentage of covered services a participant is responsible for paying after meeting the annual deductible, if applicable.

Consolidated Omnibus Budget Reconciliation Act or COBRA
The federal law that provides participants with the opportunity to continue coverage for a specified period when it would have otherwise ended.

Copayment
A pre-determined fixed fee for services a participant is responsible for paying at the time of service.

Deductible
The amount a participant must pay each year **before** a Plan will begin to pay certain benefits.

Lifetime Benefit Maximum
The highest amount a Plan will pay in a participant's lifetime for Plan benefits.

Orthodontia
A branch of dentistry that deals with irregularities of the teeth and the correction of those irregularities, often by using braces.

Qualified Change in Status
A life event, such as marriage, divorce or birth of child, that allows a change in benefit coverage to be made. Health plans that are funded in whole or in part by pre-tax employee contributions are governed by IRS regulations that indicate that a participant may only change his/her benefit election during annual enrollment unless they have a qualified change in status. Any election change must be consistent with the qualified change in status. All changes must be made within a pre-determined period of the qualified change as determined by the Plan Administrator.

Qualified Exigency

As defined by the Department of Labor, an emergency arising out of any of the following:

- Short-notice deployment;
- Military events and related activities;
- Childcare and school activities;
- Financial and legal arrangements;
- Counseling;
- Rest and recuperation;
- Post-deployment activities; or
- Additional activities not encompassed in the above, but agreed to by an employer and employee.

Qualified Practitioner
A professional licensed by the appropriate state agency to diagnose or treat a bodily injury or sickness, and who provides services within the scope of that license.

Qualifying Event
An event that entitles a person to elect continuation of coverage under COBRA, such as termination of employment or divorce.

QMCSO
A medical child support order approved by the Plan Administrator that provides for health care coverage and allocation of responsibility for the payment of costs for health care coverage for a child of an employee.

Reasonable and Customary or R&C
The most common charge made by physicians, surgeons, providers or practitioners of similar experience for a similar procedure in a particular geographic area.