

**BUCKNELL UNIVERSITY**  
**HEALTH AND WELFARE PLAN**  
**SUMMARY PLAN DESCRIPTION**

**Effective Date: January 1, 1991**  
**Restated: January 1, 2006**

**IMPORTANT INFORMATION ABOUT YOUR HEALTH INFORMATION  
PLAN PRIVACY AND SECURITY  
SUMMARY INFORMATION**

The Privacy Rules and Security Rules that are part of the Health Insurance Portability and Accountability Act (HIPAA), require that employees who elect to participate in a group health plan option receive a written notice of how an individual's health information may or may not be used without the individual's authorization and the security precautions used to protect electronically transmitted health information.

Because the health benefits offered under the Plan are fully insured, your healthcare insurance carrier is required to provide you with a separate notice that indicates your rights and protections under their health plan.

Under the healthcare insurance carrier's privacy procedures, the Plan will generally only receive summary health information from the carrier. Summary health information includes, but is not limited to, information used to evaluate plan rates, pay monthly premiums, establish plan eligibility, evaluate the terms and conditions of the insurance contract, or information used for such activities as plan amendments, plan modifications, or plan terminations. In addition, enrollment information such as names, addresses, dates of birth, and dependent status, will be shared with the healthcare insurance carrier. The Security Rules only apply to this information when it is transmitted electronically.

If a Participant requests assistance with a claim issue(s), the Plan may be required to obtain written authorization from the Participant before any specific health claim information can be obtained from the healthcare insurance carrier. Plan Participants have the right to revoke such authorizations at any time.

Please note that the requirements of the Privacy Rules and the Security Rules do not apply to health information related to disability benefits, workers' compensation benefits, life benefits, or employment-related information (i.e. sick notes, drug tests, etc.).

The following is a summary of the information that is generally applicable to protected health information created under a health plan option offered by the Plan.

**Summary of the Privacy and Security Notice Related to Your Individual Medical Information**

Covered entities which include both your healthcare insurance carrier and your group health plan are required to maintain the privacy of "protected health information," which includes any identifiable information that we obtain from you or others that relates to your health, your health care, or payment for your health care under a medical plan option.

***Uses of Protected Health Information***

- The group health plan and/or the healthcare insurance carrier can use or disclose your protected health information for purposes of health care payment, and health care operations. Additionally, the healthcare insurance carrier can use or disclose your protected health information for purposes of health care treatment.
- The healthcare insurance carrier may contact you to provide information about treatment alternatives or other health related benefits and services.

- The group health plan and/or your healthcare insurance carrier may disclose your protected health information to your family or friends or any other individual **identified by you in writing**.
- The group health plan and/or your healthcare insurance carrier will only disclose the protected health information directly relevant to their involvement in your care or payment.
- Except for certain situations, the group health plan will not use or disclose your protected health information for any other purpose unless you provide authorization. You have the right to revoke that authorization at any time.

### ***Your Rights***

- You have the right to request restrictions on the uses and disclosures of protected health information, but the group health plan and/or your healthcare insurance carrier is not required to agree to your request.
- You have the right to request to receive communications of protected health information by alternative means or at alternative locations.
- With some exceptions detailed in the full notice provided by your healthcare insurance carrier, you have the right to inspect and copy the protected health information contained in a covered entity's records.
- You may request a correction to your protected health information, but the group health plan and/or your healthcare insurance carrier may deny your request.
- You have the right to receive an accounting of disclosures of protected health information made by the group health plan and/or your healthcare insurance carrier.
- You have the right to receive a paper copy of the full notice from your healthcare insurance carrier. Please remember this is only a summary of the information that is generally applicable to protected health information created under a health plan option offered by the Plan.

### ***Whom to Contact for More Information***

If you have any questions regarding this summary or the subjects addressed in it, you may contact the Plan Administrator or your healthcare insurance carrier for more information.

**Bucknell University  
Health and Welfare Plan  
Summary Plan Description**

**Table of Contents**

<i>Section</i>	<i>Page</i>
Plan Purpose .....	1
Eligibility .....	1
How to Enroll.....	2
Schedule of Benefits.....	5
Payment of Benefit Costs .....	6
Spending Accounts .....	7
Spending Accounts - Other Facts to Consider .....	9
About Social Security Taxes .....	9
Future of The Pre-Tax Benefits.....	9
Insurance Contracts .....	9
Not a Contract of Employment .....	9
Qualified Medical Child Support Orders .....	10
Maternity and Newborn Coverage .....	10
Women's Health and Cancer Act.....	10
Family and Medical Leave .....	11
Subrogation.....	13
Benefit Termination.....	14
COBRA.....	15
Claims Procedures .....	16
Compliance with the Employee Retirement Income Security Act (ERISA) .....	19
ERISA Rights Statement .....	20
Schedule A – Schedule of Benefits	
Schedule B – Insurance Carriers and Claims Administrators	
Schedule C – Spending Accounts Schedule of Benefits	
Schedule D – Participating Employers	
Schedule E – Privacy Notice for Self-Funded Health Benefits	

**This is a Summary Plan Description only. Your specific rights to benefits under the Plan are governed solely, and in every respect, by the Bucknell University Health and Welfare Plan Document, a copy of which is available from Human Resources at Bucknell University upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan Document, the language of the Plan Document shall govern.**

**The University reserves the right, in its sole discretion under circumstances that it deems advisable (including, but not limited to, a need to address law changes, cost or plan design considerations), to terminate or amend the Plan (including amendments to reduce or eliminate benefits or changes to the premium or contribution rates) for all participants or for a specific class of participants, including current or former employees, at any time and for any reason, without notice. Current participation in the Plan does not vest in any participant (including current and former employees) any rights to any particular benefit coverage in the future. In the event of termination or amendment or elimination of benefits, the rights and obligations of participants, including current or former employees, prior to the date of such event shall remain in effect, and changes shall be prospective, except to the extent that Bucknell or applicable law provides otherwise.**

**The Plan is maintained for the exclusive benefit of faculty and staff and their dependents who meet the eligibility criteria described. Bucknell University, as Plan Administrator, has the discretion to construe and interpret the Plan and decide all questions of eligibility herein.**



## PLAN PURPOSE

The Bucknell University Health and Welfare Plan (the "Plan") became effective on January 1, 1991 and was restated January 1, 2003. The Plan provides insured benefits as described in the insurance carriers' booklets as indicated on the attached Schedule B and the ability to establish spending accounts. Certain benefits are provided by Bucknell University (the "Employer") under the Plan at no cost to participating employees; while other benefits require employee contributions. Benefits that require employee contributions may, in some instances, be purchased on a tax favored (that is, pre-tax) basis.

The following information, together with the insurance carrier's booklet, forms the summary plan description for the purposes of ERISA and the Internal Revenue Code (IRC).

## ELIGIBILITY

If you are an Employee of the Employer or a Participating Employer (a related employer that has adopted the Plan for its employees, as listed on the attached Schedule D) and you meet the following criteria you may be eligible for Plan benefits.

- Regular full-time Employees who are scheduled to work at least 35 to 40 hours per week for at least the 9-month academic year (at least 39 weeks/1,365 hours) and regular part-time employees who work a minimum of 700 hours per year (17.5 hours per week for 40 weeks or 35 hours a week for 20 weeks).
- Casual Employees whose assignment/contract spans at least 9 months; beginning October 1<sup>st</sup> and ending no later than September 30<sup>th</sup> of the following year; working a total of 1,365 hours during that 12 month period.

You are eligible to participate in the Plan on your Entry Date, which is based on your employee status and is listed below. Please note that the Entry Date for long-term disability benefits is twelve months for full-time employees, unless the employee was covered by group disability insurance with a previous employer, in which case eligibility is the first day of the month following the date of hire. Part-time and casual employees are not eligible for long-term disability.

- for regular full and part-time Employees, the first day of the month following the date of hire as an Eligible Employee;
- for casual employees, January 1<sup>st</sup> following 1 year of employment as an eligible employee.
- for Eligible Employees who experience a change in status following their original Entry Date, the date of the status change.

Prior to your Entry Date, you will be required to complete an *election* form (discussed below) for any benefits that require Employee contributions and any applicable *enrollment* forms. For those benefits that require no Employee contributions, you will automatically be covered on your Entry Date after you have completed the required *enrollment* forms.

Your election for contributory benefits stays in effect for the Plan Year or the remainder of the Plan Year if you become eligible for benefits after the Plan Year has begun. The Plan Year is defined as the twelve-month period beginning each January 1 and ending on the following December 31.

## HOW TO ENROLL

As noted above, you will automatically be covered for any non-contributory benefits that are noted below on your Entry Date. In addition, you must select which of the contributory benefits listed below you would like to purchase through the Plan. Your decision must be made during the enrollment period that is scheduled prior to the beginning of the Plan Year or at the time you satisfy the eligibility requirements of the Plan. Each year, the Employer will provide you with the opportunity to change the contributory benefits elected.

If you are already a Plan Participant and you fail to complete an election form for the upcoming Plan Year then you will maintain your prior year's election with the exception of any spending account election. You will not be re-enrolled in the spending account if you do not submit a new election form.

**If you are a participant in any of the Group Plans sponsored by Bucknell University and pay for your portion of the premium through payroll deduction, you will automatically be enrolled in the Premium Expense Account benefit of this Plan and your group health premiums will be deducted from your compensation on a pre-tax basis.**

Changes to your election for contributory benefits will be made in accordance with the provision of the insurance carrier providing the benefit plan to be changed. In addition, IRC section 125 requires that your choices are in effect for the entire Plan Year. *Only under the following special circumstances may you apply to change your selected benefits.*

### Mid-Year Election Changes Due to Status Events

If permitted by the insurance carrier, under the following special circumstances (referred to as "Status Events"), you may be able to change your selected benefits during the Plan Year:

- **Legal Marital Status:** Your marriage, divorce, legal separation, or annulment, or the death of your spouse;
- **Number of Dependents:** The birth, adoption, placement for adoption, or death of a dependent;
- **Employment Status:** The termination or commencement of the employment of you or your spouse or dependent;
- **Work Schedule:** The reduction or increase in hours of employment of you or your spouse or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence, including an absence under the Family and Medical Leave Act ("FMLA");
- **Change in Dependent Status:** Any event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance, as provided in the accident or health plan under which you receive coverage;
- **Residence or Worksite:** A change in the place of residence or worksite of you or your spouse or dependent. This event will be deemed a change in status if, due to a change in residence the employee moves from a service area of the group health plan to an area which is not served by the group health plan (or vice-versa);
- **HIPAA Special Enrollment Rights:** A change due to the requirements of the Health Insurance Portability and Accountability Act ("HIPAA"); or
- **COBRA Eligibility:** A covered individual becomes eligible for COBRA or a state mandated continuation of health coverage benefit.

The following changes are also Status Events, but these Status Events *only affect the medical benefit and medical spending account* and would not entitle you to make a mid-year election change for any other

coverage options:

- **Entitlement to Medicare/Medicaid:** A covered individual becomes entitled to Medicare or Medicaid; or
- **Judicial Order:** A change is required by a Qualified Medical Child Support Order ("QMCSO") as described in more detail in a later section in this summary, or other judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in custody.

The following changes are also Status Events, but these Status Events *do not apply to a medical spending account* and would not entitle you to make a mid-year change in your medical spending account election:

- **Automatic Increases in Your Elections:** If the costs of certain benefits under the Plan increase or decrease during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically modify your elections to reflect this increase or decrease in costs. These automatic increases/decreases generally will occur in situations where there are small periodic changes in the costs of benefits that occur during the middle of a Plan Year (e.g., an insurance carrier makes a cost-of-living adjustment to its coverage option during the middle of a Plan Year);
- **Significant Increase in Cost:** A *significant* increase in the cost of a coverage option may allow you to increase your contribution amount, revoke your election and elect similar coverage under another coverage option, or drop coverage if no similar coverage option is available. (Please note that under a dependent care spending account, the cost change rule only applies to cost changes required by a dependent care provider who is not a relative of the employee.);
- **Significant Decrease in Cost:** A *significant* decrease in the cost of a coverage option may allow you to revoke your existing election and elect coverage under such option;
- **Significant Curtailment of Coverage Option:** A *significant* curtailment of a coverage option that does not constitute a loss of coverage may allow you revoke your election and elect similar coverage under another coverage option. If the significant curtailment of coverage does constitute a loss of coverage, you also may be allowed to drop coverage if no similar coverage is available; or
- **Addition or Improvement of Coverage Option:** If a new coverage option is added, or if coverage under an existing option is *significantly* improved, you may be permitted to revoke your existing election and elect the new or improved coverage option.

A Status Event for an employee or a dependent must affect the individual's eligibility for the Plan's benefits. Additionally, any requested change in the affected benefit must be consistent with the occurrence of the underlying Status Event. Finally, mid-year election changes must be made no later than 31 days following the date of the Status Event that is the basis for the change. If the change request is not made within this time frame, the change may not be made until the next annual enrollment period.

### **Waiver of Benefits for Dependents**

If you previously elected to waive coverage for a dependent, you will be eligible to apply for coverage for that dependent during the next annual enrollment period or, in some circumstances, during a "special enrollment" period as described below. If you waive coverage for yourself, coverage will also be waived for your dependents. In no event will coverage be in force for your dependents if you have not enrolled in the Plan to receive similar coverage.

## **Special Enrollment Rights for Medical Coverage**

Under certain circumstances, eligible employees who waived coverage for themselves and/or for their dependents may elect to enroll in the Plan without having to wait for the next annual enrollment period. These special rights are provided under the Plan pursuant to HIPAA. HIPAA provides for a special enrollment period in the following two instances:

- ***Loss of Other Coverage:*** If an employee who declines coverage for himself and/or his dependents when initially eligible is covered under another group health plan or insurance arrangement, and such other coverage terminates, the eligible employee and/or his dependents may elect to enroll in the Plan effective as of the first day of the month after the Employer receives the enrollment application and "certificate of coverage" from the other health plan; provided that it is submitted within 31 days of the loss of such other coverage.
- ***New Dependents:*** If an employee declines coverage when initially eligible and subsequently acquires a dependent through marriage, birth, adoption, or placement for adoption of a child, the employee may elect to enroll the employee and the employee's dependent(s); provided that the enrollment application is submitted to the Employer within 31 days of such event with appropriate documentation reflecting this change. Coverage will be effective as of the date of the birth, adoption, or placement for adoption, or as of the first day of the month after enrolling due to a marriage, as applicable.

## **Automatic Medical Coverage for 31 Days for a Newborn Child or a Newly Adopted Newborn Child**

If you have a child or adopt a child while you are receiving medical coverage under the Plan, your new child will automatically receive medical coverage from the date of birth/adoption for a period of 31 days. If you do not notify the Employer that you have a new child and/or if you do not apply for medical coverage for the child before the end of this 31-day period, medical coverage for your new child will terminate at the end of the 31-day period.

If you are not already receiving coverage for dependents, and if you are required to contribute toward the cost of coverage, you must apply (and pay any required contribution) within 31 days of having your new child in order to continue the child's coverage beyond that date. If you are already receiving coverage for dependents, you must still notify the Employer of your new child so that his/her claims can be processed. Also, if the addition of this new child changes your Plan election, i.e. "Employee + 1" to "Family," your contribution amount may be increased accordingly. If you fail to apply (or pay the required contribution) within the 31-day period, benefits will be payable only for covered expenses incurred by the child while coverage was in force. If you fail to timely enroll your new child during the 31-day period, coverage for your new child will cease at the end of the 31-day period and you will have to wait until the next annual enrollment period to enroll your child under the Plan.

## **Periods of Creditable Coverage**

In addition to the special enrollment rights described above, HIPAA also establishes rules that may limit the length of any pre-existing condition exclusions provided under a particular coverage option that is available under the Plan. Although the booklets prepared by the insurance carriers and claims administrators will contain a more detailed description of these pre-existing conditions and HIPAA's rules, keep in mind that a pre-existing condition exclusion generally may not last for more than 12 months (18 months for certain late enrollees) and that, in some instances, this time limit may be reduced by a prior period of creditable coverage. If you have a prior period of creditable coverage (as evidenced by a certificate of creditable coverage provided by your prior employer's plan), you must provide this certificate of creditable coverage to the Employer and your insurance carriers. If you are not sure if these pre-existing condition or creditable coverage rules apply to you, you should contact the Employer or your insurance carriers. Also, when your coverage ends under this Plan, you will be provided with a certificate of creditable coverage reflecting your period of coverage under this Plan.

### **Contributions and Benefits During a FMLA Leave**

Generally speaking, if you stop making contributions during the middle of a Plan Year, your benefits will cease at that time. Although you will be able to resume these contributions and reinstate your benefits in most cases, you will not be able to resume these contributions on a pre-tax basis (unless you experience a Status Event as described above). The earliest that you could resume pre-tax contributions would be the following Plan Year.

If you take leave that is approved under the Family and Medical Leave Act ("FMLA"), you may elect to continue your benefits during the period of your FMLA leave or you may elect to discontinue your benefits. To continue your benefits during a period of FMLA leave, you will need to make arrangements with the Employer to continue your contributions during this period of leave. When you resume employment after a FMLA leave, you generally will be permitted to resume your benefits and to resume making contributions on a pre-tax basis. A more detailed description of FMLA leaves can be found in the Family and Medical Leave section below.

### **Rehired Employees**

If you should terminate your employment and stop your elections under this Plan, you may, if rehired begin to participate in the Plan upon your date of hire as an Eligible Employee. If you are rehired after one year, you may begin to participate in the Plan upon again satisfying the eligibility requirements, disregarding your prior employment.

## **SCHEDULE OF BENEFITS**

The Employer provides the following benefits at no cost (non-contributory) to Eligible Employees. The schedules of insured benefits are described in the insurance carrier's booklet for each benefit (See Schedule B).

- basic life
- basic accidental death and dismemberment
- long term disability

In addition to the non-contributory benefits listed above, you may elect to purchase the following contributory benefits. The following options may be purchased with pre-tax income as described above for you and your eligible dependents.

- A medical plan
- A dental plan
- Two spending accounts
  - Medical spending account
  - Dependent care spending account

Finally, you may also elect to purchase additional life benefits for yourself and your family. This benefit is only available on a post-tax basis.

The exact plan option and any required contributions will be communicated to Eligible Employees when they are first eligible for the Plan and to Participants during each enrollment period. Please remember that each benefit under the Plan has separate rules governing benefits and plan administration. The rules for insured benefits are explained in more detail in the insurance carrier's or claims administrator's booklet and the Plan document available from the Director of Human Resources at the University.

### **Coordination of Benefits**

If you have other coverage that is available to you (e.g., Medicare coverage or coverage under another group health plan), there may be situations where the Plan will need to "coordinate" benefits (that is, determine which coverage is primary and which coverage is secondary for purposes of paying benefits). The booklets prepared by the insurance carriers and the claims administrators contain a more detailed description about the coordination of benefits rules. If you have questions about how the coordination of benefits rules may apply to you, you should contact the Employer or the insurance carriers and claims administrators directly.

### **PAYMENT OF BENEFIT COSTS**

If you elect to receive benefits other than the Employer-provided benefits described above, the premiums for these benefits will be paid by you through payroll deductions (either on a pre-tax or after-tax basis, depending upon the type of benefit). In addition to this share of the premium payments, the following is a brief description of the other types of costs that you may be required to pay under the Plan, but keep in mind that the exact amount of the costs will be described in the booklets prepared by the insurance carriers:

- ***Copayments:*** For most services, including office visits or purchasing prescription drugs, you will need to pay a flat fee known as a copayment.
- ***Deductible Amounts:*** A deductible is the amount of covered expenses you must first pay during each Plan Year before the Plan will start reimbursing you for covered expenses. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that Plan Year.
- ***Coinsurance:*** Once you have paid your deductible amount, you may be responsible to pay a percent of your medical expenses. The percent that you are required to pay will depend upon the type of service/benefit that is provided.

- ***Out-Of-Pocket Expense Maximums:*** If the amount you pay for covered expenses reaches a certain amount, the Plan will pay 100% of any additional covered expenses. Please note that out-of-pocket expense maximums for network providers will not apply toward out-of-pocket expense maximums for out-of-network providers. Also, please note that certain amounts are not included in the calculation of out-of-pocket maximums. These expenses include, but are not limited to, any amounts for which you were "balanced billed" (as described below) and expenses not covered under the Plan.

Your share of these costs is dependent upon the insurance plan selected and whether you use in-network providers or not. Network providers have agreed to accept a negotiated fee/discount for services. A network provider cannot, unless an ineligible service is provided, bill you for amounts over these negotiated rates. An out-of-network provider can bill you for expenses over the prevailing costs as determined by the Plan. This is known as "balance billing." Therefore, you generally can reduce your costs by using an in-network provider. A current listing of the network hospitals, physicians, and other providers will be given to you at the time you become covered and you will receive periodic updates to this list. Please note that if you elect to use a health maintenance organization (HMO) Plan option, out-of-network services generally are not available.

## **SPENDING ACCOUNTS**

You may elect to establish a spending account(s). There are two types of spending accounts available to you, medical spending and dependent care.

### **How Medical and Dependent Care Spending Accounts Work**

You can create up to two spending accounts for two separate categories of predictable expenses—medical and/or dependent care. You may defer up to the annual maximum described in Schedule C attached.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills to the claims administrator designated by the Employer. The name and address of the claims administrator will be indicated on the claim form that you receive.

Upon submission of a claim to your Medical Spending Account, you will be reimbursed the full amount of your eligible expenses up to the remaining balance of your Plan Year election. For your Dependent Care Account, you will be reimbursed up to your current balance. Claims will be paid as soon as administratively possible but not less frequently than on a monthly basis.

After the designated claims administrator reviews the claim, you will be informed of the amount to be reimbursed. If you believe that you been reimbursed incorrectly, you may submit a written request to the designated claims administrator, or if there is no designated claims administrator, the Director of Human Resources to provide either an explanation of how benefits are reimbursed or further information of your Benefits. The designated claims administrator or the Director of Human Resources must respond to your request within a reasonable time. Additionally, the designated claims administrator or the Director of Human Resources will provide to every claimant who is denied a claim for benefits, a written notice that includes:

1. the specific reason for the denial;
2. specific reference to pertinent plan provisions on which the denial is based;
3. a description of any additional material or information necessary for you to complete an accurate claim;  
and
4. an explanation of the claim review procedure described below.

Within 60 days of your receiving a notice denying a claim, you or your authorized representative may request in writing a full and fair review of the claim by the designated claims administrator or the Director of Human Resources. The designated claims administrator or the Director of Human Resources may extend the 60-day period if your circumstances make such extension appropriate. In connection with this review, you may review pertinent documents and may submit issues and comments in writing. The designated claims administrator or the Director of Human Resources will make a decision promptly, but not later than 60 days after such individual receives your request for review. However, if there are special circumstances that require an extension of time for processing, a decision will be provided as soon as possible, but not later than 120 days after receipt of your request. The decision on this review will be in writing and will include specific reasons for the decision, written in a manner calculated to be understood by you, and specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within such period, the claim will be considered denied.

### **The Medical Spending Account**

Under this category are expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care and hearing care. Generally, the expenses covered must be “medically necessary”, or prescribed by a licensed physician to qualify. Covered expenses *do not include* premiums paid for other health plan coverage (including plans maintained by the employer of your spouse or dependents), expenses for non-reconstructive cosmetic surgery, nor do they include expenses for personal mileage.

One way to predict your reimbursable expenses is to look at your bills over the past couple of years. It is important not to overestimate your needs, because the tax law requires *unused amounts* in your spending accounts to be forfeited at the end of each Plan Year.

### **The Dependent Care Spending Account**

For this purpose, dependents are defined as children up to age 13, handicapped children or adults, or elderly individuals who rely upon you for financial support and are eligible to be claimed as an exemption on your federal tax return. If dependent care is required to enable you (a spouse or a single person) to work, these expenses may be eligible for reimbursement. Included are payments to child-care centers, nursery schools, kindergartens, and schools for children up to, but not including, first grade. Eligible expenses also include payment for summer day camps, after-school care, and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption, provided the relative is not a child under 19), or a non-relative, as long as such a person is reporting payments as income, is also eligible.

***Important Notice:*** You may be able to take a federal tax **credit** for eligible expenses up to \$3,000 (for one dependent) or \$6,000 (for more than one dependent). Additionally, the credit can equal 35% of eligible expenses and the credit is reduced after your adjusted income exceeds \$15,000. Any amounts deferred to a dependent care spending account will reduce dollar-for-dollar the maximum allowable expense under the tax credit.

## **SPENDING ACCOUNTS - OTHER FACTS TO CONSIDER**

In order to allow this unique opportunity to reduce your taxable income, the IRS has placed some restrictions on this type of benefit:

- Compensation deferrals authorized for both medical and dependent care expense reimbursement are in effect for the entire year unless you have a change in family status as detailed above.
- You must use all of the compensation deferrals in your Spending Account by the end of the Plan Year or you will lose them; the balances cannot be combined, carried over into the next year, or converted to cash. So, if you choose to open a Medical or Dependent Care Spending Account, it is wise to be conservative in your estimate of future reimbursable expenses.
- You will receive statements periodically to remind you how much money is left in your account. This money must be used for expenses incurred before the end of the Plan Year or it will be forfeited. You may continue to submit claims up to three months after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given three months from their date of termination in which to submit expenses incurred prior to their termination.

### **ABOUT SOCIAL SECURITY TAXES**

Social Security taxes are not deducted from the amount you pay in premiums on a pre-tax basis. This could result in a small reduction in the Social Security benefit you receive at retirement. This is because Social Security benefits are based on what you earned while you were working, up to the Taxable Wage Base ("TWB"). The TWB for 2003 is \$87,000 and is adjusted annually. If your compensation is above the TWB, your Social Security benefit is not likely to be affected. If your salary is below the TWB, the benefit would be reduced. The tax advantages you gain through the Plan may offset any possible reduction in Social Security benefits.

### **FUTURE OF THE PRE-TAX BENEFITS**

The Plan is based on the Employer's understanding of the current provisions of the Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

### **INSURANCE CONTRACTS**

Any monies refunded to the Employer due to an actuarial error in the rate calculation will be the property of and retained by the Employer.

### **NOT A CONTRACT OF EMPLOYMENT**

No provision of the Plan is to be considered a contract of employment between you and the Employer or any Participating Employers. The Employer's rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

### **QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order (QMCSO)." Basically, a QMCSO is a court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relations law which either

creates or extends the rights of an “alternate recipient” to participate in a group health plan, including this Plan, or enforces certain laws related to medical child support. An “alternate recipient” is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant’s group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if it receives a medical support order that applies to you and the Plan’s procedures for determining whether the medical child support order is qualified.

### **MATERNITY AND NEWBORN COVERAGE**

Since this Plan offers medical benefits that include maternity and newborn coverage, you are advised that under Federal law, this Plan may not restrict benefits (or fail to provide reimbursement) for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require authorization from this Plan or its Administrator or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, 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 a length of stay not in excess of 48 hours (or 96 hours).

### **WOMEN’S HEALTH AND CANCER ACT**

The Women’s Health and Cancer Act (“Women’s Health Act”) was signed into law on October 21, 1998. This law requires that all medical plans cover breast reconstruction following a mastectomy.

Under this law, if an individual who has had a mastectomy and elects to have breast reconstruction, the medical plan must provide the following coverage as determined in consultation with the attending physician and the patient.

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications at all stages of the mastectomy, including lymphedema.

Benefits received for the above coverage will be subject to any deductibles and coinsurance amounts required under the medical plan for similar services.

### **FAMILY AND MEDICAL LEAVE**

Under the federal Family and Medical Leave Act of 1993 ("FMLA"), you may take up to 12 weeks of unpaid leave during a 12-month period under certain circumstances with certain assurances of job security and health insurance benefits during the leave.

To be eligible for FMLA benefits, you must: (1) have at least twelve (12) months of service; and (2) have worked at least 1,250 hours during the 12-month period preceding the start of the leave. The Employer uses a rolling 12-month method to measure eligibility for requested leave. The 12-month period is measured backward from the date on which the leave is requested to begin.

### **Reasons for Leave**

Family and medical leave is available for the following reasons:

- the birth, adoption, or placement of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a "serious health condition" (as defined below); or
- for your own "serious health condition", which renders you unable to perform the essential functions of your position.

A "serious health condition" is an illness, injury, impairment or physical or mental condition that causes a period of incapacity for more than three calendar days plus "continuing treatment by a health care provider" (as defined below), or that involves: (1) inpatient care in a hospital, hospice or residential medical care facility; (2) incapacity due to a chronic serious health condition or a long-term condition; (3) incapacity due to pregnancy or prenatal care; or (4) absence for restorative surgery. The phrase "continuing treatment by a health care provider" means that the individual has been treated two or more times, either by, under the supervision of, or due to a referral by a health care provider, or has been treated on at least one occasion that results in a regimen of continuing treatment under the supervision of a health care provider.

### **Amount of Leave**

An eligible employee is entitled to a total of up to 12 weeks of family or medical leave in any 12-month period, measured on a rolling basis backwards from the date the leave in question begins. Each time you take family or medical leave, the remaining leave entitlement would be the balance of the 12 weeks that had not been used during the immediate preceding 12 months. If you and your spouse are employed by the Employer and are both otherwise eligible for family and medical leave, the two of you are entitled to a combined total of up to 12 weeks of family and medical leave for the birth, adoption, or placement for adoption or foster care of a child. Family and medical leave must be taken consecutively except that taking intermittent leave or working on a reduced schedule is permitted when medically necessary due to your own serious health condition or that of your spouse, child or parent.

### **Notice and Certification Requirements**

When the need for leave is known in advance, an application for leave should be submitted in writing to your supervisor at least 30 days before you want the leave to begin. When the need arises unexpectedly, notice should be given as soon as possible, at a minimum within two days of learning of the need for leave. If you request leave due to your own or a family member's serious health condition, you will be required to provide, within 15 days of the request, medical certification from a health care provider on an Employer-provided

form. Recertification of a serious health condition during leave and an update regarding your intent to return to work is required every 30 days in most cases. Your supervisor has the forms and related information or will know whom you need to contact to get them. Failure to comply with certification requirements will result in denial or revocation of family or medical leave.

### **Integration with Other Leave**

Family and medical leave runs concurrently with any one or more of the following types of leave: occasional absence, short-term disability, salary continuation, workers' compensation benefits, vacation and personal days. All accrued vacation, personal leave and sick days must be used as part of the family or medical leave. You will then be entitled to an additional period of leave on an unpaid basis for a combined total of 12 weeks leave. Even absent a request for family and medical leave, the Employer may designate an absence as family or medical leave and count it toward your statutory entitlement of 12 weeks if the Employer determines that the leave qualifies or may qualify as family or medical leave.

### **Benefits**

While on family or medical leave, your health insurance and other benefit coverage will continue under the same terms as if you were working, and you continue to be responsible for the same portion of your health insurance premiums and for payment(s) for other Employer benefit coverage as you paid before taking the leave. During unpaid family or medical leave, you must arrange for personal payment in accordance with the provisions of the applicable plans. If a required premium is not received within 30 days of the due date, the coverage may be dropped for the remainder of the leave. If you do not retain health benefits during a family or medical leave, coverage may be reinstated upon return from the leave on the same terms that were in effect prior to the leave, subject to any adjustments made for similarly situated employees, without any qualifying period, physical examination or exclusion for pre-existing conditions.

Except as required by COBRA, the Employer's obligation to maintain health benefits ceases upon any of the following:

- you inform the Employer of your intent not to return from leave;
- you elect not to continue health coverage during the leave;
- your required premium payment is delinquent by more than 30 days; or
- you fail to return after a family or medical leave is exhausted.

There will be no loss of seniority rights or any benefits accrued prior to the date on which leave is commenced. During a family or medical leave of absence, personal leave, sick time, holidays, and vacation time will not accrue unless otherwise determined by the Employer on a uniform and nondiscriminatory basis.

### **Return to Work**

With limited exceptions for certain "key employees," as defined by law, employees who timely return from family or medical leave, upon or prior to exhaustion of such leave, will be returned to their original or equivalent position, with equivalent pay, benefits and other employment terms. You may be required to provide a fitness-for-duty medical certification prior to returning to work if leave was taken for your own serious health condition. Such certification may also be required by the Employer whenever there is a question about fitness for duty. The Employer may require a second medical opinion, by a physician of its choice and at its expense. Given conflicting opinions, the Employer may require and pay for a third medical

opinion from a jointly selected physician. A voluntary election not to return to work will result in termination of health insurance and an obligation to repay any health insurance premiums paid by the Employer on your behalf during any period of unpaid leave. Repayment may not be required if the failure to return is due to a continuation, recurrence or onset of a serious health condition or other circumstances beyond the employee's control. As with any leave, a failure to return upon expiration of a family or medical leave may be treated as a voluntary resignation.

### **SUBROGATION**

This provision applies whenever someone else (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you for an *illness* or *injury* suffered by you or your dependent(s). In that case, you must reimburse the Plan for any benefits it paid relating to that *illness* or *injury*, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized). The reimbursement required under this provision will not be reduced to reflect any costs or attorney's fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan administrator in the exercise of its sole discretion.

Benefits relating to such *illness* or *injury* need not be payable by the Plan until you sign and return a statement, provided by the Plan, acknowledging your obligation to reimburse the Plan under this provision. (That obligation will arise upon the payment of any Plan benefits relating to the *illness* or *injury*, whether or not you sign such a statement.)

## BENEFIT TERMINATION

Your benefits will terminate in accordance with the following schedule. In addition to this schedule your benefits will terminate on the occurrence of the earliest of the following events:

- the termination of the Plan;
- the date the Plan is amended to terminate coverage with respect to a class of Employees or former Employees of which you are a member;
- the cessation of such Participant's qualification as an Eligible Employee as defined in this document or under an insurance contract listed on Schedule B;
- the revocation by such Participant of the election to participate in an Insurance Program because of a change in family status in accordance with the applicable insurance carrier's provisions; or
- the failure of such Participant to make any required contribution required by the Plan.

In addition to the above, if you are absent due an authorized leave of absence you may continue as a Participant for so long as such authorized absence continues in accordance with such rules and regulations as the Participating Employer may direct.

Benefit	Benefit Termination Due To:	Benefits End
Medical	Termination of Employment Reduction of Hours	End of the month, COBRA will then be offered.
	Disability	The date following 26 weeks of short-term disability (includes Family and Medical Leave under federal and state laws), COBRA will then be offered. If approved for long-term disability, then the date following 26 weeks of long-term disability, COBRA will then be offered.
	Death of Employee	End of the month, COBRA will then be offered. If COBRA is elected, the University will pay the full COBRA premium for the first 3 months of health care coverage to the dependents of the deceased employee.
Dental	Same as Medical	
Life	Termination of Employment Reduction of Hours	End of the month, conversion will then be offered.
	Disability	If eligible for waiver of premium, life benefits will continue under the provisions of the life carrier's waiver of premium provision. If not eligible for waiver, benefits terminate on the date following 26 weeks of disability. Conversion will then be offered.
Long Term Disability	Termination of Employment Reduction of Hours	Date of termination or the date your regularly scheduled work hours are below the hours required for benefits. Conversion will then be offered.

## COBRA

If you are covered under one of the Employer's group health plans you shall have the right to choose continuation of coverage if you lose group health coverage for any reason other than termination due to gross misconduct. Your spouse or eligible dependents, including children born or adopted during the COBRA coverage period, covered under the employer's group health plan shall have the right to continuation coverage for themselves if they lose group health coverage under the group health plan for any of the following reasons:

- your death;
- the termination of your employment (for reasons other than gross misconduct) or reduction in your hours of employment;
- your divorce or legal separation;
- you become entitled to Medicare; or
- the dependent ceases to be a "dependent child" under the terms of the group health plan.

The continuation coverage will not be conditioned on a physical examination or other evidence of insurability, and will be identical to the coverage provided to similarly situated employees or family members.

Under this law, you must notify the Employer within 60 days of the event in the case of divorce, legal separation, or a child losing dependent status under the group or you will lose your rights to continuation coverage because of these events. Once the Employer has notified you of your COBRA rights and the cost, if any, for continuation coverage, you will have 60 days to respond from the date of notice or the date of the event, whichever is later. You then will have 45 days to pay for any required premium. The law permits the Employer to charge any person who elects to continue coverage 102% of the full cost to the Plan.

The continuation coverage will extend your plan coverage for either 18 months, in the event you lose benefits due to termination (except for gross misconduct) or reduction in hours; or 36 months for your spouse and dependents in the event of your death, divorce, entitlement to Medicare, or if a dependent child no longer qualifies as a dependent under the health plan.

The 18-month coverage period may be extended if any event which would otherwise qualify you or your eligible dependents for the 36-month coverage period occurs during the 18-month period. Coverage cannot continue longer than 36 months from the initial qualifying event.

Also, if you or your eligible dependent(s) are disabled (within the meaning of the Social Security Act) on or within 60 days of the date of the qualifying event, the disabled individual may qualify for an 11-month extension of the continuation period. To qualify for this extension, two things must happen during the initial 18-month continuation period.

1. A disability determination letter must be obtained from the Social Security Administration; and
2. Within 60 days of receiving the determination, notification must be provided to the Employer.

COBRA permits the Employer to charge up to 150% of the full cost of the Plan during the 11-month extension period.

Further, continuation of coverage can be terminated sooner than the specified periods if the Employer no longer provides a group health plan; if the premium for such coverage is not paid on time; if you become covered under another group health plan after electing COBRA; you become entitled to Medicare after electing COBRA; or, you are no longer determined to be disabled during the 11-month extension.

However, if you become covered under another group plan, but are denied coverage or given limited coverage for a pre-existing condition, continuation coverage may remain in effect for the earlier of 18 months or until the date the pre-existing condition becomes covered under the new plan.

## **CLAIMS PROCEDURES**

In most instances, claims for benefits will be handled under the claims procedures set forth in the booklets prepared by the insurance carriers or claims administrators that are providing/administering benefits under the Plan. To the extent that the claims procedures in these booklets do not apply, however, the following claims procedures will be used for claims related to healthcare.

Most claims that are submitted with all required information will be processed and paid within a few days after the Claims Administrator receives completed proof of expenses incurred. Further, if a claim cannot be paid, the Claims Administrator will promptly explain why.

The Claim Administrator will notify you of the benefit payment determination in accordance with the following situations.

### ***Urgent Care Claims***

If the claim involves the need for urgent care, the Claim Administrator will notify you of the Plan's benefit determination (whether to pay or not) within 72 hours after receipt of the claim unless you do not provide enough information to determine how or if the claim should be paid. You will be notified within 24 hours if the claim did not have all the necessary information and what additional information is needed to process the claim. You will have at least 48 hours to provide any additional information. Once all the information is submitted a claim determination will be made no later than 48 hours from the earlier of the following:

- The Plan's receipt of the required information; or
- The end of the period given to you to provide the additional information.

### ***Concurrent Care Claims***

If a claim is for services for a Plan approved ongoing course of treatment that will be provided over a period of time or requires a number of treatments, the following will apply.

- If the Plan determines that there should be a reduction in treatment or a termination of treatment other than by a Plan amendment or the termination of the Plan before treatment ends, you will be notified in enough time to appeal this decision before treatment is actually reduced or terminated.
- Any request to extend treatment beyond the originally approved number of treatments or period of time for a claim involving urgent care will be determined within 24 hours of the request unless the claim is submitted less than 24 hours before the treatment is to end.

- Appeals and requests for additional information will be the same as described under All Other Medical Claims, unless the claims relates to an urgent care claim, in which case, it will be the same as described under urgent care.

### *All Other Medical Claims*

If a claim does not involve urgent care or ongoing treatment for urgent care the following policy will apply

#### 1. Pre-Service Claims

- You will be notified within 15 days of the decision to approve or not approve a claim; however,
- This period can be extended for up to another 15 days if there are matters beyond the control of the Plan. In such cases, you will be notified of this in the first 15-day period and when a decision will be made; however,
- If an extension of time is due to not enough information being submitted to make a decision, you will be given at least 45 days to submit this information.

#### 1. Post-Service Claims

- You will be notified within 30 days after receipt of the claim if the Plan is not going to pay the claim; however,
- This period can be extended for up to another 15 days if there are matters beyond the control of the Plan. In such cases, you will be notified of this in the first 15-day period and when a decision will be made; however,
- If an extension of time is due to not enough information being submitted to make a decision, you will be given at least 45 days to submit this information.

Notices of denial will include the specific reason(s) for the denial, the specific Plan provisions upon which the denial is based, a description of any additional material or information necessary for you to prove the claim and an explanation of why such material or information is necessary.

To appeal a denied claim, you should request a review of your claim in writing within:

- (i) 60 days after receipt of a Notice of Denial with respect to a Health Claim resulting from a determination by the Plan Administrator to reduce or terminate benefits approved under previously filed Health Claim.
- (ii) 180 days after receipt of a Notice of Denial with respect to any other Health Claim.

You will then be given an opportunity to review pertinent documents and submit questions and comments in writing. The request for review must explain the reasons for the request and should be directed to the Claims Administrator. A written decision on the request for review will be made within 60 days of the receipt of the request for review, or within 120 days under special circumstances that require an extension of time for processing. If special circumstances prevent a decision from being made within 60 days, you will be notified in writing of the extension prior to the commencement of the extension. The decision on the review will be sent to you in writing and will include the specific reasons for the decision and the Plan provisions upon which the decision is based. If you still feel that you were improperly denied a benefit under the Plan, further appeal can be made to the Plan Administrator. It must be made within 60 days

after receipt of the denial of claim by the Claims Administrator. The Plan Administrator will then follow the same procedures as in the initial review process.

### **Initial Claim for Benefits**

If you disagree with the decision, you may appeal the denial to the Employer. To appeal a denied claim, you should request a review of your claim in writing within:

(i) 60 days after receipt of a Notice of Denial with respect to a Health Claim resulting from a determination by the Plan Administrator to reduce or terminate benefits approved under previously filed Health Claim.

(ii) 180 days after receipt of a Notice of Denial with respect to any other Health Claim.

For purposes of the review, you have the right to:

- the specific reason or reasons for the denial;
- specific reference to the Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order to present a thorough appeal and an explanation of why such material or information is needed; and
- an explanation of the claim appeal procedure and time limits applicable to the procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA after a denial on appeal.

If the Employer needs more than 60 days to review your claim for benefits, you will be advised in writing within 60 days after the Employer receives your claim. The notice will tell you why the Employer needs more time (which cannot exceed an additional 60 days), and the date by which you can expect a decision.

### **Appeal of Denied Claim for Benefits**

If you disagree with the decision, you may appeal the denial to the Employer. To appeal a denied claim, you should request a review of your claim in writing within:

(i) 60 days after receipt of a Notice of Denial with respect to a Health Claim resulting from a determination by the Plan Administrator to reduce or terminate benefits approved under previously filed Health Claim.

(ii) 180 days after receipt of a Notice of Denial with respect to any other Health Claim.

For purposes of the review, you have the right to:

- submit written comments, documents, records and other information relating to the claim for benefits;
- request, free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it: (1) was relied upon in making the benefit decision; (2) was submitted, considered or generated in the course of making the benefit decision, regardless of whether it was relied upon in making the benefit decision; or (3) demonstrates compliance with the administrative processes and safeguards required in making the benefit decision; and

- a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether the information was submitted or considered in the initial benefit decision.

The denied claim will be reviewed by the Employer and within 60 days after receipt of the request for review you will receive a written notice of the Employer's decision. The notice will:

- provide the specific reason(s) for the denial;
- refer to the provisions of the Plan on which the denial is based;
- contain a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim; and
- describe any voluntary appeal procedures offered by the Plan and your right to obtain information about the procedures, and a statement of your right to bring an action under Section 502(a) of ERISA.

If the Employer needs more than 60 days to review the denied claim, you will be advised in writing within 60 days after the Employer receives the request for review. The notice will tell you why the Employer needs more time (which cannot exceed an additional 60 days), and the date by which you can expect a decision. If you do not agree with the decision of the Employer, you may bring legal action in Federal District Court. You cannot bring legal action unless your claim has been reviewed and denied by the Employer or the Employer has failed to follow reasonable claims procedures, as described above.

#### **COMPLIANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)<sup>1</sup>**

The information furnished herein together with the insurance carrier's booklet constitutes the Summary Plan Description required by federal law. To comply with the law, the following additional information is also furnished.

##### *Name and Identification Number of Plans*

Bucknell University's Health and Welfare Plan, Plan Number 510

##### *Participants*

The plans provide benefits for all employees of Bucknell University who meet the eligibility requirements described herein.

##### *Plan Sponsor*

Bucknell University  
Lewisburg, PA 17837  
(570) 577-1631

##### *Plan Administrator*

Bucknell University  
Lewisburg, PA 17837  
(570) 577-1631

---

<sup>1</sup> Dependent care assistance plans are not covered under the Employee Retirement Income Security Act (ERISA)

*Employer Identification Number (EIN)*

24-0772407

*Type of Plans*

Section 105 - Medical Spending Account Plan  
Section 106 – Insured Welfare Plan  
Section 125 - Pretax Benefit Plan  
Section 129 - Dependent Care Spending Account Plan

*Agent for Service of Legal Process*

Bucknell University  
Lewisburg, PA 17837  
(570) 577-1631

*Plan Year*

January 1 - December 31

*Plan Definition and Funding*

Insured benefits are classified by the Department of Labor as “welfare” plans. Additionally, the Plan was also established to meet the requirements of a Section 125 plan classified as a "Cafeteria" Plan and includes a section 105 Health Care Spending Account and a section 129 Dependent Care Spending Account under the IRC. The Plan is funded by both employer and employee contributions.

**ERISA RIGHTS STATEMENT**

As a participant in the Health and Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) for insured benefits and Medical Spending Account 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.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation 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 health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

**SCHEDULE A**

**SCHEDULE OF BENEFITS**

**Non-Contributory Benefits**

Basic Life  
Basic Accidental Death and Dismemberment  
Long Term Disability

<b>Contributory Benefits (1)</b>	<b>Employee cost per pay</b>	<b>Tax Status (3)</b>
----------------------------------	------------------------------	-----------------------

*Medical*

Single	(2)	Pre-tax
Employee + 1	(2)	Pre-tax
Family	(2)	Pre-tax

*Dental*

Single	(2)	Pre-tax
Employee + 1 Adult	(2)	Pre-tax
Employee + Child(ren)	(2)	Pre-tax
Family	(2)	Pre-tax

Voluntary Life	(2)	Post-tax
----------------	-----	----------

*Medical Spending Account*

*See Schedule C*

*Dependent Care Spending Account*

*See Schedule C*

- (1) The exact insurance provider and plan benefits offered will be communicated to Participants at the beginning of the Plan Year and to Employees when they first become eligible for the Plan.
- (2) The exact amount of any required contributions will be communicated to Participants at the beginning of the Plan Year and to Employees when they first become eligible for the Plan.
- (3) Plan Participants can elect to contribute on either a pre-tax or post-tax basis for these benefits.

**SCHEDULE B**

**INSURANCE CARRIERS AND CLAIMS ADMINISTRATORS <sup>(1)</sup>**

Carrier	Contract Number	Funding	Benefits Covered	Contributions
Geisinger Health Plan P.O. Box 8200 Danville, PA 17822-8200 1-800-498-9731 or 1-800-447-4000 www.thehealthplan.com	1018200007, 1018200002,	Fully Insured	Medical	Contributory – Pre-tax or Post-tax Basis
Highmark Blue Shield P.O. Box 890052 Camp Hill, PA 17089-0052 1-800-345-3806 www.highmarkblueshield.com	28878-00, 28878-01, 28878-02, 28878-20, 28878-21, 28878-22, 28878-70, 28878-71, 28878-72	Fully Insured	Medical & Prescription Drug	Contributory – Pre-tax or Post-tax Basis
Pennsylvania Manufacturers’ Association Insurance Company (PMA) 380 Sentry Parkway Blue Bell, PA 19422-0754 1-888-476-2669 www.pmagroup.com	100350-0010	Fully Insured	Long Term Disability	Non-Contributory
American International Group, Inc. (AIG) 1-877-638-4244		Fully Insured	Basic Life and AD&D	Non-Contributory
American International Group, Inc. (AIG) 1-877-638-4244		Fully Insured	Voluntary Group Term Life, PAI	Post-tax Basis
United Concordia 4401 Deer Path Road Harrisburg, PA 17110 1-800-332-0366 www.unitedconcordia.com	833511000	Fully Insured	Dental	Contributory – Pre-tax or Post-tax Basis
FlexAmerica, Inc. 6500 Rock Spring Drive Suite 105 Bethesda, MD 20817 1-301-530-9400 www.flexamerica.com			Spending Accounts	Contributory – Pre-tax basis

<sup>(1)</sup>As of January 1, 2006

**SCHEDULE C  
SPENDING ACCOUNTS  
SCHEDULE OF BENEFITS**

	Employee Election (1)	
	<u>Minimum</u>	<u>Maximum</u>
<b>Medical Spending Account</b>	\$0.00	\$3,000
<b>Dependent Care Spending Account</b>	\$0.00	\$5,000

<sup>(1)</sup> Per Plan Year

**SCHEDULE D  
PARTICIPATING EMPLOYERS\***

Bucknell University

\* As of January 2003