

**ALLEGHENY COLLEGE**  
**Summary Plan Description**  
**For**  
**Medical, Dental, Vision, Life/AD&D**

**Amended and Restated Effective**

**July 1, 2003**

This document with the attached documents listed on the final page, constitute the written plan document required by ERISA §402 and the Summary Plan Description required by ERISA §102.

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## 1. Definitions

Capitalized terms used in the Plan have the following meanings:

|                           |   |
|---------------------------|---|
| <b>COBRA</b>              | “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.   |
| <b>Code</b>               | “Code” means the Internal Revenue Code of 1986, as amended.   |
| <b>College</b>            | “College” means Allegheny College.  |
| <b>Employee</b>           | “Employee” means any common-law employee of the College who satisfies the eligibility provisions of Section 4 and is not excluded from participation by the terms of an applicable component benefit program. |
| <b>ERISA</b>              | “ERISA” means the Employee Retirement Income Security Act of 1974, as amended.  |
| <b>HIPAA</b>              | “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.  |
| <b>NMHPA</b>              | “NMHPA” means the Newborns’ and Mothers’ Health Protection Act of 1996, as amended.   |
| <b>Plan</b>               | “Plan” means this Allegheny College Medical Expense Benefits Plan.  |
| <b>Plan Administrator</b> | “Plan Administrator” means Allegheny College.   |
| <b>WHRCA</b>              | “WHRCA” means the Women’s Health and Cancer Rights Act of 1998, as amended.   |

## 1. Introduction

The College established and maintains the Plan for the exclusive benefit of its eligible employees and their spouses and dependents. The plan provides benefits through the following component benefit programs:

- Medical (Attachment 1)
- Dental (Attachment 2)
- Vision (Attachment 3)
- Life (Attachment 4)
- Accidental Death and Dismemberment (Attachment 4)

These component benefit programs require you to make an annual election to enroll for coverage. Each of these component benefit programs is summarized in a certificate of insurance, benefit booklet or a description of benefits issued by an insurance company. A copy of each booklet or other document is attached to this document in Attachments #1 through #4 as noted above.

This document and its Attachments constitute the plan document required by ERISA §402 and the summary plan description for each of the component plans as required by ERISA §102.

## 3. General Information About the Plan

### Facts

|                        |  |
|------------------------|--|
| <b>Plan Name:</b>      | Allegheny College Medical Expense Plan.  |
| <b>Type of Plan:</b>   | Welfare plan providing medical, dental, vision, life and accidental death and dismemberment benefits.                        |
| <b>Plan Year:</b>      | July 1 to June 30.   |
| <b>Plan Number:</b>    | 503  |
| <b>Effective Date:</b> | August 1, 1978. The Plan has been amended several times since its original effective date, most recently as of July 1, 2003. |

Funding Medium and  
Type of Plan

Administration:

This plan is fully insured. Benefits are provided under group insurance contracts entered into between Allegheny College and various insurance companies listed below. Claims for benefits are sent to the Insurance Companies. The Insurance Companies and not Allegheny College are responsible for paying claims. Note that the Insurance Companies and Allegheny College share responsibility for administering the plan.

Insurance premiums for employees and their eligible family members are paid in part by the Plan Sponsor out of its general assets and in part by employees' pre-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable.

Plan Sponsor:

Allegheny College  
520 North Main Street  
Meadville, PA 16335-3903  
814-332-3100

Plan Sponsor's  
EIN:

25-0965212

Insurance Companies:

Highmark Blue Cross Blue Shield (Active and Retiree PPO Blue)  
One Fifth Avenue Place  
Pittsburgh, PA 15222  
1-800-235-4999

United Concordia Companies, Inc. (Dental)  
100 Senate Avenue  
Senate Plaza  
Camp Hill, PA 17011  
1-412-544-2346

Vision Benefits of America (Vision)  
300 Weyman Plaza  
Pittsburgh, PA 15236-4900  
1-412-881-4900

Hartford Insurance Company (Life and AD&D)  
900 SW Fifth Avenue  
Portland, OR 97204  
1-503-321-7000

Plan Administrator:

Allegheny College  
Office of Human Resources  
520 North Main Street  
Meadville, PA 16335-3903  
814-332-2312

Named Fiduciary:

Allegheny College  
520 North Main Street  
Meadville, PA 16335-3903  
814-332-3100

Agent for Service of  
Legal Process:

Director of Human Resources  
Allegheny College  
520 North Main Street  
Meadville, PA 16335-3903  
814-332-3100

Service for legal process may also be served on the Plan Administrator.

Plan Document: The Plan and its attachments constitute the written plan document required by ERISA §402.

**Important Disclaimer:** Benefits hereunder are provided pursuant to insurance contracts or pursuant to a governing plan document adopted by the College. If the terms of this document conflict with the terms of such insurance contracts or governing plan document, then the terms of the insurance contracts or governing plan document will control, rather than this document, unless otherwise required by law.

#### 4. Eligibility and Participation Requirements

##### Eligibility and Participation

An eligible employee with respect to the Plan will be any common law employee of the College who is eligible to participate in and receive benefits under one or more of the component benefit programs. To determine whether you or your family members are eligible to participate in a component benefit program, please read the eligibility information contained behind the Attachments for the applicable component benefit programs. A summary of this information is set forth below.

| <b>Summary of Eligibility and Participation Provisions</b> |                         |   |
|--|-------------------------|---|
|  | <b>Who is Eligible</b>  | <b>When Participation Begins</b>                    |
| Active Medical   | Employee and Dependents | First day of the month following date of hire       |
| *Retiree Medical (includes retirees on Phased Retirement)  | Retiree and Dependents  | First day of the month following date of retirement |
| Active Dental  | Employee and Dependents | First day of the month following date of hire       |
| Active Vision  | Employee and Dependents | First day of the month following date of hire       |
| Active Life  | Employee                | First day of the month following date of hire       |
| Active AD&D  | Employee                | First day of the month following date of hire       |

\*\*Retiree Medical” applies to any employee who retires at age 58 and with 10 years of continuous full-time employment immediately upon retirement date. If an employee satisfies both conditions, the College considers the employee a “retiree.” The same medical coverage provided to active employees will continue for the retiree until the age of 65. If a spouse is under age 65 at the time the retired employee turns age 65, the spouse would be offered continued medical coverage under COBRA for 36 months, or until age 65, whichever occurs first.

## **Termination of Participation**

Your participation and the participation of your eligible family members in the Plan will end based on the date upon which you terminate employment with the College. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims or for any other reason as set forth in the certificate of insurance, benefit booklets, benefit summaries, or other governing documents for the component benefit program. You should consult the applicable Attachments for specific termination events and information.

## **COBRA Rights**

If medical, dental or vision coverage for you or your eligible family members ceases because of certain “qualifying events” specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child ceasing to meet the definition of “dependent”), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. If you have any questions about your COBRA rights, please read the COBRA Notification Form, a copy of which has been previously furnished to you and your spouse (if covered). Please contact the Plan Administrator if you need another copy.

Any or all plans in which a qualified beneficiary participated in the day before the qualifying event may be elected.

## **5. Summary of Plan Benefits**

### **Benefits and Contributions**

The Plan provides you and your eligible dependents (if applicable), with medical, dental, vision, life and accidental death and dismemberment insurance. A summary of each benefit provided under the Plan is set forth in the attached certificate of insurance, benefit booklet or other governing document behind the applicable Attachment.

The cost of the benefits provided through the component benefit programs may be funded in part by College contributions and in part by employee pre-tax contributions. Please contact the Office of Human Resources for specific contribution rates required for each benefit plan. The College will determine and periodically communicate your share of the cost of the benefits provided through each component benefit, and it may change that determination at any time.

The College will pay its contributions and your contributions to an insurance carrier(s) to pay benefits directly to or on behalf of you or your eligible family members from the College’s general assets.

The Plan will provide benefits in accordance with the requirements of all applicable laws, such as COBRA, HIPAA, NMHPA and WHCRA.

**Qualified Medical Child Support Orders**

The Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA §609(a)), and will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants and beneficiaries, in accordance with ERISA §609(c). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

**Benefits for Adopted Children**

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

**Special Rights on Childbirth**

Group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. 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 the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

**6. How the Plan Is Administered**

**Plan Administration:**

The administration of the Plan is under the supervision of the Plan Administrator. The Director of Human Resources is the person who has been designated to act on behalf of the Plan Administrator.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under the Plan.

The College will bear its incidental costs of administering the Plan.

**Power and Authority Of Insurance Companies:**

Benefits under the Plan are fully insured. Group Insurance Contracts with the various companies listed above provide medical, dental, vision, life and AD&D benefits.

**Questions:**

If you have any general questions regarding the Plan, please contact the Director of Human Resources, who acts on behalf of the Plan Administrator.

If you have any questions regarding your eligibility for, or the amount of, any benefit payable under the plan, please contact the appropriate insurance company.

**7. Circumstances Which May Affect Benefits**

**Denial or Loss of Benefits**

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates according to Section 4.

Your benefits will also cease on termination of the Plan.

Other circumstances can result in the termination, reduction, or denial of benefits. You should consult the certificate of insurance, benefit booklets and other governing documents in the applicable Attachments for additional information.

**8. Amendment of Termination of the Plan**

**Amendment or Termination**

The College, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the College or any of its delegates

The Vice President of Finance and Planning of the College may sign insurance contracts for this Plan on behalf of the College, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

**9. No Contract of Employment**

**No Contract of Employment**

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the College to the effect that you will be employed for any specific period of time.

**10. Claims Procedures**

**Claims for Fully Insured**

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative remedies, which is generally a prerequisite to bringing a suit in state or federal court.

See the attached certificate of insurance, benefit booklet or other governing document for more information about how to file a claim and for details regarding the insurance company's claims procedures.

If an insurance company denies your claim, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth: (i) the specific reason(s) for the denial; (ii) reference to the specific Plan provision on which the denial is based; (iii) a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and (iv) appropriate information as to the steps to be taken if you wish to appeal the determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim and exhausting all internal administrative remedies.

### **Appealing Denied Claims**

If your claim is denied in whole or in part, you may appeal to the insurance company for a review of the denied claim. Your appeal must be made in writing within 180 days (60 days for life insurance) of the initial notice of adverse benefit determination, or else you will lose the right to appeal your denial. If you do not appeal on time, you will lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information relevant to your appeal.

### **Review of Appeal**

The insurance company will review and decide your appeal within a reasonable time not longer than 60 days (45 days for disability plans) after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The insurance company may secure independent medical or other advice and require such other evidence as it deems necessary to decide your appeal, except that any medical expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth: (i) the specific reason(s) for the denial; (ii) the specific Plan provision(s) on which the decision is based; (iii) a statement of your right to review (on request and at no charge) relevant document and other information; (iv) if the insurance company relied on an "internal rule, guideline, protocol, or other similar criterion in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request"; and (v) a statement of your right to bring suit under ERISA §502(a).

## 11. Statement of ERISA Rights

### Your Rights

As a participant in an ERISA plan you are entitled to certain rights and protections under ERISA. ERISA provides that, as a participant, you are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor (if any) such as annual reports and Plan descriptions;
- Obtain copies of the component benefit program documents and other program information on written request to the Plan Administrator (the Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, if any (the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report).

### Fiduciary Obligations

In addition to creating rights for participants, ERISA imposes duties on the people who are responsible for the operation of the component benefit program. These people, called "fiduciaries" of the program, have a duty to operate the program prudently and in the interest of you and other program participants. Fiduciaries who violate ERISA may be removed and may be required to make good any losses they have caused the program.

### No Discrimination

No one, including the College or any other person, may fire you or discriminate against you in any way with the purpose of preventing you from obtaining welfare benefits or exercising your rights under ERISA.

### Right to Review

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.

### Filing Suit

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted all administrative remedies, you may file suit in a state or federal court.

If it should happen that component benefit fiduciaries misuse the Program'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 (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

### Questions

If you have any questions about this statement or your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

**ATTACHMENTS:**

- |                      |   |
|----------------------|---|
| <b>Attachment #1</b> | <b>Highmark Blue Cross Blue Shield (Medical)</b>  |
| <b>Attachment #2</b> | <b>United Concordia (Dental)</b>                  |
| <b>Attachment #3</b> | <b>Vision Benefits of America (Vision)</b>        |
| <b>Attachment #4</b> | <b>Hartford Insurance Company (Life/AD&amp;D)</b> |